Introduction to Social Work Documentation

Social work documentation, like any good writing, is a skill that is built. "You might believe that good writing comes naturally for some people, but even for the experienced writer, it is hard work" (Szuchman & Thomlison, 2008, p. xi).

The online Cambridge Dictionary (n.d.) defines *documentation* as the "activity of recording facts related to a particular subject." In social work, its meaning is more specific. The term is well known to students and practitioners alike, despite the fact that it does not appear in the sixth edition of *The Social Work Dictionary* (Barker, 2014). It is a communication tool with which social workers record their work; the means by which cases are managed; and the manner in which services are evaluated, assessed, and often reimbursed. It is a required professional social work function, a permanent record of client service provision. One study asked social workers to estimate the amount of time they spent writing each day; they reported 50 percent or more (Lillis et al., 2020). While not often acknowledged, the reality is that social work today is a writing-intensive profession. "It is a crucial daily activity for social workers" (McDonald et al., 2015, p. 360). In all practice settings with all types of clients, social workers spend significant time and effort writing (Thomas et al., 2016). It can be helpful to think about records as being subject to activities performed over time. These activities may include "creating, storing, using, changing, sharing, redacting, destroying, and providing or withholding access" (Hoyle et al., 2019, p. 1860).

Despite so much time spent documenting, social workers often have a negative response to documentation—it is the bane of many professionals' existence. To many social workers, it means spending time away from their true passion of working with clients, responding to unnecessary bureaucratic demands, and tending to tedious and boring details. Overworked social workers do not appreciate the requirement for case recording and often delay the task. The phrase "If it's not documented, it's not done" is commonly used to encourage better documentation habits, but the particulars of how to do so are less well noted.

The lack of appreciation for case recording is nothing new. Colcord and Mann (1930) wrote that "the charity organization group learned early to keep records, and some of their number, as time went on, became very much dissatisfied with the clumsy way of doing things revealed by these records" (p. 585).

HISTORY OF DOCUMENTATION

From the beginning of organized social work, efforts were made to record information about clients. Often, these notes were kept in public files in local offices and had minimal content (Strode, 1940). Timms (1972) noted that early recording of service delivery took the form of a registry in which poor-relief workers entered the name of the client; the amount of cash assistance provided; the client's residence; and a few remarks such as "destitute," "very aged," or "large family." These cursory notes were often the only record of service delivery.

The next phase of documentation, beginning in the second half of the 19th century, was characterized by more detail and verification of key facts (Timms, 1972). Guidelines presented at the first national Conference of Boards of Public Charities in 1874 illustrate this type of documentation. They advised including the following items in the record:

- Kinds of mental and moral perversion;
- Descriptions of morbid and debasing conditions of the mind;
- Points at which neglect of social and moral duties began;
- Information regarding the totally idiotic or weak-minded in three generations, living and dead;
- Total inebriates in three generations, living and dead; and
- Capacity for self-support without the direction and control of a superior authority or constant advice and supervision. (Conference of Boards of Public Charities, 1874, pp. 88–89)

Documentation content has changed since 1874, but it is still a work in progress for the profession. In 1922, Mary Richmond wrote that "the habit of full recording is not yet well established" (p. 30). Depending on the location in which services were provided, the habit seemed to vary widely. In the same year that Richmond wrote these words, Josephine Brown, a pioneer in rural social work, advised against keeping notes on services delivered: "The taking of notes is even less advisable in the country than in the city. . . . Unless some obvious reason for using paper and pencil exists—such as securing information for the court—notes are out of the question" (Brown, 1922, p. 188).

Disagreeing with Brown five years later was Harold J. Mathews (1927/1980):

One of the greatest sins of the rural case worker, which she is more guilty of than the city worker, is that she does not keep as good records. Too many times we find them with only copies of letters and a few ragged notes, if anything at all. This is not fair to the profession and the development of the

work in rural sections, to say nothing of being unfair to the client and the next case worker who comes along. It is bad business to say the least. (p. 172)

In 1932, Brown wrote this of rural case records: "If any information about a family receiving relief is on record anywhere, it may be in the pocket notebook of a county supervisor" (p. 17). Clearly, inconsistency and loose practices seemed to be prevalent and accepted.

Case notes were a challenge for more than just rural social workers. When the Federal Emergency Relief Administration was established in 1933, there was an immediate need to obtain information about relief given to the unemployed and their families across the United States. A research division tasked with developing a standardized means of reporting relief statistics was created for the first time in the country's history:

> There were in existence few satisfactory state systems for reporting the numbers of relief recipients and the amounts of expenditures. As a result, a vague uncertainty prevailed concerning the size of the relief problem. . . . Little was known about the characteristics or composition of the relief population. (Brown, 1940, p. 194)

In 1934, poor-relief workers still kept little or no permanent record of their services:

> Check book stubs, loose sheets of paper, duplicate order blanks, and pocket note books are frequently the only evidence of such uses to which public funds have been put. In several instances even such informal memoranda are lacking. Some poor directors have destroyed their records upon going out of office. (Pennsylvania Department of Public Welfare, 1934, p. 87)

Records were often inadequate and inaccurate. Before 1937 and the passage of the Public Assistance Law, 967 people were responsible for the administration of poor relief in Pennsylvania's 425 established districts. The organization of relief in Pennsylvania was likely not unique. Administrators there maintained very few records, which were described as

> usually fragmentary and unsatisfactory. . . . They supplied but little information regarding relief expenditures or the circumstances of the recipients which justified helping them with public funds. The records often consisted of no more than the lists of names of relief recipients which were printed in annual reports of the county government or in the newspapers, supplemented by the financial reports of the county treasurers which gave unitemized amounts of grocers' bills and the accounts of other tradesmen who furnished goods to the poor. (Brown, 1940, pp. 15–16)

In the late 1930s, the trend in social work documentation turned from scant notes to process recordings (Timms, 1972). Although never practiced on a day-to-day basis, process recordings signified an attempt to document everything. From

there, the pendulum swung back to a compromise between keeping a simple register and detailing everything: differential recording, which involved selectively choosing what was considered the most important content to record. A narrative summary account of services provided, based on the unique nature of the case, gradually emerged.

By the mid-1950s, the selective and analytic diagnostic record was widely used (Kagle, 1984b). This type of record existed primarily to show the worker's supervisor how the case was being approached. Changes in the 1960s and 1970s included an increased demand for accountability, early computer technology, and new complexities in service funding, all of which had an impact on the record-keeping practices of social workers. A survey conducted in 1979 and 1980 revealed that educational supervision was no longer the primary function of social work records. They were being used increasingly for purposes such as ensuring continuity of services, evaluating the effectiveness of service delivery, and enabling professionals involved with the same client to communicate with one another (Kagle, 1984b). Audiences included other service providers, clients, and funding sources. During this period, the conviction emerged that no single approach to documentation met each need in every case (Timms, 1972). This new approach stressed flexibility based on the client's situation and agency requirements.

Although no one recording formula will be effective in all cases, a systematic approach to documentation can be helpful, particularly for inexperienced workers and for seasoned professionals working with a new population. Despite a great deal of variety in today's documentation styles, one point remains clear: Documentation is essential to the effectiveness of social workers and the well-being of their clients.

HISTORY OF EFFORTS TO TEACH DOCUMENTATION

Three books were written about case documentation between 1920 and 1936 (Timms, 1972)—more titles than at any other time. Sheffield's (1920) *The Social Case History: Its Construction and Content* identified three purposes for documentation: improving client treatment, advancing and improving society, and enhancing the worker's critical thinking skills. Bristol's *Handbook on Social Case Recording* and Hamilton's *Social Case Recording* were published in 1936. Hamilton (1936) argued that standardization of record keeping was impossible: "There is no such thing as a model record, no routines which will make the case inevitably clear, accessible, and understandable. Records should be written to suit the case, not the case geared to a theoretical pattern" (p. 2). Hamilton predicted that practice and documentation skills would develop simultaneously, a notion that is also prevalent today.

More recent books were written by Timms in 1972 (*Recording in Social Work*) and by Wilson in 1980 (*Recording Guidelines for Social Workers*). Both offered practical guidelines on elements of recording. Kagle's *Social Work Records* followed in 1984; it is currently in its third edition (Kagle & Kopels, 2008). Although many social work practice texts include introductory material on documentation skills and methods (for example, Kirst-Ashman & Hull, 2020; Sheafor & Horejsi, 2015), practical recording guidelines are not included.

Documentation should matter to every practicing social worker and every student considering entry into the profession. It is a vital professional responsibility in which ongoing training is needed. Lyman and Unger (2017) made the point that much of a social worker's life is impossible to schedule and plan. However, documentation of services provided is something that a social worker can control. It does not need to become a stress point if adequate training has occurred. This book provides specific training on documentation to help social workers prepare for and manage their record-keeping responsibilities.

SUMMARY

Wide disparity in note-taking has been evident from the social work profession's beginnings. Today's documentation looks different from the notes written by early social work pioneers, and its importance is probably greater today than it was in the past. Both practitioners and their clients will benefit if social workers receive detailed instruction on the basic requirements of documentation.