SMICA
SERIOUS MENTAL ILLNESS
CALIFORNIA ADVISER

Your Words Matter: A Guide to Bias-Free and Effective Documentation

Clinical documentation serves multiple purposes within forensic mental health systems. It is a record of patient care, a communication tool among multidisciplinary team members, a legal document, and often a source of information reviewed and cited by courts, attorneys, oversight agencies, and external reviewers.

This guide provides tips for mastering documentation that is accurate, descriptive, concise, clinically relevant, and defensible while minimizing bias, stigma, and unsupported conclusions.

The Three Pillars of Effective Documentation

Pillar	Ask Yourself	Instead of This	Write This
Accurate & Descriptive	What did I *see* and *hear*?	"Patient is paranoid."	"Patient stated, 'People are following me,' and frequently looked over his shoulder."
Concise	Can I say this in fewer words?	"At this point in time, the patient is currently refusing to attend the group."	"Patient did not attend the AM group."
Neutral & Person-First	Am I labeling the person or describing the situation?	"The schizophrenic in room 4…"	"The patient with schizophrenia…"

Words to Avoid & Words to Use

Avoid (Stigmatizing)	Use (Neutral/Descriptive)
claims / admits	*states / reports*
non-compliant	*has not taken medication for 3 days; is non-adherent with treatment plan*
drug / med-seeking	*requesting specific clinically unindicated pain medications and psychiatric medications*
attention-seeking	*repeatedly requesting staff attention, seeking additional time with staff, making multiple call-outs for non-urgent concerns, being unable to reduce call-outs after repeated staff intervention*
manipulative	*repeatedly sought exception to unit rules and attempted to negotiate changes in restrictions with three separate psychiatric technicians*
refuses	*did not attend / chose not to participate / declined to participate*
faking / malingering	*reported symptoms are not consistent with observed behaviors; reports multiple inconsistent symptoms*

Manipulative behavior = Behavior appeared aimed at influencing the outcome of the interaction.

It is important to avoid including incriminating information in documentation.

Remember: "Claims" and "admits" imply doubt or confession. "States" and "reports" are neutral. You are a documentarian, not a judge.

Quick Fix Examples: Before & After

Problematic	Improved
"The patient was belligerent and refused to participate."	"The patient stood up, raised his voice, and stated, 'I'm not doing this.'"
"She claims the voices told her to do it."	"She reported, 'The voices told me to do it.'"
"He is non-compliant with his meds."	"He has not taken his prescribed medication for the past 3 days."
"The schizoaffective patient was tearful."	"The patient with schizoaffective disorder was tearful."
"The patient is antisocial."	"The patient frequently assaults staff, violates unit rules, and ignores staff redirection attempts."
"The patient is manipulative with staff."	"The patient repeatedly sought exception to unit rules and attempted to negotiate changes in restrictions with three separate psychiatric technicians."
"The patient became unprovokedly aggressive."	"Following a verbal announcement that the morning courtyard privilege was cancelled due to rain, the patient raised both fists to chest level and shouted at the floor staff."

Special Considerations in Competency to Stand Trial Language

Documentation should remain grounded in describing *functional capabilities*. Avoid vague terminology and conclusory statements without supporting evidence.

Track Specific Functional Abilities

- ✗ Instead of: "Patient is making progress in competency groups."
- ✓ Write: "Patient can now accurately identify the roles of the judge, defense attorney, and prosecutor, and describe the nature of the charges against him." OR "Patient demonstrated the ability to recall and describe scenes and characters from a movie he watched one week ago, indicating improved memory functioning."
- ✗ Instead of: "Patient is unable to rationally assist counsel with their defense."
- ✓ Write: "Patient's fixed belief that aliens have taken over his mind interferes with his ability to formulate a coherent narrative of events relevant to his legal case and to communicate effectively with his attorney."

Ground Competency Language in Observable Data

Vague or Conclusory	Specific and Descriptive
"Patient lacks capacity to understand court proceedings."	"When asked to describe the role of the judge, patient stated, 'He works for the CIA,' and could not describe the judge's function in his case."
"Patient's insight is impaired."	"Patient stated, 'There's nothing wrong with me,' and refused to discuss his diagnosis despite being provided with documentation of prior hospitalizations."
"Patient cannot assist with defense."	"Patient reported he would not share information with his attorney because 'she's in on it with the prosecution.'"

SMICA
SERIOUS MENTAL ILLNESS
CALIFORNIA ADVISER

Trauma-Informed Documentation

Trauma-informed documentation recognizes that many patients in forensic settings have experienced significant trauma, and that retraumatization can occur through insensitive language or invasive documentation practices.

Key Principles

1. Focus on behavior and presentation, not character.
2. Avoid pathologizing survival strategies that may have been adaptive in traumatic contexts.
3. Use neutral, descriptive language that does not imply blame or judgment.
4. Frame safety concerns as collaborative, not punitive.

Avoid	Write Instead
"Patient is hypervigilant and overreacts to staff."	"Patient appears alert to environmental cues and responds quickly to changes in staff presence, consistent with trauma history."
"Patient is avoidant and refuses to talk about past."	"Patient declined to discuss traumatic experiences during this session. Trust-building continues."
"Patient is distrustful and paranoid of staff."	"Patient maintains distance and is guarded during interactions. He expressed concern that staff may not have his best interests in mind."
"Patient is attention-seeking."	"Patient frequently approaches staff for interaction and expresses distress when not the focus of attention."

SMICA
SERIOUS MENTAL ILLNESS
CALIFORNIA ADVISER

Cultural Considerations

Cultural differences in communication style, expression of distress, and beliefs about mental health can be misinterpreted as psychopathology. It is crucial to guard against this error by documenting with cultural awareness and humility.

Avoiding Cultural Misinterpretation

Risk	Best Practice
Interpreting cultural expressions as psychosis	Distinguish culturally normative religious or spiritual beliefs from delusions and clearly document the cultural context.
Misreading communication styles	Recognize that eye contact avoidance, verbal hesitancy, or emotional restraint may reflect cultural norms, not pathology.
Labeling culturally based behaviors as “odd”	Describe the behavior neutrally and objectively; avoid labeling as “bizarre” or “unusual” without cultural consultation.

Examples

Avoid	Write Instead
“Patient reports hearing the voice of her deceased grandmother giving advice—suggests auditory hallucinations.”	“Patient describes culturally normative experiences of receiving guidance from deceased ancestors, consistent with her reported cultural and spiritual background.”
“Patient avoids eye contact and appears suspicious—consistent with paranoid ideation.”	“Patient maintains limited eye contact, which she reports is consistent with cultural norms of respect. She engaged appropriately with interview content.”
“Patient’s religious beliefs about being ‘chosen’ suggest grandiosity.”	“Patient describes religious beliefs that appear consistent with her faith traditions.

Culturally Informed Documentation

1. Describe the behavior or belief specifically.
2. Inquire about cultural context.
3. Document the patient’s own explanation.
4. Consult cultural resources when unsure.

SMICA
SERIOUS MENTAL ILLNESS
CALIFORNIA ADVISER

The Danger of Inferences: Objective Facts vs. Conclusions

One of the most common pitfalls in clinical documentation is presenting inferences or conclusions as facts. This table, adapted from Dahl, et al., demonstrates the difference.[1]

Inference or Conclusion	Objective Observation or Fact
Delusional	Tells staff that the CIA is monitoring personal email; wrote 37 complaints to the Warden
Grandiose	Reports history as a famous rap star
Manic	Pacing in cell most of the day for seven days
Hallucinating	Yelling loudly and gesturing at unseen others
Suicide attempt	Hanged self from sprinkler head; cut down by custody staff
Cell is unkempt	Food particles on floor; trays strewn about; toilet unflushed
Thought disorder	"I could not follow the expressed chain of thought" OR direct quotation
Disorganized	Prison jumpsuit worn on upper half of body; naked below

Practice: Before writing a clinical conclusion, ask: "What did I observe that led me to this conclusion?" Then document the observation first, and the conclusion second (or not at all in the objective section).

Before You Write, Ask Yourself:

- Am I describing an observable behavior or am I assigning a potentially judgmental label?
- Would I say this directly to the patient? Would I be comfortable with this document being read in court?
- Does this sentence add value or just take up space?
- Could this word bias a judge or another clinician?
- Am I providing incriminating information in my documentation?
- Have I separated observation from inference?
- Have I considered alternative explanations, including cultural factors or normal reactions to confinement?

[1]Dahl, T. A., DiCiro, M., Kukor, T. J., & Yang, J. (2022). *Through a glass darkly: Finding reliable evidence for qualifying mental health disorder in forensic evaluations at jails and prisons* [PowerPoint slides]. California Department of State Hospitals.

Key Takeaways

Avoid This	Do This
Using labels like “belligerent” or “manipulative”	Describe observable behaviors
Paraphrase using judgmental language	Use direct quotes
Presenting conclusory statements as data; e.g., “delusional” without describing the belief and behavior	Separate direct observation from inference
Write “patient claims” or “patient admits”	Write “patient states” or “patient reports”
Defining someone by their diagnosis (“a schizophrenic”)	Use person-first language
Leaving risk status undocumented	State what did not happen (e.g., no suicidal ideation)
Documenting events without context, failing to note environmental triggers (e.g., privilege cancellations, cell moves, custodial actions), which can lead to misinterpretation of behavior as spontaneous pathology	Use contextual neutrality (document institutional/setting infractions, rule violations, or volatile encounters within their environmental and interpersonal contexts)

Diagnostic Overshadowing: A Critical Caution

Diagnostic overshadowing occurs when clinicians attribute all of a patient’s behaviors, symptoms, or problems to their primary diagnosis or forensic status, overlooking other explanations or comorbidities.

Why It Matters in Forensic Settings

Once patients are deemed Incompetent to Stand Trial (IST) or Not Guilty by Reason of Insanity (NGRI), there is a significant risk that subsequent non-pathological behaviors will be misinterpreted as manifestations of psychiatric illness or ongoing risk of violence. Additionally, diagnostic overshadowing may lead to inaccurate diagnoses and treatment delays.

Examples

Diagnostic Overshadowing	Neutral, Descriptive Documentation
“Patient is becoming more paranoid and psychotic.”	“Patient expressed concern about his cellmate’s behavior. This occurred after an argument about the television and threats from his cellmate. Context noted.”
“Patient’s anger is a symptom of his schizophrenia.”	“Patient raised his voice after being told his yard time was cancelled due to rain.”
“Patient is non-compliant due to lack of insight.”	“Patient declined morning medication. He stated he ‘didn’t feel like it today’ and was not observed to be in distress.”
“Patient’s threats to staff reflect ongoing dangerousness.”	“Patient stated, ‘If you come near me, I’ll hurt you,’ following a pat-down search.”

SMICA
SERIOUS MENTAL ILLNESS
CALIFORNIA ADVISER

Best Practice

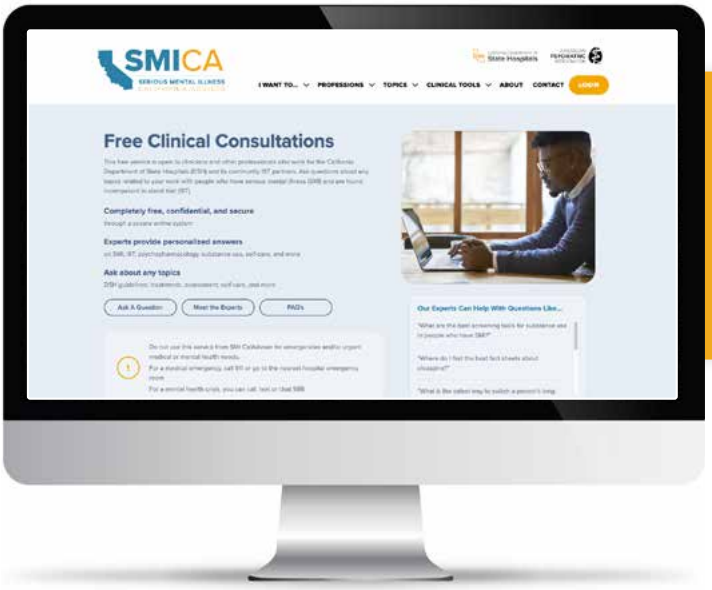
Describing the behavior and its context without adding interpretation allows for neutral integration of the behavior. This approach:

- Prevents confirmation bias (i.e., interpreting all behavior as confirming the diagnosis)
- Protects against anchoring (i.e., sticking with an initial diagnostic impression despite new information)
- Creates a more accurate record for treatment and legal review
- Reduces risk of stigmatization in court and community settings

When documenting, ask:

1. What is the behavior?
2. What is the context?
3. Could there be a non-pathological explanation?
4. Is this behavior best understood as a response to environment, a medical issue, or a psychiatric symptom?

Your words follow the patient. Make them accurate.
Make them neutral. Make them matter.



If you have questions about the information presented in this guide, visit the SMI CalAdviser consultation portal.

Visit the consultation portal

Funding for SMI CalAdviser was made possible by the State of California Department of State Hospitals (DSH) (the Department), but does not necessarily represent the views of the Department or any of its employees except to the extent, if any, that it has formally been approved by the Department.