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(954) 771-2091 – Fax (954) 771-2098

## **Documentation Section**

**Section Outline** - This course will provide the information necessary to enable professionals to document sessions appropriately.

Course Objectives:

1. Student will understand the purpose of documentation.
2. Student will learn the benefits of clinical documentation.
3. Student will learn the documentation process and requirements for progress notes.
4. Student will learn the documentation process and requirements for group and family sessions.
5. Student will learn the legal standards set for documentation, release of information and maintenance of client records.

## **Documentation**

### **Introduction**

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***TAP 21 Definition of Documentation: The recording of the screening and intake process, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client-related data.***

Documentation and recordkeeping requirements, often viewed as a chore, yet another burden heaped upon behavioral health care practitioners, are a familiar part of agency practice. The clinical record has an important place in assuring the quality of health and behavioral health services.

Professional practice standards require that treatment must be based on a proper diagnostic assessment and must be implemented in a planned manner, which is reviewed periodically, with identified goals, methods, time frames, and criteria to measure its efficacy and appropriateness. The clinical record should document compliance with these basic practice standards.



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Documentation, the primary focus of clinical chart audits, is scrutinized by regulatory bodies. Among other things, chart audits assess for medical necessity to determine whether or not the treatment is necessary and/or effective. Documentation that does not support medically necessary treatment potentially results in a recoupment of disbursements and, in extreme cases, a loss of clinical licensure. Whether in an agency or private practice setting, all practicing behavioral health providers are required to meet regulatory standards of practice, and under healthcare reform, these standards are increasingly stringent. To meet the demands of these standards, clinicians must have a working knowledge of the process and an understating of the standards and requirements to which they are expected to adhere.

Charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries and other client-related data are of the utmost importance and needed in most, if not all, levels of care and various treatment facilities, whether privately funded or not for profit..

## **CLINICAL DOCUMENTATION AND RECORDKEEPING**

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***TAP 21 Competency: Demonstrate knowledge of accepted principles of client record management.***

***Instructor Note: I have set up this chapter in a bullet point fashion to help your learning process and to help with studying. When it comes to documentation there can be some differences from treatment center to treatment center or agency to agency but some things do NOT change, HIPAA and 42 CFR standards never change, these are written in stone and need to followed to the letter in order to maintain professional ethics, agency standards, auditing need and of course, client protection.***

### **Purposes of Clinical Documentation**

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The seven key purposes of clinical documentation which, at times, overlap with each other, are:

- 1) Document professional work:
  - to record what was done, by whom, with, to, for, and/or on behalf of whom, when, where, why, and with what results
  - to document assessment and differential diagnosis, treatment and other services provided, the client's clinical course and clinical decision making (including assessment-



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based treatment and service planning and periodic reviews and modifications of the treatment/service plan)

- 2) Serve as the basis for organization and continuity of care of the client by the practitioner:
  - to record clinically meaningful information that the practitioner can later rely on to refresh his or her memory of crucial events in treatment, the patient's response to treatment and other services, problems experienced in treatment, key historical facts and details of substantive collateral contacts
  - to create a longitudinal record of the history of the client's complaints, symptoms, co-morbidities, assessments, diagnoses, treatment and other services provided, clinical course, and response to treatment and other services so that the treating practitioner and other practitioners who are, or who later become involved in working with the client can use this information to identify potential trends, guide their assessment and guide their development and implementation of their treatment/service plans
  - to provide a basis for practitioner reflection and self-supervision on the client's evaluation, diagnoses, treatment and services, assessment-based treatment/service plan, clinical course and progress
- 3) Serve as the basis for subsequent continuity of care of the client by recording for use by other practitioners who may serve the client in the future clinically meaningful data regarding the client's:
  - assessment, diagnoses, treatment and other services provided, clinical course, progress and response to treatment and other services
  - assessment-based treatment and service plans and the periodic reviews and modifications of those plans
  - trends, crises and problems in treatment, so that they may have sufficient data based upon which they can provide meaningfully clinically informed continuity of care to the patient
- 4) Risk management purposes to protect against malpractice lawsuits and professional discipline complaints, and to aid in defending effectively against any such lawsuits or complaints; (in this regard, be aware that if you didn't document something of importance contemporaneously in the client's clinical record and that becomes the subject of



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contention in a legal or disciplinary proceeding against you, it can be treated by a court or administrative body as if it did not happen or you missed it or you ignored it or you did not address it, etc., all of which may well ensure to your detriment in such proceedings)

- Document informed consent (i.e., for treatment, disclosure of information) and the nature and extent of the professional relationship and of duty owed with regard to the patient
- Explain, detail and justify professional decision-making, problems encountered in working with the patient, and the professional response to crises and other special or problem situations
- Record the details of supervision/consultation obtained in relation to the assessment and treatment of the patient, particularly with regard to crises or other special or problematic situations that arise
- Supervisors (who are legally professionally responsible and accountable for the professional services provided by their supervisees) to document each of their supervisory sessions, each of their contacts with the patients whose care they are supervising, and their oversight of the assessments, treatment and other services rendered by their supervisees under their supervision in order to enable them to defend the quality and appropriateness of their supervision and the quality of their supervisee's professional work against any malpractice lawsuit or professional discipline complaint alleging negligent supervision or malpractice by them or their supervisee
- Record information that will support the adequacy of the clinical assessment, the appropriateness of the treatment/service plan and the application of professional skills and knowledge in the provision of professional services
- Substantiate the treatment/services provided and the results of such treatment/services

5) Comply with legal, regulatory and institutional requirements

- Assure compliance with clinical documentation and recordkeeping requirements imposed by federal and state (including licensing boards) laws, regulations and rules
- Assure compliance with clinical documentation and recordkeeping standards set by specific accreditation programs (i.e., JCAHO) and by health care institutions, facilities and agencies



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- Fulfill clinical documentation and recordkeeping requirements of various third-party payers (i.e. Medicare, Workmen's Compensation, Medicaid, insurance, managed care plans)
- 6) Facilitate quality assurance and utilization review
- Record professional activities, the process and substance of assessment, differential diagnosis, treatment and service planning, clinical decision-making and the results of treatments and other services provided
  - Document the appropriateness, clinical necessity and effectiveness of treatments and other services provided
  - Substantiate the need for further assessment, testing, treatment and/or other services, or to support changes in or termination of treatment and/or services
  - Facilitate supervision, consultation and staff/professional development
  - to help improve the quality of services by identifying problems with service delivery by providing data based upon which effective preventative or corrective actions can be undertaken to improve and assure the quality of care
  - Provide data for use in planning educational and professional development activities, policy development, program planning and research in agency setting
  - Provide data to guide choices of continuing professional education programs to attend, ongoing review and revision of the organization and operation of the practitioner's professional practice and research in private practice settings
- 7) Facilitate coordination of professional efforts by fostering communication and collaboration between members of the treatment team
- Assure coordinated rather than fragmented treatment/service delivery
  - Assure appropriate utilization of team members from multiple disciplines in order to bring to bear collaboratively in an interdisciplinary/transdisciplinary manner the particular competencies of team members from various disciplines and/or who have specific specialties to maximize the quality of services to clients.

### **The Role of Clinical Documentation in Quality Assurance**



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Writing up appropriate initial assessments and proper progress/session notes requires thought and reflection. Having to prepare proper clinical documentation serves an important role of helping assure quality client care by making practitioners think about their clients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work and weigh alternative approaches to the care of their clients. The capacity for professional self-reflection and self-appraisal of one's professional work is essential to a practitioner's professional development, to the maintenance of his or her professional skills and to the provision of high quality clinical services. Rather than viewing clinical documentation as a meaningless chore that consumes precious time, practitioners should view it in this light, as a form of self-supervision that is an essential element of their professional practice and of their provision of quality clinical services.

### **Good Clinical Documentation**

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***TAP 21 Competency: Prepare accurate and concise screening, intake and assessment reports.***

***TAP 21 Competency: Record treatment and continuing care plans that are consistent with agency standards and comply with applicable administrative rules.***

What is good clinical documentation? Who decides? What needs to be included? What does not need to be included?

### **Elements of Good Clinical Documentation**

Clinical documentation should be recorded and organized as follows:

1. Each page of a client record should have the client's name clearly printed or typewritten on the top.
2. ALL entries in the client record should be signed (either in handwritten form or electronic form) by the practitioner making the entry.
3. Entries in the client record should be written contemporaneously (in the present) with the events they are documenting.
4. Each entry in a client record should be dated the day it is written.
5. If an entry in a client record documents an interview, therapy session, missed session, any follow-up of the missed session, assessment or other substantive client related collateral contact (i.e.; with another treating practitioner, with a family member, with the parents of a



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child who is in treatment) that took place earlier than the day the entry is written, the entry should include clear documentation of the day the activity being documented occurred.

6. Any materials or information received regarding a client which are entered in the clinical record should be dated and initialed on the day the information or material is initially reviewed and placed in the client record. Additionally, a progress note should be written to document the review of the material or information and any action taken as a result of that review.
7. All substantive collateral contacts with others relating to the client and all referrals made relating to the client should be documented contemporaneously in the client's clinical record. Timely follow-up on any referral made should be documented in the client's clinical record.
8. The record should be kept neatly, in date order for each section, in at least the following sections:
  - a) basic contact and demographic information about the client,
  - b) intake information including demographic and contact information about the client,
  - c) progress notes, initial and interval updates of treatment plans and closing/termination summary,
  - d) referrals made, tests requested, and the reports of consultations, referrals or test results which are received,
  - e) communications with other practitioners received or sent relating to the client,
  - f) non-professional correspondence to or from the client or from non-professional collateral contacts,
  - g) documents relating to HIPAA compliance, informed consent for treatment documents, consents and authorizations for use and/or disclosure of clinical information and records, etc.

### **Elements of Good Clinical Documentation - Writing**

Clinical documentation should be written (typed) in a manner that is well organized and that allows rapid location, recovery and utilization of clinical and other information about the patient. Writing good, useful clinical documentation requires thinking about and reflecting on the event(s) being documented in the context of the client's history and condition, the treatment and services being provided, and the client's treatment plan.



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**Good clinical documentation:**

- 1) provides relevant information in appropriate detail
- 2) is organized with appropriate headings and logical progression
- 3) is thoughtful, reflecting the application of professional knowledge, skills and judgment in the treatment/services provided
- 4) is appropriately concise
- 5) serves the purposes of clinical documentation (as outlined above) that are applicable to a given situation
- 6) uses relevant direct quotes from the client and from other sources identified as such by utilizing quotation marks
- 7) distinguishes clearly between facts, observations, hard data and opinions
- 8) states the source(s) of the facts, observations, hard data, opinions and other information being relied upon, and provides an assessment of the reliability of that material
- 9) is internally consistent
- 10) is written in the present tense, as appropriate.

**Documenting Elements of an Appropriate Initial Intake and Assessment.**

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An initial diagnostic assessment, which may be abbreviated or elongated depending on the circumstances of a particular case, provides the basis for the development and implementation of the treatment plan. In clinical practice the lack of a proper clinical assessment is likely to result in less than optimal and, perhaps inadequate or inappropriate treatment. The failure to conduct an appropriate differential diagnostic assessment or to develop an appropriate treatment plan is a serious deviation from the standard of care owed by a clinician to a client. The conduct and documentation of a proper initial assessment, and the development of the initial treatment plan includes:

- 1) identification of the referral source(s), gathering information about the background and reasons for the referral and assessing the client's response to and expectations with regard to the referral
- 2) defining the presenting problem(s) and what the patient wants to accomplish in treatment, both in the client's own words using appropriate quotes (identified by using quotation





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marks), as well as in terms of the practitioner's perception of the presenting problem(s) and needs of the patient

- 3) detailing the history and clinical course of presenting problem(s) and the details of treatment or services the client has sought or received to deal with those problems in the past (either in the long term or in the immediate past)
- 4) gathering and documenting relevant history from the client and from collateral sources, in appropriate detail, by topic, identifying the sources of such historical information and assessing the reliability of the information, regarding:
  - a) family history including a list of family members in families of origin and procreation and basic demographic information about them (i.e., age, birthplace, education, occupation, age, and cause of death if applicable), a brief description about their relationship with the client, marital history, and any family history of mental, neurological, substance abuse/alcoholism or serious medical problems
  - b) medical history including details of serious or chronic ailments, hospitalizations, serious physical trauma and/or surgery, allergies or adverse drug reactions; any physical disabilities and how the client has and/or is coping with them; any chronic medications and all current medications including OTC drugs, supplements, herbs and other alternative treatments, and information about their relationships and feelings about past and current treating practitioners
  - c) psychiatric history including details of mental health symptoms, diagnoses and treatments, hospitalizations (including whether voluntary or not), what precipitated or triggered the symptoms, treatment or hospitalization, and the client's response to prior mental health treatment (including response to and side effects of particular psychotropic medications that have been prescribed), prior psychotherapy and/or psychopharmacotherapy and the client's response to and feelings about psychotherapy and/or psychopharmacotherapy; history of treatment compliance and non-compliance (if patient left treatment, why he or she did so and with what results), details of the degree of the client's mental disability and how the patient is coping with this; and information about their relationships and feelings about past and current treating mental health practitioners;
  - d) history of alcohol and other substance abuse and alcoholism and substance abuse treatment including, for each substance of abuse, including alcohol, the substance, the first and most recent use of the substance, the route(s) of use, the amount used/time



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period (i.e., \$10 of crack/day, five 40oz cans of beer/weekend), the frequency of use (i.e., steady on a daily basis, bingeing once every three of four weeks for one to three days) the duration of use, any significant periods of abstinence (including how these were achieved and why they ended), the social context of the substance abuse (i.e., alone, sharing with others, only at parties), identified triggers for the substance abuse, treatment programs attended (which ones, when and for how long, what the patient liked and disliked about the program, what the client felt that he or she accomplished and did not accomplish in the program, and whether the patient completed the program successfully, if not, why), and the bio-psychosocial impact of the substance abuse on the client and his or her significant others

- e) child and adolescent developmental history including family and peer group relationships, home life, socio-economic status, schooling, parenting and discipline, type of neighborhood and housing, learning disabilities and other developmental delays (in children and young adolescents a more detailed developmental history is usually indicated)
- f) educational history including level of academic achievement, academic strengths weaknesses, relationships with teachers, history of being denied regular promotion, placement in special education or other special educational programs, school behavior including any suspensions, expulsions or school transfers
- g) history of occupational training/skills and work history including significant employment, work related difficulties, how the client views his or her work, the client's career goals, general salary information and adult economic status
- h) history of interpersonal relationships including the nature and extent of peer group relationships, marriages and other close relationships over the life span, what has kept or keeps these relationships functioning, why and how these relationships end, the client's reactions and feelings about the end of close interpersonal relationships, the nature and type of any significant interpersonal problems the patient has had or is having
- i) history of past and current social support systems including the nature and impact of these or the lack of these on the client's development and functioning
- j) juvenile and criminal justice history including the nature of any arrests, convictions and any sentences imposed, and history of patterns of antisocial behavior



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(954) 771-2091 – Fax (954) 771-2098

- k) history of sexual relationships, issues including sexual orientation issues and any sexual dysfunction
  - l) history of religious affiliation and practices and issues relating to religion
  - m) spirituality (aside from religion) including the values, thoughts, emotions, motivations, needs, dreams, experiences, assumptions and relationships that make the person a unique individual, and provide him or her with the vitality, drive and determination to develop and function as a fully actualized person
  - n) social issues his or her functioning in relation to other persons and his or her environment including, but not limited to interpersonal and social relatedness, skills and capacity; behavioral responses to environmental, mental and emotional events and stimuli; responsiveness to the environment and to other persons; adaptive functioning and behavior; stress and frustration tolerance and impulse control; linguistic and communicative functioning; social judgment; and the influences of age, culture, customs, disability, discrimination, economic factors, gender, geographic and other environmental factors, health status, illness, injury, loss, national origin, pain and suffering, politics, race and religion his or her development and functioning
  - o) history of physical, emotional or sexual abuse or other victimization including where and when these occurred, the patient's view of the impact of these on his or her life, whom the client told about these events and the response of people who learned about these occurrences.
- 5) describing the professional's observations of the client and the results of a mental status examination which generally includes an assessment (which may be abbreviated depending on the client's presentation) of the following:
- sensorium (attention, concentration, orientation, memory, intelligence, cognition and learning)
  - appearance, eye contact with practitioner, and psychomotor functioning
  - the form, nature and quality of speech and other communication;
  - mood, feelings, affect and emotions, suicidality and violence potential;
  - the form, nature, process and content of thought, and perception;
  - attitudes, motivations and behavior;
  - stress and frustration tolerance and impulse control;
  - ego functioning and ego defenses;
  - adaptive functioning and behavior;



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(954) 771-2091 – Fax (954) 771-2098

- sense of self, autonomy and competence;
  - interpersonal and social relatedness, skills and capacity (object relations);
  - client's self-assessment of his or her strengths and weaknesses; and
  - reality testing; insight, and judgment.
- 6) gathering information about the client's current/recent general physical health (including any current or recent symptoms or health problems and any current or recent health care treatment)
  - 7) detailing prior clinical services, the background and reasons for which those services were sought and provided, the results of such services and the reason(s) for termination of those services
  - 8) making a substance related diagnosis using the DSM 5 and an assessment of the patient in functional as well as diagnostic terms, which distinguishes between observations, hard data and opinions, sets forth the support for generalizations and conclusions in the assessment, and makes a determination about the practitioner's degree of confidence in the assessment
  - 9) developing an initial differential treatment/service plan with identified short-term goals and longer-term objectives, methods to be used, time frames and standards to measure treatment progress in functional terms, with a rationale for prioritizing of treatment goals and for the choice from among various treatment alternatives and strategies; the plan may include services from other providers, in which case these should be identified by function and/or name, and the services to be provided by them specified
  - 10) an assessment of prognosis with supporting rationale
  - 11) describing the client's response to the assessment and to the proposed treatment plan and, if the patient agrees to proceed with that plan, documenting informed consent for implementation of that plan.

### **Elements of Documentation of a Treatment Session**

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The ongoing provision of clinical services should be documented, keeping in mind the seven key purposes of clinical documentation and the ten elements of good clinical documentation discussed above. Depending on the changing circumstances of each case, certain purposes of documentation will be more crucial than others at various points in treatment. For instance, if a client's mental status deteriorates and he or she becomes threatening, the purpose of carefully documenting the practitioner's professional response and clinical decision-making and the purpose of risk management/malpractice protection will predominate. In a case where a client



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(954) 771-2091 – Fax (954) 771-2098

who has significant medical, family and mental health problems is being served by several different practitioners, documentation dealing with coordination of the professional efforts of the various practitioners will predominate. A proper progress note, which need not be particularly extensive, in most cases merely several sentences, should include:

1. the date and length of the contact
2. the specific services provided, including CPT [Current Procedural Terminology] descriptions and codes; in the case of other non-clinical services (i.e., case management, advocacy, referral, etc.) indicate the service(s) in words
3. description of the type of contact (i.e.; in person, telephone, mail)
4. indication of who initiated the contact (i.e.; regularly scheduled session, client showed up without appointment, phone call by client, phone call by patient's family who put client on the phone, inquiry from another practitioner/service provider who is with the client in the emergency room and puts the client on the phone)
5. statement of where the contact took place (i.e.; office, if a home visit - the address visited, if by phone - the phone number called)
6. indication of who, besides the patient, was involved in the contact (i.e.; client, family, other practitioner, friend)
7. a description of the themes of the session, in generic terms, addressing particular symptoms, feelings, thinking, beliefs or behaviors (i.e., pain, anxiety, dysphoria, suspiciousness, avoidance, etc.) or relating to specific relationships or situations (i.e.; work problems, interpersonal relationships, parent-child problems, marital relationship, school problems, the effects of chronic physical illness)
8. an assessment of the client's mental status during the session, relating this to the client's baseline mental status and the client's mental status in the recent past
9. notation of any symptoms or complaints that may indicate a physical health problem (i.e., side effects of psychotropic medication, sleep problems, confusion)
10. description of any new significant history obtained
11. description of relevant problems newly identified
12. description of relevant significant new events (i.e., changes in medication, results of tests, exacerbation of a concurrent physical ailment, break-up of a relationship, beginning new relationship)



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

13. description of therapeutic interventions with clinical justification and reasoning to support these in relation to the treatment plan and clinical circumstances, particularly when in response to crisis situations or special/markedly changed circumstances
14. statement of what was accomplished in the session
15. statement of what wasn't accomplished in the session that needs to be followed up on
16. details of obstacles to progress in treatment, if any, and a plan to address these
17. a description of a plan for further care or follow-up (including date and time of next appointment), changes in diagnosis and/or treatment plan/goals, if any, and reasoning to support these changes (particularly when in response to crisis situations or special/markedly changed circumstances) and any referrals made or testing ordered (including the nature of the referral, to whom the referral is made, the reason for the referral, tests ordered and the reason they were ordered, and the patient's response to the referral and/or ordering of tests).

### Progress Notes

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***Instructor Note: Right up front I am going to state this is the area where many a professional fall down ☹ Professionals are busy with very full caseloads and a lot of groups and meetings, and I have heard many say, "I'll catch up on my notes later". Well late either never comes and that professional ends up out of compliance on most or all of their cases or they write a bunch of notes at one go and forget most of the clinical details necessary to meet standards and provide assistance in the client's treatment process. To be professional and maintain ethical standards and practice guidelines professionals have to have great organizational skills and excellent time management. Excelling in these two areas allows the professional to complete all of their required tasks in a timely manner and in a clinically proficient style. Don't fall into this trap, if you find yourself falling behind speak to your clinical supervisor right away; get tips on how to tighten up your time management and organizational skills or to get help with a problem related to a specific client that may be taking up extra time.***

Progress notes are vital to good clinical treatment. Professionals often see progress notes as "busywork" and consequently write them in ways that don't enhance the client's treatment episode. Carefully documenting the treatment process can be time consuming, and often tedious, but it is critical to quality treatment. The written record supplies the details of how the



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(954) 771-2091 – Fax (954) 771-2098

client utilized their treatment plan. It is similar to drawing a map, in that it charts the client's journey through the continuum of care.

A quick review of progress notes is the best way to refresh your memory when you sit with your clinical team to discuss your client's progress. It is common to have case conferences with social workers, mental health case managers, PO's, and other related professionals. Life-changing decisions are often made in those meetings and it is essential that the professional is able to give a complete picture of their client's progress and/or lack of progress. Remember that the purpose of progress notes is not to satisfy supervisors and auditors; the primary purpose is to improve and enhance the treatment process by helping the professional track the client's progress in treatment while staying focused on the treatment plan. Good progress notes also assist other program staff to participate intelligently in the client's treatment process. If the primary professional is not available to provide support to the client, the chance that another professional will be able to provide meaningful assistance may be dependent on the quality of documentation in the progress notes. A series of notes that only reports the client's attendance and indicating that they had "good participation" are clinically useless.

### **Progress Notes – a different description & break down**

Progress notes are the threads that tie treatment together. A good progress note addresses progress of current treatment goals, identifies new goals, assesses the client's response to treatment, includes new information not previously identified in the mental health assessment, notes changes in diagnoses, and ultimately represents evidence of treatment. As with the mental health assessment, progress notes should include the client's demographic information, date of service (with start and end time), description of services, and location of service (e.g., office, school, hospital). In the event documentation occurs at a time other than at the time of service delivery, include a notation of the late entry (including entry date/time) along with the date service occurred. Organizing a progress note can be done in several ways. One way is using the Data, Assessment, and Plan (DAP) format.

The first step is recording the subjective and objective data about the client. Subjective information is what the clients says or feels. As a general rule, incorporate specific statements made by the client into every note. Objective data is what is observable by the therapist (e.g., behaviors, actions, and emotions), notations about progress of presenting problems, review of client homework when given, and a summary of the content and process of the session.





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The assessment step involves analysis of what is going on in or outside of treatment that is impacting the client. The clinician should describe which interventions are working or not working and include a working hypothesis that may lead to further interventions or a change in goals.

Finally, the note should describe the next steps. This includes homework assignments, date of the next session, and any topics to be addressed at the next session.

Another common format used in a clinical setting is Subjective, Objective, Assessment, and Plan (SOAP). The content areas of the SOAP note are very similar to DAP, and depending on the treatment setting and clinician preference, either format is a generally acceptable.

### **Client Responses**

Suppose the intervention asked for the client to interview others in recovery and get suggestions for what to do if they have a craving to use. Be brief but specific about what information they were given. In other words, don't simply say, "Client reports he asked three men in his support group for recovery ideas." Document what he learned and/or experienced: "Client was given phone numbers and told to call if needed. Client felt hopeful that people cared." Or, "It was suggested to client for him to volunteer for service, because having a commitment helps people when they feel like using. Client is ambivalent about making that commitment at this point." As treatment progresses, continue to follow up with the client and enquire what they are following through with and document that progress in the notes. This is a relevant indicator of the client's process of change.

At the same time, don't feel like you have to report everything the client tells you. If the client got lost and was ten minutes late to the meeting – that would not be relevant to the treatment plan assignment.

### **Lack of Progress**

There are times when clients do not follow through with the interventions on their treatment plans. Try to catch this as early as possible because it may be an indication that the client does not have a "buy-in" on the treatment plan. Or it could be that a new issue has surfaced that is more immediate for the client. Sometimes the client is confused about what they agreed to do and needs additional clarification or help organizing her/his plan.





6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

When there appears to be lack of progress, be sure and document the particular issue in the notes along with how you are helping the client work through it. Always update changes in the client's SOC along with their progress or lack thereof.

The progress notes are the record of your client's treatment experience. Progress notes tell the story of the treatment episode. As with any story, there must be enough detail to make the client come to life as a unique individual that is struggling to save his/her life.

### **Documenting Group/ Family Therapy**

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Even when a client is being seen in group or family, the client must have his or her own client record. The practice of writing one note for each group or family session and then placing a copy of that note in the chart of each client who participated in the session is not appropriate, even if each client is referred to only by his or her initials in the one note. Additionally, notes of group or family therapy that are placed in a client's record should be kept separate from, and written on a separate page than any notes relating to individual therapy sessions. In this manner, if a client's clinical record must be disclosed, this can be accomplished easily without disclosing information about other persons with whom he or she is receiving group or family therapy.

For documentation of a group or family therapy session, a note which reflects the information that should be documented in a general progress note as indicated above should be written and should be supplemented by addition of comments about the client's functioning in the group/family/couple session and his or her reactions and responses in the context of the group/family/couple process. **The progress/session note for each person in the group or family therapy, should focus on that individual's mental status, behavior, participation and functioning in the session, and their reactions and responses to the themes and processes that arose during the session. It should avoid, to the extent possible, mentioning any identifiable material from or about other particular members of the group, couple or family, unless this is necessary for clarity. In writing an individual group therapy note for each group member, only the name of the individual group member whose note is being written should appear in that note.**

In this regard, in the case of group therapy the number of clients attending the group session should be documented in the progress/session note, along with the initials of the other clients



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(954) 771-2091 – Fax (954) 771-2098

who attended. A separate attendance list of the clients in each group, by session (date of service) should be filed in a group therapy record folder so that there is a record of which clients attended which group and when.

Professionals have a tendency to just note that the client attended a group or watched a film or was part of the discussion of a particular topic. Phrases like “good participation”, “participated actively”, “attended and participated appropriately”, etc. do not document progress or lack of progress, only that the client was there and apparently talking. Even a statement that the client “shared her triggers with the group” does not provide enough detail to evaluate progress or lack of progress. A far better note would state “Client demonstrated an understanding of her relapse triggers by sharing that rainy days and Mondays (or whatever) always bring her down and makes her feel like using.

Professionals may need to make a shift in order to accommodate each client and their specific treatment plan during group. One really good way to do that is to remind clients to consider how the group topic relates to their treatment plan and invite them to discuss that.

In addition to recording treatment plan progress based on individual and group sessions, it is also important to note significant observations. Make sure to distinguish between observations and personal opinions or judgments.

Here is an example of a observation: “Client appeared extremely angry in group; sat with fists clenched and rigid posture. When asked to talk, client refused.” An opinion or judgment by the professional would be, “Client was hostile toward others and looked like he was ready to hit someone. Client probably drank last night.” Documenting observations is important – documenting opinions and judgments is inappropriate.

### **Documenting the Treatment Plan**

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***Instructor Note: Just a few words.....once the master treatment plan is formulated between you, the professional and your client, ALL ROADS (NOTES) SHOULD LEAD BACK TO THE TREATMENT PLAN.***

Treatment planning begins at the first encounter with the client. During the initial assessment and diagnostic formulation, identifying symptoms and a focus for treatment emerges. The treatment plan is a written document that identifies the target problem (the problem that will



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(954) 771-2091 – Fax (954) 771-2098

be the central focus of the current treatment efforts), the goal (the outcome that needs to be achieved to resolve the target problem, and an action plan (the specific steps that will be taken to resolve the problem and achieve the stated goal, an outcome evaluation that measures the level of completion of step of the action plan and the overall level of achievement of the stated goal.

### **Components of a treatment plan**

Information gathered through a comprehensive assessment should be used to guide the negotiation of a treatment plan with the client. Problem areas and strengths should be clearly identified.

The treatment plan should specifically address how each problem area will be managed. For each problem area, the treatment plan should specify the specific nature of the problem(s), the desired change (short- and long-term goals) and the means by which the goals will be achieved. It should also describe how the problem will be managed, including the type of treatment (e.g., group vs. individual counselling, the frequency of treatment contact, the provider(s) responsible for the treatment service and the time frame for re-evaluating treatment progress).

The treatment plan should prioritize problems requiring immediate focus and those of less urgency.

All major problems, once formulated, regardless of whether or not they will be addressed, should be documented in a formal treatment plan. If a decision is made not to address a major problem, the justification for this decision should be explained in the treatment plan.

### **Treatment planning as a collaborative process**

Treatment plans should take into account the client's motivation to engage in counselling. Clients and counsellors need to collaboratively develop a treatment plan.

To foster a sense of individual responsibility, clients need to feel they control decisions about their treatment. This will also help clients to feel that their concerns are being addressed and help reduce client resistance to the counsellor's interventions.

- **Client goals:** State client goals, preferably in their own words. Clients may not be able to identify the specific issue and may state they just want to feel better. In these cases, attempt to assist the client in clarifying what would need to happen or change in order to meet the goal of "feeling better."
- **Recovery/Wellness goals/objectives:** From the identified symptoms and diagnostic formulation, specify the goals/objectives for specific symptoms. For example, if a client presents with a history of relapse with untreated anxiety as an underlying cause, the



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(954) 771-2091 – Fax (954) 771-2098

goal is to reduce intensity and frequency of anxious feelings. This is where measurement of symptoms plays into the treatment plan. If the client reports feeling anxious 6 times per day at least 5 times per week at an intensity level of 5/6, the goal may be to reduce the frequency to 3 times per day not more than 3 times per week and to reduce intensity to not more than a 3.

- Interventions and their focus: How the clinician plans to reduce symptoms should be noted. Using the example of anxiety, interventions might include teaching stress-reduction techniques, identifying situation-specific triggers, and developing a mindfulness practice. If indicated, additional interventions may include referrals to external providers, such as a psychiatrist.
- Duration and frequency of treatment/interventions: Delineate a general plan for how often the client is expected to attend therapy, the duration of treatment required to address the symptoms, and issues in the treatment plan. This is usually assessed based on acuity, level of functioning, and specific client needs.
- Coordination of care: When other providers are directly involved in the care team or treatment of a client, document the names, agencies, contact information, and reason for coordination of care in the treatment plan. This may include a case manager at an outside agency, a psychiatrist or other prescriber, or a school therapist.
- Termination/discharge/transition plan: Planning for the achievement of treatment goals is an essential part of the overall conceptualization of treatment planning. Early focus on this part of the process supports a sense of purpose in the therapy and identifies the next steps, resulting in a feeling of progress and growth for the client.
- Additional notes: The signature and licensure of the clinician engaged in the treatment plan should be included at the end of the document along with the date of completion. The client should review and sign and date the plan as evidence of his or her participation, and a copy should be given to the client as well. If indicated, note any referrals given and include copies of signed and dated releases of information if collateral information will be requested from an outside provider, such as in coordination of care.
- Updates: When updates are made, include these changes in the treatment plan. This could include changes to diagnoses, new risk behaviors/situations, client strengths and resources, overall response to treatment, and modifications to measurable goals.



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## **Documenting Client Discharges**

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### **Elements of an Appropriate Closing/Termination Summary**

A closing/termination summary, which may be abbreviated or elongated depending on the circumstances of a particular case, documents the practitioner's thoughtful reflection on the course of the client's treatment (to date in relation to an interval summary, or with regard to the entire period of treatment in relation to a closing/termination summary). Such summaries can be useful if the client later seeks treatment from another practitioner and requests that a summary be sent to that practitioner.

The documentation of a proper closing/termination summary includes:

1. the dates the client was referred, first contacted the practitioner and was first seen, the referral source, and the time period covered by the summary (if this is a closing/termination summary, the date the client was last seen and the last contact with the client)
2. a synopsis of the initial reason for and background circumstance of the referral and the presenting problem(s) from the client's perspective at intake
3. a review of the problem areas and symptoms addressed (noting changes, if any, in the patient's symptoms, thinking, emotions, beliefs, behaviors and other areas of bio-psychosocial functioning), and of the extent that the identified symptoms/problems were resolved
4. a summary of any concurrent treatments, including the provider(s) of such treatments, the names and dosages of medications prescribed, other treatments rendered or any other relevant assessments performed; the steps taken to coordinate care with other practitioners (including the extent and success of achieving collaboration, or any problems that interfered with collaborative efforts), the results of any referrals made or testing ordered, and the impact/results of the other concurrent treatments
5. if this is a closing/termination summary, a statement regarding the circumstances of the termination of treatment (precipitants, was it planned or unplanned?, was it mutually agreed upon by client and the practitioner?, did the client stop coming and, if so, what steps were taken to address this and with what results)
6. if this is a closing/termination summary include final diagnoses and a statement as to the client's functioning, as well a statement as to which, if any, of the concurrent treatments (including medication) the client is receiving the client intends to continue whom and to



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(954) 771-2091 – Fax (954) 771-2098

what extent) and does not intend to continue (if so, what are the client's reasons for discontinuation of those services)

7. if this is a closing/termination summary include a statement detailing any referrals or recommendations provided to the client regarding further care, and the client's response to such referrals and recommendations
8. if this is a closing/termination summary include a statement of whether the client poses a risk of decompensation, suicidality, assaultiveness, homicidality, relapse back to alcoholism or substance abuse, inability to care for himself or herself, of being victimized, of victimizing others, or is at any other serious risk at the time of termination/closing, the basis of the risk assessment, details of the steps taken to address any of these risks, and the results of such steps.

### **Discharge Summary – different description...**

As treatment comes to a close, the client will have met all of his or her goals and be moving on to either another level of care or no longer engaging in treatment. Although it gets little recognition as part of the overall treatment record, the discharge summary is the book end that supports all the documentation that has come before.

Generally, the format of the discharge summary will include the client's demographics, date of discontinuation of treatment, reason for discontinuation of treatment, a summary of treatment provided and the client's overall response (with specific reference to treatment goals), and notation about whether goals were met and to what degree. If treatment goals were not met, this should also be noted. Include any change to diagnoses and medications being taken at the time of discontinuation of treatment. Finally, include details about referrals made and any aftercare plans that were discussed and are part of the client's plan of action post-treatment.

### **Documentation Through the Eye of HIPAA**

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***Instructor Note: LEARN IT, LIVE IT, PRACTICE IT!! Nothing else to say ☺***

### **The General Medical/Clinical Record Contrasted with Counseling Notes**

HIPAA does not alter the requirements for clinical documentation and recordkeeping established by Florida State law, regulation and court decisions, as well as by federal statutes and regulations which govern the operation of certain federal health care benefit programs.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

The elements of clinical documentation noted above remain the standard for information that, consistent with the type of case, should be collected and recorded by behavioral health practitioners. However, HIPAA has made provisions for the way that some mental health related material may be recorded and organized in order to provide greater protection for the privacy and confidentiality of some of the material obtained during counseling sessions.

The passage of HIPAA and the promulgation of the HIPAA Privacy Regulations have impacted on how some mental health information may be recorded and how mental health records may be organized. In this regard, HIPAA provided that counseling notes, “are held to a higher standard of protection because they are not part of the medical record and are never intended to be shared with anyone else.” Counseling notes are defined in the HIPAA Privacy Regulations as, “notes recorded [in any medium] by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Counseling notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.”

HIPAA does not require mental health practitioners to keep “psychotherapy notes,” as defined above. It merely provides that if a mental health practitioner maintains notes of the information covered in the definition of “psychotherapy notes,” and maintains those notes physically separate from the patient’s general medical/clinical record [which general medical/clinical record is required to be maintained under Florida State laws and regulations and the regulations governing various federal health care benefit programs], those notes are subject to special confidentiality protections.

Under HIPAA regulations, a behavioral health provider who is a covered entity under HIPAA must obtain an authorization for any use or disclosure of counseling notes, to carry out treatment, payment or health care operations,

**except for.....**

**(a) use by the originator of the counseling notes [the treating therapist who created the notes] for treatment,**





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(954) 771-2091 – Fax (954) 771-2098

**(b) use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or**

**(c) use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the patient.**

Also, a health plan may not condition the enrollment of the client in the plan or a client's eligibility for plan benefits on receiving an authorization from the client for disclosure to the plan of the client's counseling notes.

The HIPAA dichotomy between the general medical/clinical record and psychotherapy notes is not inconsistent with Florida State's recordkeeping and clinical documentation requirements for health care providers. The information that is kept in the general medical/clinical record, is material that is necessary to assure continuity of care if the provider is not or will no longer be available, and to fully document the extent of care, services and supplies furnished. This includes: diagnoses (including the details of the client's history, clinical course, symptoms and functioning needed to support the diagnoses); details regarding the client's history, symptoms and functioning needed to document the client's clinical course during treatment; the therapeutic interventions used and the client's response to them; the identified problems that are the focus of the treatment plan; the evolving short-term goals and long-term objectives of treatment in terms of improving mental, emotional, behavioral, and physical functioning, addressing and resolving bio-psychosocial issues, symptoms and dysfunction, and addressing the impact of and resolving various types of events in the client's life history; and, prognosis (including the details of the client's history, clinical course symptoms and functioning that support the prognosis). Additionally, the general medical/clinical record includes results of tests and consultations, clinical information obtained from other providers, and material gained through collateral contacts.

Counseling notes document the actual detailed, highly personal and private material elicited in the therapy or counseling session, which information the client never intended to be shared with anyone else, and the therapist's analysis of that material. This material is often helpful to the therapist in treating the client over time, but is not necessary to assure continuity of care in the absence of the professional/therapist. This material is also not necessary to document adequately the client's diagnosis and prognosis and the basis of those assessments, the





6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

evaluation and treatment of the client, the services provided, the necessity of those services, and the treatment plan, all of which can be accomplished using the information contained in the general medical/clinical record.

### **Organizing the Client Record**

The client record should be organized into various sections. This has been and remains the manner in which records are kept in hospitals, clinics and other health care agencies, as contrasted with the manner in which records have been kept in individual practices, particularly by behavioral health practitioners.

With the introduction of electronic records some of the following information will not pertain to everyone. Those professionals who work for facilities that have electronic health records must follow all the same documentation standards, requirements etc. Regarding keeping these electronic records safe – the professional must lock their computer when they leave their office or walk away from their desks even for a “minute”. This ensures no one can access personal health information (PHI) of any client, even if they work for the same agency. Disclosure of client information is always on a need to know basis.

The information in the following paragraph will not apply to electronic client records.

The practice of maintaining patient records in spiral notebooks, loose-leaf binders, or composition [bound] notebooks, either one for each client, or combining client records on various pages of the same notebook is inappropriate. Each client should have his or her own record maintained in a file folder (preferably one which has fasteners) exclusively for that client. The reason for using folders is that the record should be arranged in sections and can be easily secured in a locked filing cabinet. Using spiral or bound notebooks makes it difficult to keep materials received in the client’s record.

### **42 CFR Part 2**

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***TAP 21 Competency: Protect client rights to privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of client information with third parties.***

***Instructor Note: LEARN IT, LIVE IT, PRACTICE IT!! Nothing else to say 😊 AGAIN!***



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

Just about anyone who has ever received medical care has heard of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the law that regulates the use and disclosure of Protected Health Information (PHI) held by "covered entities" such as health plans. But far fewer are familiar with the special privacy protections afforded to alcohol and drug abuse patient records by 42 Code of Federal Regulations ("CFR") Part 2.

The privacy provisions in 42 CFR Part 2 were motivated by the understanding that stigma and fear of prosecution might dissuade persons with substance use disorders from seeking treatment. To add an extra layer of protection on these records, the regulations outline under what limited circumstances information about a patient's treatment may be disclosed with and without the patient's consent. Who and what are covered can be confusing, though.

The Legal Action Center has developed some handy-dandy FAQ's for the [Substance Abuse and Mental Health Services Administration](#). Here is the summary of them:

- 42 CFR Part 2 applies to any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11). Most drug and alcohol treatment programs are federally assisted. For-profit programs and private practitioners that do not receive federal assistance of any kind would not be subject to the requirements of 42 CFR Part 2 unless the State licensing or certification agency requires them to comply. However, any clinician who uses a controlled substance for detoxification or maintenance treatment of a substance use disorder requires a federal DEA registration and becomes subject to the regulations through the DEA license.
- The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program (42 CFR § 2.3(a)). The restrictions apply to any information disclosed by a covered program that "would identify a patient as an alcohol or drug abuser ..." (42 CFR §2.12(a) (1)). In laymen's terms, the information protected by 42 CFR Part 2 is any information disclosed by a covered program that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a covered program.
- With limited exceptions, 42 CFR Part 2 requires patient consent for disclosures of protected health information even for the purposes of treatment, payment, or health care operations. Consent for disclosure must be in writing.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
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### Concluding Instructor Note

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*Understanding the basic function and purpose of documentation is important. However, learning to write quality notes is an ART that takes time and practice. Becoming adept at this art puts you ahead of the game, EVERYONE benefits from a professional who is really good at forming observations and then accurately documenting those observations for the treatment team to read and use in providing clients with best, strength-based, focused individualized treatment possible.*

*Notes are, however, more than a mere jotting of information derived from sessions. They are structured legal documents with a basis in state and federal law, a legal record, and a reference point for treatment interventions and progress validating.*

*Developing quality documents involves determining local, state, and federal laws that apply to your specific practice setting and developing standardized forms that adhere to the applicable laws and guidelines. Clinicians should keep content concise, neutral, and specific (e.g., measurement of symptoms) and adhere to level-of-care guidelines (medical necessity). It is important to ensure continuity of content between documents throughout the assessment and treatment process.*

*Remember, like anything else in life that is new.....practice makes perfect. Find practice case studies and write mock progress notes, treatment plans, integrated summaries, group notes and discharge summaries. The more you practice the better and more effective you will be.*

*Happy documenting 😊*

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3. The Clinician's Guide to Writing Treatment Plans and Progress Notes; Version 7/31/2008, Edited by: Michael Hutchinson, MFT; Pauline Casper, MS, CADC II; John Harris, RADI; Jeremy Orcutt, CADC II; Maria Trejo, MSW, RADI.



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## **Community Education, Awareness & Impact**

### **Overview**

A significant portion of this course relates to learning about and understanding the impact of substance abuse on communities. The information provided in this chapter will look at some statistics to give you an actual idea of how many people and in what ways substance abuse impacts communities. Also included is information on prevention and intervention and their proven positive impact on individuals, families and communities as a whole.

The goal of both prevention and intervention is to reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

### **Impact of Substance Abuse on Communities**

Drug abuse is a major public health problem that impacts society on multiple levels. Directly or indirectly, every community is affected by drug abuse and addiction, as is every family. Drugs take a tremendous toll on our society at many levels.

This includes health care expenditures, lost earnings, and costs associated with crime and accidents. This is an enormous burden that affects all of society - those who abuse these substances, and those who don't.

### **Drug Abuse is a Major Public Health Problem**

Americans Perceive Drug Abuse as a Major Public Health Problem

Many of America's top medical problems can be directly linked to drug abuse:

- **Cancer:** Tobacco contributes to 11-30% of cancer deaths.
- **Heart Disease:** Researchers have found a connection between the abuse of tobacco, cocaine, MDMA (ecstasy), amphetamines, and steroids and the development of cardiovascular diseases. Tobacco is responsible for approximately 30% of all heart disease deaths each year.



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- **HIV/AIDS:** Approximately one-third of AIDS cases reported in 2000 (11,635) and most cases of hepatitis C (approximately 25,000 in 2001) in the United States are associated with injection drug use.
- Approximately half of pediatric AIDS cases (4,700 reported through 2002) result from injection drug use or sex with injection drug users by the child's mother.

**Many of America's top community problems relate to or impact drug abuse:**

- **Drugged Driving:** The National Highway Traffic Safety Administration estimates that drugs are used by approximately 10 to 22 percent of drivers involved in crashes, often in combination with alcohol.
- **Violence:** At least half of the individuals arrested for major crimes including homicide, theft, and assault were under the influence of illicit drugs around the time of their arrest.
- **Stress:** Exposure to stress is one of the most powerful triggers of substance abuse in vulnerable individuals and of relapse in former addicts.
- **Child Abuse:** At least two-thirds of patients in drug abuse treatment centers say they were physically or sexually abused as children.

**Drug abuse impacts the individual, family, and community**

**Individual:**

- **Adolescence:** This is a time period of high vulnerability to drug abuse and other risk taking behaviors.
- **Mental Illness:** People with mental illness are particularly at risk for problems related to substance abuse.
- **Consequences of Substance Abuse:** These can include illness, injuries, and death. Each year approximately 40 million debilitating illnesses or injuries occur among Americans as the result of their use of tobacco, alcohol, or another addictive drug.
- **Deaths:** In 2000, approximately 460,000 deaths were attributable to illicit drug abuse and smoking.

**Families**

- **Prenatal:**
  - **Smoking:** Infants born to women who smoke during pregnancy have a lower average birth weight and may be at increased risk for attention deficit hyperactivity disorder, conduct disorders, and childhood obesity.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- **Cocaine:** Babies born to mothers who abuse cocaine during pregnancy can be born prematurely and have low birth weights. There may be as many as 45,000 cocaine-exposed babies per year.
- **Child Abuse:** Approximately 50% to 80% of all child abuse and neglect cases substantiated by child protective services involve some degree of substance abuse by the child's parents.

#### **Community:**

- **Homelessness:** 31% of America's homeless suffer from drug abuse or alcoholism.
- **Crime:** As many as 60% of adults in Federal prisons are there for drug-related crimes.
- **Education:** Children with prenatal cocaine exposure are more likely (1.5 times) to need special education services in school. Special education costs for this population are estimated at \$23 million per year.
- **The Workplace:** In 1997, illicit drug users were more likely than others to have missed 2 or more days of work in the past month and to have worked for three or more employers in the past year.

#### **Prevention (more information)**

The primary goal of prevention is to delay the first use of alcohol or other drugs. Research indicates that adolescents who begin drinking before age 14 are significantly more likely to experience alcohol dependence at some point in their lives compared to individuals who begin drinking after 21 years of age. In addition, youth who drink alcohol are more likely to experience a number of negative consequences, such as physical or sexual assault, unintentional injuries, memory problems, legal problems, and impaired school performance. That's why delaying the age of first use of alcohol and drugs is a critical goal of prevention. However, other protective factors, especially proactive parenting and strong family bonds, can help delay adolescents' experimentation with drugs and alcohol and thus help reduce long-term problems.

Prevention works best when attention is given to multiple risk and protective factors. Such factors exist in many areas of an adolescent's life and common risk factors can predict many problems. Reducing one risk factor may result in reduction of multiple problems in the family, school, peer group, and/or community. Increasing protective factors supports healthy development in all life areas, which helps them to resist influences to use.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

Research has identified seven key strategies shown to be effective in preventing and reducing substance abuse and related risky behaviors:

- Changes in public policies (laws and regulations)
- Rigorous enforcement of laws and regulations
- Collaboration among groups of citizens
- Communications to impact public perceptions about alcohol, tobacco, and drugs
- Education for both children and adults;
- Alternatives: activities, such as recreational programs, after-school, and weekend programs, community service activities, and tutoring and mentoring
- Early intervention—with pre-adolescents showing signs of antisocial behavior.

### **Prevention Prepared Communities**

A prevention prepared community is one where individuals, families, schools, faith-based organizations, workplaces, and communities take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide.

### **Community Process: Strategic Prevention Framework (SPF)**

- The recommended approach to support effective prevention in communities is the Strategic Prevention Framework (SPF), which identifies ***five phases: assessment, capacity building, planning, implementation, and evaluation***. In addition, cultural competence and sustainability are identified as key aspects that cut across the five phases.
- Prevention programs should take into consideration the target audience, which may be described in three levels: universal (all populations), selective (populations at risk) and indicated (populations that have demonstrated early involvement with substance use). The type of prevention strategies used should vary across these audience types.
- Prevention programs need to understand their target audience in terms of risk factors and protective factors, which may be categorized in multiple domains: individual, family, school, and community.



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### **Risk Factors**

- Risk factors are conditions that increase the likelihood that youth will get into trouble or expose themselves to danger.
- The greater the intensity or number of risk factors, the greater the likelihood that youth will engage in delinquent or other risky behaviors.
- Examples of risk factors are: inadequate life skills, low self-esteem, emotional or psychological problems, family conflict, a lack of bonding with the school environment, and association with delinquent peers.

### **Protective Factors**

- Protective factors are safeguards that promote resiliency and enhance a young person's ability to resist risks or hazards and make good decisions. Like risk factors, protective factors can exist in—and be addressed by—individuals, families, communities, and institutions.
- Examples of protective factors are: problem-solving skills, communication skills, a sense of self, positive parenting, bonding with a positive school environment, and association with peers who have a constructive influence.
- Exposure to protective factors helps young people make better decisions, confront obstacles, and find the supports they need. They may prevent, diminish, or counteract the effects of risk factors.
- Families and communities are keys to enhancing positive youth development when they provide strong parenting, good adult role models, and dependable sources of adult supervision, a strong sense of community, safe neighborhoods, and effective community-based and government services.

### **Perception of Risk (Consequences) and Its Relationship to Substance Use**

- Perception of risk of substance use is associated with use rates. Youth who perceived greater risk from substance use were less likely to engage in substance use.
- The most effective approach in getting youth to perceive risk in substance use is to engage in meaningful conversation that encourages the young person to reflect on the negative consequences of substance use.





6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- Research indicates that use of “scare tactics” or purely didactic delivery of information about substance use is minimally effective. However, focusing information dissemination on the consequences of substance use can increase perception of risk and have positive results.

### **Early Intervention: Bridging the Gap between Prevention and Treatment**

This study examined a SAMHSA model program— ‘keepin it REAL’—that has been demonstrated to be effective in delaying initiation of substance use among middle school students. The focus here, however, was whether this universal prevention program is also effective in leading to reductions or cessation in substance use among middle school students who were already using substances prior to the delivery of the prevention program. Results indicated that participation in the program increased the odds of substance use cessation by 65 percent and of reduction in use by 73 percent.

Except for alcohol, the time windows for targeted intervention to prevent progression to malignant patterns in adolescence are critically small, leaving little time for targeted intervention to prevent transition. The fast transitions to abuse and dependence in adolescence may be indicative for the increased vulnerability to substance effects in this time period.

### **Intervention Services**

Activities that are sub-clinical or pre-treatment (ASAM .05) and designed to explore and address problems or risk factors that appear to be related to substance use, and/or to assist individuals in recognizing the harmful consequences or inappropriate substance use. ***Early Intervention services are for individual(s) whose problems and risk factors appear to be related to substance abuse but do not meet any diagnostic criteria for substance abuse related disorders.*** Such individuals are defined "at risk" and early intervention may be delivered in a wide variety of settings to at-risk adolescents or adults with the length of such service varying according to the type of activity. The ultimate goal is the reduction of the effects of substance abuse within the targeted community by identifying and engaging those in need of services.

Early intervention services are delivered in a variety of settings, including clinical offices, schools, work sites, community centers, or an individual's home.



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Substance abuse treatment services and this early intervention component are delivered by community-based agencies who are under contract to DHS/Office of Alcoholism and Substance Abuse. Generally, these services are available locally in communities throughout states. This system enables clients to be assessed and treated as close to their home communities as possible, allows communities to take ownership of their programs, and facilitates public information. Treatment services are delivered through a ***continuum approach***, with individual clients moving from one level of care to another based on their assessed needs.

## **What's New in Prevention, Intervention and Treatment**

### **Evidence-Based Prevention Practice**

Evidence-based prevention refers to a set of prevention activities that evaluation research has shown to be effective. Some of these prevention activities help individuals develop the intentions and skills to act in a healthy manner. Others focus on creating an environment that supports healthy behavior.

### **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

SBIRT is a public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders. Many different types of community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

#### **About SBIRT**

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

SBIRT includes an early intervention approach that targets individuals with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive services..



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### **SBIRT Consists of Three Major Components:**

Screening – a healthcare professional assess a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.

Brief Intervention – a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.

Referral to Treatment – a healthcare professional provides a referral to brief therapy or additional treatments to patients who screen in need of additional services.

*Instructor Note: There are many more types of intervention services available in communities everywhere. Intervention is a response to the devastation substance abuse has on individuals, families and entire communities. Remember that the premise for prevention and intervention services is to stop substance abuse by addressing situations and circumstances that have been proven to promote substance experimentation (prevention) and intervening on risky substance use by addressing situations and circumstances that promote risky behaviors and practices (intervention).*

## **Service Coordination**

**Service Coordination:** The administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan.

Service coordination, which includes case management and client advocacy, establishes a framework of action for the client to achieve specified goals. It involves collaboration with the client and significant others, coordination of treatment and referral services, liaison activities with community resources and managed care systems, client advocacy, and ongoing evaluation of treatment progress and client needs.



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### **The competent professional is able to:**

#### **1. Initiate collaboration with the referral source.**

**Awareness:** Recognizes the importance of collaboration with referral sources in the implementation of individualized treatment plans.

**Initial Application:** Communicates specific client needs in the exchange of referral data, maintaining awareness of the importance of collaborative relationships with the referral resource.

**Competent Practice:** Routinely communicates client needs effectively in collaboration with other professionals in a manner consistent with confidentiality rules and regulations.

**Mastery:** Demonstrates a willingness to make treatment adjustments to accommodate the needs of both clients and referral resources taking into account eligibility criteria, service availability, and unanticipated circumstances.

#### **2. Establish accurate recovery expectations with the client and involved significant others.**

**Awareness:** Appreciates the importance of orienting clients and involved significant others to the treatment program, rules regarding client conduct, costs of care, and client rights and responsibilities.

**Initial Application:** Engages in orienting clients and involved significant others to all aspects of the treatment and recovery process.

**Competent Practice:** Develops accurate understanding of administrative and clinical rules and procedures, schedule of activities, program participation, and nature of service with the client and involved significant others.

**Mastery:** Demonstrates respect for the input of clients and significant others in establishing clear treatment and recovery expectations, including guidelines for both agency staff and client behavior and responsibilities.

#### **3. Coordinate all activities with services provided to the client by other resources.**

**Awareness:** Lists the most important issues related to effective coordination of client care



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**Initial Application:** Participates as a member of the treatment team and coordinates client activities both within the agency and community as directed by the team leader.

**Competent Practice:** Regularly engages in client advocacy, facilitation of client activities, resolution of conflicts, and problem solving in the delivery of agency and community services indicated in the treatment plan.

**Mastery:** Coordinates all aspects of client care including utilization of recovery services, resolution of service reimbursement issues, and assuring thorough documentation of client progress and services received.

**4. Summarize the client's personal and cultural background, treatment plan, recovery process, and problems inhibiting progress to ensure quality of care, gain feedback, and plan changes .**

**Awareness:** Understands the need to periodically assess treatment progress, taking into account the client's personal and cultural background, current bio-psychosocial status, treatment plan, and emerging needs.

**Initial Application:** Uses clear and concise oral and written communication in summarizing the relationship between the treatment plan, current status, and problems that might impede progress.

**Competent Practice:** Synthesizes available treatment information, solicits and interprets feedback related to progress and integrates relevant data into continuous treatment planning.

**Mastery:** Formulates and presents comprehensive case summaries. Prioritizes and integrates relevant client data into the treatment planning process. Recognizes setbacks as opportunities for improvement.

**5. Understand the terminology, procedures, and roles of other disciplines related to the treatment of substance use disorders.**

**Awareness:** Is aware of the roles a variety of disciplines and community service providers play in facilitating recovery.



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**Initial Application:** Gathers and seeks to understand information from a variety of sources regarding client progress and treatment.

**Competent Practice:** Demonstrates familiarity with the terminology and procedures used by other disciplines in the treatment of substance use disorders.

**Mastery:** Participates in interdisciplinary collaboration, demonstrating knowledge and appreciation for the role played by the range of involved community resources.

#### **6. Contribute as part of a multidisciplinary treatment team.**

**Awareness:** Appreciates the value of a multidisciplinary treatment team.

**Initial Application:** As a member of the multidisciplinary treatment team, contributes to problem solving and decision making related to client progress.

**Competent Practice:** With an understanding of treatment team processes, helps coordinate treatment services with external providers, maintaining appropriate confidentiality boundaries.

**Mastery:** Demonstrates leadership in facilitating the development of an effective interdisciplinary treatment team and the coordination of client care within the community.

#### **7. Apply confidentiality rules and regulations appropriately.**

**Awareness:** Has knowledge of confidentiality rules and regulations, consent guidelines, and client rights and responsibilities.

**Initial Application:** Helps clients understand their rights, responsibilities and applicable confidentiality rules, regulations and protections.

**Competent Practice:** Applies confidentiality guidelines appropriately in communicating with the client, family, significant others, and community service providers.

**Mastery:** Manages client emergency situations in a manner honoring clients' rights, prevailing confidentiality rules and regulations.

#### **8. Demonstrate respect and nonjudgmental attitudes toward clients in all contacts with community professionals and agencies.**



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**Awareness:** Acknowledges importance of maintaining a non-judgmental attitude toward all clients and community agencies.

**Initial Application:** Adopts an objective and respectful communication style in communicating with clients, significant others, and allied community providers.

**Competent Practice:** Demonstrates clear, concise and accurate communication when exchanging client information with other service providers.

**Mastery:** Advocates in a professional manner on behalf of the client in planning the most appropriate course of action among community partners consistent with confidentiality guidelines.

**9. Maintain ongoing contact with the client and involved significant others to ensure adherence to the treatment plan.**

**Awareness:** Recognizes the importance of continuously assessing client motivation and progress toward treatment objectives.

**Initial Application:** Engages the client and involved others in treatment activities, documenting adherence to the treatment plan, while continuously assessing progress toward treatment goals.

**Competent Practice:** Provides encouragement and support to client and involved others, continually assessing client investment in the treatment process; recognizing and addressing ambivalence and other barriers to progress.

**Mastery:** Assists client in maintaining motivation for change, increasing appreciation of personal strengths and skills and acknowledging incremental progress toward treatment goals.

**10. Understand and recognize stages of change and other signs of treatment progress.**

**Awareness:** Describes stages of change and methods for assessing treatment progress.

**Initial Application:** Utilizes standard measures in documenting treatment progress, including adherence to the treatment plan.



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**Competent Practice:** Recognizes how individual client characteristics affect preparedness for change and progress towards treatment goals.

**Mastery:** Provides support, encouragement, and optimism regarding treatment progress, reinforcing positive change and observable steps toward achievement of treatment goals.

#### **11. Describe and document the process, progress, and outcome.**

**Awareness:** Has a basic understanding of treatment planning, documentation of client progress, and generally accepted outcome measures.

**Initial Application:** Communicates clearly in both oral and written form, statements of client progress, and outcome.

**Competent Practice:** Applies progress and outcome measures in documenting client treatment achievements and setbacks.

**Mastery:** Prepares clear and concise documentation of treatment processes and recovery progress in a manner useful to the multidisciplinary treatment team.

#### **12. Conduct continuing care and relapse prevention with the client and involved significant others.**

**Awareness:** Is familiar with the principles of relapse prevention, continuing care, and discharge planning.

**Initial Application:** Uses knowledge of relapse and early recovery to assist client and significant others in developing basic relapse prevention and continuing care plans.

**Competent Practice:** Utilizes information from both treatment and community resources in negotiating a continuing recovery plan with the client and involved significant others.

**Mastery:** Negotiates continuing care planning in a manner emphasizing client autonomy, conflict, and problem solving skills and encouragement to engage in continuing strength based recovery.

#### **13. Document service coordination activities throughout the continuum of care.**





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**Awareness:** Understands the importance of maintaining accurate documentation of all service coordination activities.

**Initial Application:** Prepares clear and concise summaries of service coordination activities for the clinical record.

**Competent Practice:** Documents service coordination in an accurate and timely manner, consistent with confidentiality rules and regulations.

**Mastery:** Uses available technology to maximize efficiency, accuracy, and timeliness of clinical documentation related to service coordination

## **Referral**

**Referral:** Identifying the needs of a client that cannot be met by the professional or agency and assisting the client to utilize the support systems and community resources available.

### **Global Criteria:**

1. Identify need(s) and or problem(s) that the agency and/or professional cannot meet.
2. Explain the rationale for the referral to the client.
3. Match client needs and/or problems to appropriate resources.
4. Adhere to applicable laws, regulations and agency policies governing procedures related to the protection of the client's confidentiality.
5. Assist the client in utilizing the support systems and community resources available.

### **Explanation:**

In order to be competent in this function, the professional must be familiar with community resources, both alcohol and drug and others, and should be aware of the limitations of each service and if the limitations could adversely impact the client. In addition, the professional must be able to demonstrate a working knowledge of the referral process, including confidentiality requirements and outcomes of the referral. Referral is obviously closely related to case management when integrated into the initial and on-going treatment plan. It also includes, however, aftercare or discharge planning referrals that take into account the continuum of care.



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## **Referral is.....**

The process of facilitating the client's utilization of available support systems and community resources to meet needs identified in clinical evaluation and/or treatment planning.

### **The competent professional is able to:**

**1. Establish and maintain relationships with civic groups, agencies, other professionals, governmental entities, and the community at large to ensure appropriate referrals, identify service gaps, expand community resources, and help address unmet needs.**

**Awareness:** Is aware of the importance of community resources and their impact on client needs.

**Initial Application:** Knows local community resources and how to access them to improve client care.

**Competent Practice:** Builds effective relationships with community resources, utilizing them to help meet client needs in a manner consistent with confidentiality rules and regulations.

**Mastery:** Routinely involved with community partners in the treatment planning process, helping establish new resources to better meet unmet client needs.

**2. Continuously assess and evaluate referral resources to determine their appropriateness.**

**Awareness:** Recognizes the need to include community partners in the treatment process.

**Initial Application:** Makes initial contact with community partners and learns the function, mission, and resources of each service agency.

**Competent Practice:** Assesses the effectiveness of community resources, providing them feedback in order to assure or improve quality of care.

**Mastery:** Utilizes and maintains collaborative relationships among service organizations, advocating for innovative quality care.

**3. Differentiate between situations in which it is most appropriate for the client to self-refer to a resource and situations requiring professional referral.**



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**Awareness:** Knows client self-referral to a resource is different from professional referral

**Initial Application:** Makes referrals to community resources when referral is part of the treatment plan.

**Competent Practice:** Identifies situations in which it is appropriate for client to make initial contact with a community resource. Monitors client to assure follow through and makes referrals in situations requiring agency initiative.

**Mastery:** Empowers client to access needed community resources and collaborates with the client in situations requiring agency referral, utilizing crisis intervention methods when necessary.

**4. Arrange referrals to other professionals, agencies, community programs, or appropriate resources to meet the client's needs.**

**Awareness:** Researches protocols and procedures necessary to refer clients to community services.

**Initial Application:** Uses referral protocols, documents the process, and follows up to assure client engagement.

**Competent Practice:** Seeks opportunities for clients to engage community resources and makes necessary arrangements to insure engagement.

**Mastery:** Makes effective referrals and nurtures relationships with community resources to assure access to and creation of services that meet client needs.

**5. Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow-through.**

**Awareness:** Recognizes importance of explaining thoroughly to client how to accept community resources to enhance early recovery.

**Initial Application:** Explains the treatment plan and how use of community resources relates to client goals and objectives.



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**Competent Practice:** Interprets the treatment plan utilizing negotiation and education in securing client commitment to use of community resources.

**Mastery:** Secures client commitment to all aspects of the treatment plan, assuring client engagement with relevant community resources.

**6. Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality rules and regulations and generally accepted professional standards of care.**

**Awareness:** Is familiar with referral protocols, confidentiality rights, agency rules, and ethical standards of practice.

**Initial Application:** Obtains informed client consent, forwards relevant information to referral resource and documents the process consistent with agency protocol and the assurance of privacy rights.

**Competent Practice:** Accurately exchanges relevant client information with community resources utilizing oral, written, and electronic technology as appropriate.

**Mastery:** Demonstrates professionalism in communicating with a variety of community resources including legal and health care professionals in the exchange of client information.

**7. Evaluate the outcome of the referral.**

**Awareness:** Is aware of the importance of referral follow up in determining success of the referral.

**Initial Application:** Initiates contact with both client and referral resource to seek reports on client engagement and progress.

**Competent Practice:** Utilizes a variety of methods and techniques to evaluate referral outcomes.

**Mastery:** Uses appropriate measurement processes and instruments, both objective and subjective to evaluate and improve referral outcomes.



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