



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

Documentation

Introduction

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.

Clinical 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.

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.



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Instructor Note: This course is relatively brief, but don't let that fool you! Learning how to document a client's entire treatment episode is important for the client's treatment process, the agencies' standards and the counselor's ability to provide individualized up to the moment clinical interventions. Becoming a good clinical writer is what sets apart one average counselor from an excellent counselor. This course is short but integral in your professional education.

CLINICAL DOCUMENTATION AND RECORDKEEPING: The Purpose

Chapter 1

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 be followed to the letter in order to maintain professional ethics, agency standards, auditing need and of course, client protection.

Purposes of Clinical Documentation

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-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 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



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- 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
 - 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

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

Chapter 2

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 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.

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.

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 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 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
- 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 counselor'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;
 - 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

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 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)
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).



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Progress Notes

Chapter 3

Instructor Note: Right up front I am going to state this is the area where many a counselor fall down 😊 Counselors 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 counselor 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 counselors have to have great organizational skills and excellent time management. Excelling in these two areas allows the counselor 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. Counselors 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 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 counselor 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 counselor 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 counselor is not available to provide support to the client, the chance that another counselor will be able to provide meaningful assistance may be dependent on the quality of



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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.

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.



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Another less common format used in a clinical setting is BIRP – Behavior, Intervention, Response and Plan. Behavior is the counselor observations and client statements; Intervention is counselor's methods used to address goals and objectives, observation and client statements; Response is client's response to intervention and progress made toward treatment plan goals and objectives; and Plan is documenting what is going to happen next.

The premise of having a set format is to guide the content of the note. More importantly, the content areas should adhere to the documentation standards required by the clinician's regulatory body. In most cases, additional content includes diagnosis, MSE results, risk assessment, referrals, medications, and unresolved issues from past session. If a client misses a session, a progress note should document the missed appointment; any attempted contact with client, and/or if contact was received from the client. If non-billable services are performed, these should also be documented in a progress note as such.

The Process of Change

Progress notes should contain three specific elements: 1) The Counselor's Interventions, 2) The Client's Response to those interventions and, 3) The Process of Change. Think of it as a simple formula: The Counselor's Interventions X The Client's Response = The Client's Process of Change.

Chart documentation includes the expectation that progress notes include details that elaborate on how the client actually responded and/or related to a particular intervention, assignment, topic, discussion, film, etc. during counseling activities (individual, group, psycho-ed, etc.) In addition, progress notes should always connect the various aspects and interventions in treatment back to the primary purpose of providing substance use treatment services.

The Counselor's Interventions

Clinical interventions are creative methods and techniques counselors use to help the client make progress. In short, they are the action steps used on treatment plans to assist clients in reaching their goals. The progress notes should reflect which of the interventions (action steps) you are referring to. Describe specifically what the client is working on and what they have discovered or accomplished up to this point.

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.

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

Chapter 4



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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 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.

Counselors 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



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relapse triggers by sharing that rainy days and Mondays (or whatever) always bring her down and makes her feel like using.

Counselors 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 clinical observations. Make sure to distinguish between observations and personal opinions or judgments.

Here is an example of a clinical 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 counselor would be, “Client was hostile toward others and looked like he was ready to hit someone. Client probably drank last night.” Documenting clinical observations is important – documenting opinions and judgments is inappropriate.

Documenting the Treatment Plan

Chapter 5

Instructor Note: Just a few words.....once the master treatment plan is formulated between you, the counselor 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 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 clinical goals/objectives for specific symptoms. For example, if a client presents with a history of relapse with untreated anxiety as an underlying cause, the 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.

Documenting Client Discharges

Chapter 6

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 clinical 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, the presenting problem(s) from the client's perspective at intake, the client's initial clinical presentation, and the initial assessment, including the initial diagnoses and initial identified problems as identified by the practitioner
3. a review of the problem areas and symptoms addressed in treatment, the treatment modalities used, of the client's clinical course in treatment during the treatment period in question (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 and the treatment goals established were achieved during the treatment period in question; a brief assessment of the client's condition at the end of the time period in question; and, if this is an interval summary, a notation explaining any changes in diagnosis, prognosis, or the treatment/service plan
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

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.

Clinical Documentation Through the Eye of HIPAA

Chapter 7

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

The General Medical/Clinical Record Contrasted with Counseling Notes



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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. 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.....



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

(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



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the absence of the counselor/therapist. This material is also not necessary to document adequately the client's diagnosis and prognosis and the basis of those assessments, the 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 counselors 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 counselor 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 clinical 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 clinical record.

42 CFR Part 2

Chapter 8

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!

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.

Concluding Instructor Note

*Understanding the basic function and purpose of clinical documentation is important. However, learning to write quality clinical notes is an ART that takes time and practice. Becoming adept at this art puts you ahead of the game, **EVERYONE** benefits from a counselor who is really good at forming clinical 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.*

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

Developing quality clinical 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 clinical 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.



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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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2. ATP - Assessment & Treatment Planning; T. Gorski. August 2001
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