



Documentation and Record Keeping

The first and fundamental need of any organised society is the regulation of its network of relationships by means of objective, consistent, meaningful and useable documentation.

Luciana Duranti

The quote from Luciana Duranti points to the value of documentation as a means of regulating a society's network of relationships. We in the helping profession understand that objective, consistent, meaningful, and usable documentation serves as an essential element in ethical and effective practice. Record keeping and documentation for those in professional practice is an ethical mandate, a legal requirement, and a guide to effective practice. As will be described below, the maintenance of accurate records and documentation of one's practice decisions ensures that counselors follow the rules, regulations, and standards for health care set by the counseling profession and the state laws and federal regulations.

As you may anticipate, documentation and record keeping are an important part of your internship training. As counselor-in-training, you will begin to receive information about documentation and record keeping as it takes form and practice within your field site. The specific nature of the records to be maintained and the exact format to be used will often be site specific, but the general principles guiding record keeping cut across the specifics of any one locale or practice, and these will be discussed within this chapter. After completing this chapter, readers will be able to

- describe the nature and value of clinical documentation and record keeping,
- explain the ethical and legal requirements on documentation and record keeping,

- detail what should be included in progress notes,
- describe the common elements/formats of clinical note taking,
- describe issues involved in documentation and record keeping, and
- give details about the strategies to write clinical documentation.

Purpose of Documentation and Record Keeping

Professional counselors are ethically mandated to “create, safeguard, and maintain documentation necessary for rendering professional services” (ACA, 2014, A.1.b). The maintenance of clinical records and documentation ensures the ethical application of standard of care, provides a means for effective communication among all helping professionals, and serves as the data from which to respond to ethical and/or legal challenges.

Standard of Care

Standard of care in mental health professions is reflected in two aspects: what we do, that is the services provided, and the qualification of the provider to engage in those activities. As directed by our *Code of Ethics*, “Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience.” (ACA, 2014, C.2.a). The documentation of activities with any one client serves as the data from which counselors can demonstrate that they have been engaging in those activities that fall within their level of competence and current supervision. But beyond demonstrating that counselors are providing the services they are competent to provide, the clinical record and documentation when listing dates and types of service, as well as evidence of outcomes achieved, serve to demonstrate that this counselor is engaging in the highest standard of care by employing best practice procedures with demonstrated effectiveness.

Communication

The second purpose and value of good documentation and record keeping is that it allows for meaningful exchange and professional communication regarding client treatment or clinical practice. Clearly, there will be times when you wish to engage other professionals in the treatment of a client or perhaps arrange for a referral to a specialist. Sharing of clinical documents, with client permission, will facilitate the ongoing nature of care. Beyond concern for continuation of care, professional documentation is necessary when communicating with third party payers and professionals from accreditation bodies, or in case of legal questions.

As an intern, you will need to review your work and your cases with your on-site supervisor. The records you create, as directed by your site and your supervisor, will be useful when seeking and receiving supervision. It is important to check with your supervisor in order to understand the depth, breadth, and format for the records you are to keep.

Desirable Defense Against Litigation

Although a counselor's intent may be notable and his or her efforts to provide the best service may be commendable, it is not unusual for a client to be dissatisfied and even to file a complaint to the Division of Professional Licensure or state board of registration. This is certainly true in those cases where the mental health counselor failed to maintain acceptable standards of competence and integrity.

The possibility of legal action is a reality. Each year there are significant numbers of complaints filed to state boards of registration against mental health professionals, and the chance of lawsuits against mental health professionals has been high (Sanders, 2006; Slovenko, 2006). Obviously, the best defense against such legal action is to be proactive in reducing and managing one's risk. But in situations where defense is necessary, the presence of accurate documentation depicting the types and level of services provided, along with supervisory notations, will serve as the foundation for that defense. Good, accurate record keeping provides a good foundation for counselors against legal issues and ethics violation claims (Mitchell, 2007).

The value of keeping and maintaining documentation and records cannot be overemphasized. As you continue in your field training, it is important to become informed about the types of data you are to record as well as the format for reporting and maintaining those data. Not only is this a training requirement during your internship, but also an obligation in your lifelong profession. While doing your internship and becoming a competent counselor, you want gradually to build this part of counseling practice into your professional identity.

Ethical and Legal Ramifications

Learning about ethical and legal ramifications of clinical documentation and record keeping during your internship is as crucial as developing your competence in other areas of counseling or counseling psychology. As you know, documentation serves as a road map of clinical treatment that the counselor provides, and record keeping is the only way that reflects the contact between the counselor and the client has been made. Due to the essential function of documentation and record keeping, all health professions have created codes of ethics to govern their members' professional behaviors, and counseling is no exception. As a counselor, one must know the requirements of the *ACA Code of Ethics* concerning clinical documentation and record keeping. As noted in our *Code of Ethics* (ACA, 2014),

Counselors create, safeguard, and maintain documentation necessary for rendering professional services. Regardless of the medium, counselors include sufficient and timely documentation to facilitate the delivery and continuity of services. Counselors take reasonable steps to ensure that documentation accurately reflects client progress and services provided. If amendments are made to records and documentation, counselors take steps to properly note the amendments according to agency or institutional policies. (ACA, 2014, A.1.b)

In reviewing this guideline, a number of concepts emerge as requiring special attention. Counselors *create* and *safeguard sufficient* and *timely* documentation to facilitate the delivery of continuity of services and also take reasonable steps to ensure *documentation accurately reflects client progress and services* provided. Table 10.1 contains a list of specifications of the *Code of Ethics* by the ACA (2014) concerning documentation and record keeping.

The mandate to keep and maintain records is not limited to those associated with the American Counseling Association. Although it does not provide specific procedures on how to document, the American School Counseling Association (ASCA) requires the following:

The professional school counselors: (a) Maintain and secure records necessary for rendering professional services to the student as required by laws, regulations, institutional procedures, and confidentiality guidelines. (b) Keep sole-possession records separate from students' educational records in keeping with state laws. (c) Recognize the limits of sole-possession records and understand these records are a memory aid for the creator and in absence of privilege communication. (ASCA, 2010, A8)

Further, the American Psychological Association (APA, 2010) requires its members to create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in

Table 10.1 ACA Code of Ethics on Documentation and Record Keeping

Counselors ensure that records and documentation kept in any medium are secure and that only authorized persons have access to them. (B.6.b)
Counselors take reasonable precautions to protect client confidentiality in the event of the counselor's termination of practice, incapacity, or death and appoint a records custodian when identified as appropriate. (B.6.i)
Counselors provide reasonable access to records and copies of records when requested by competent clients. Counselors limit the access of clients to their records, or portions of their records, only when there is compelling evidence that such access would cause harm to the client. (B.6.e)
When clients request access to their records, counselors provide assistance and consultation in interpreting counseling records. (B.6.f)
Counselors store records following termination of services to ensure reasonable future access, maintain records in accordance with federal and state laws and statutes such as licensure laws and policies governing records, and dispose of client records and other sensitive materials in a manner that protects client confidentiality. (B.6.h)
Counselors maintain electronic records in accordance with relevant laws and statutes. Counselors inform clients on how records are maintained electronically. (H.5.a)

Source: Code of Ethics. American Counseling Association (2014).

order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (APA, 2010, 6.01)

In addition to these, other mental health professions, such as the American Association for Marriage and Family Therapy (AAMFT) and the National Association of Social Workers (NASW), articulate the same ethical requirement for documentation and record keeping.

Our professional organizations have directed the creation and maintenance of clinical records for a long time, but record keeping took on a new dimension with the enactment of HIPAA (1996). The Federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, was passed to establish a national framework for security standards and protection of confidentiality with regard to health-care data and information. HIPAA also has specific regulations stipulating health professionals' behaviors in terms of documentation. As it states in its Simplification Regulation Text about documentation standards, health professionals "(i) maintain policies and procedures implemented to comply with this subpart in written (which may be electronic) form; and (ii) if an action, activity or assessment is required by this subpart to be documented, maintain a written (which may be electronic) record of the action, activity, or assessment" (Department of Health and Human Services, 2013, Sect. 164.316 b). Furthermore, HIPAA requires that documentation is reviewed periodically and updated as needed and such documentation kept for 6 years from the date of its creation or the date when it last was in effect, whichever is later. In addition to HIPAA, each state also has laws governing health professionals' actions on documentation and record keeping. All practicing counselors need to be aware of and in compliance with the federal and their state guidelines.

As an intern, you may have received ethics training on documentation and record keeping. The purpose of your training and discussing ethics on documentation and recording keeping in your internship class is to help you reduce unethical behaviors and become more aware of ethical conflicts in your work. With that training, you will be able to work through potential conflicts or correct unethical behaviors to reach more morally responsible decisions while you create clinical documentation and maintain records. Exercise 10.1 invites you to do a thorough search on policies and regulations on clinical documentation and record keeping of your internship site and the state where you intend to work after you graduate.

The "What" of Case Documentation

The specific form and details to be included in one's treatment plan and progress notes may vary according to the nature of the work one is doing and the site at which it is being done. However, having said that, there are some general considerations on the what and how of case documentation that cut across these specifics.

EXERCISE 10.1

A Preliminary Search

Directions: In this exercise, you are asked to do a preliminary search on the documentation and record-keeping requirements of your internship site and the laws and regulations of the state where you intend to work after you graduate.

	Internship Site Policies and Requirements	Your Professional Organization's Standards and Requirements	Your State Law	Similarities & Differences Among Three
Documentation	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
Record Keeping	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.

Treatment Plans

The articulation of a treatment plan is another component of your clinical writing and case documentation. However, this does not happen as frequently as writing your session notes. Institutions and agencies may have different requirements in terms of time and frequency for the development of clinical treatment plans. Some may require the counselor to complete the treatment plan after he or she sees the client two or three times and update it every 3 or 6 months. Others may be more flexible.

It is important for you to inquire about the nature, format, and frequency of developing or adjusting treatment plans at your site. Further, because it is an ethical requirement that we engage our clients in the development of such plans as well as receive their informed consent acknowledging their understanding of what will occur, the development and modification of treatment plans within session can prove useful. Doing the treatment plan during the session may have a few advantages. First, it obviously saves you time. You can finish this piece of paperwork in session instead of out of session. Second, you meet the requirement of the accuracy and timely efficiency of documentation. Finally, it allows for your client's full participation and your ability to check for the reasonableness of the plan as detailed. As with the process of recording session progress notes, engaging in the development and subsequent modification of a treatment plan in session with the client will, with repetition, become a professional habit giving form to your developing professional identity. You are invited to complete Exercise 10.2, My Habit of Clinical Documentation.

EXERCISE 10.2**My Habit of Clinical Documentation**

Directions: In this exercise, you are asked to explore your habit of documenting the service you have provided. After you finish it, identify if there is a pattern in your behavior of clinical writing and paperwork completion.

1. The number of clients that I have seen in the past 2 weeks is _____.
2. The number of clients that I have seen a day in the past 2 weeks is _____, _____, _____.
3. I completed the progress note immediately after the session _____ times.
4. I completed the progress note by the end of the day _____ times.
5. I completed the progress note the next day _____ times.
6. I completed the progress note within 2 days _____ times.
7. I completed the progress note within 3 days _____ times.
8. I completed the progress note within 4 days _____ times.
9. I completed the progress note by the end of the week _____ times.
10. I completed the progress note in the following week _____ times.

Progress Notes: A Fundamental and Practical Form of Recording

You may have heard of the 50-minute hour. For many in clinical practice, a session is one that extends for 50 minutes. The value of such timing is that it allows the clinician to take time at the end of a session to reflect on what just occurred and consider the directions to be taken in the next session with that client. It is often during this 10-minute interval that a clinician will record his or her session notes. Session notes can be easy when they are done immediately after each session is over. One can imagine how confusing and burdensome it would be to try to recreate session notes for all clients at the end of a day or, worse yet, a week. Imagine what it would look like if this counselor accumulates his or her unfinished session notes, treatment plans, test interpretation, and so forth for a week. Because of counselors' tendency to value the interaction and the human element in our counseling, it may be tempting to see our note taking as administrative, bothersome, and even unrelated to "real" treatment. Such a perspective toward note taking can be problematic if counselors are not supervised or audited periodically. Case Illustration 10.1 is a real example about how a senior counseling professional managed his clinical writing. Sadly, such behavior may not be that rare.

CASE ILLUSTRATION 10.1

A Real Surprise

Jim is a licensed professional counselor and has practiced for more than 15 years at a state college counseling center. As the only senior staff, Jim supervises two other professional counselors and he reports to the Dean of Students at the college. Once in a while, Jim also acted as supervisor for one or two master's-level interns and provided them weekly supervision. Besides some administrative work, Jim saw four or five clients each day. Jim enjoyed working with his clients and always pleasantly taught the interns in supervision. His colleagues and students loved him in all areas that he did but one—paperwork. The interns and the two counselors he supervised often complained that Jim did not complete their evaluations in a timely manner. Particularly when Jim promised the interns to write them letters of recommendation, he did not do it. Although Jim liked where he was, he was still looking for other places to work because there was no position for him to be promoted to at the college counseling center. Recently, he received a job offer from a state university as director of the counseling center. Because he was leaving, two other counselors would take over all his cases. After the two counselors accessed Jim's clients' files, they were very much surprised to find that he had not done his paperwork—case notes, treatment plans, and so forth—for 2 years.

The importance of accurate, immediate recording is seen in the American Psychological Association (APA, 2007) requirement that its members “make efforts to see that legible and accurate entries are made in client records as soon as is practicable after a service is rendered” (p. 995).

It is important to use this time during your field experience to begin to develop your professional habit of documentation and record keeping. With practice, the creation of meaningful and useful records will become as natural to your practice as the skills of attending and will eventually become part of your professional identity. The development of your habit of recording the service you provide serves to highlight your professionalism and your intention of doing no harm to your clients. Your good habit of documenting the service you provide builds a solid foundation for the high quality of care.

As noted previously, if allowed within your agency, it is useful to schedule your appointments so that you have safeguarded 10 minutes at the end to reflect on the session and make legible and accurate entries of the service provided and perhaps the directions to be taken. If for some reason you can't finish your session notes before your next appointment, you will want to finish your case notes either before your lunch or before you leave the office at the end of the day. Further, if there is a time when your client fails to attend a session, we suggest that you use that time to review your notes and clarify and expand as needed. Although you may find that various pressures make it difficult to develop your notes immediately following the

end of a session, it is essential that you commit to not leaving the process of recording session notes until the next day.

Perhaps this directive “not to wait until tomorrow” appears reactive, but there are a few issues of concern that exist if you leave your session notes for the next day. First, we all know how memory decays as time moves on. Your ability to recall what happened in sessions can be restricted the next day. Second, after you go home, anything can happen. If something happens at home, you may not be able to come to work, or the event(s) at home can interrupt your ability to recall what happened in your sessions. Third, when you see multiple clients, sometimes the clients and client issues can be similar, which may confuse you while you recall during the next day. Both the second and third situations can make your accuracy of documentation questionable.

Recommendations for Case Notes Writing and Record Keeping

We are very positive that you will receive quality training at your internship site and from your faculty supervisor about documentation and record keeping. We also believe both your site supervisor and faculty supervisor are experienced in clinical practice and will be able to provide you with tips and recommendations for case notes writing and knowledge about record keeping based on their clinical experiences. In addition to those resources, we also offer you some suggestions on case notes writing gained from our professional practice. We hope you will find these useful as you engage in your field work and even in your future practice.

1. Write your case notes in a timely fashion.

Case notes are the key tracking records that provide (a) evidence of your client’s treatment, progress, or lack of progress; (b) evidence of your decisions and actions taken during treatment; (c) a rationale and defense for you should the case become a legal one; and (d) evidence that you follow the best practice (Hodges, 2011). The timing of taking case notes has both ethical and legal implications, and events recorded immediately reflect more accuracy than events recorded later on. Therefore, you want to develop a good habit of writing your case notes immediately after the session or as soon as possible.

2. Include essential elements in your case notes.

The content of case notes is crucial because it reflects the treatment of standard care, and there is the potential that the case notes may be reviewed by professionals from a variety of fields and your clients. How much to include in your case notes is a decision you need to make based on whether the information is a necessary part of the session you have conducted. Table 10.2 contains some examples of essential elements that should be included in case notes. We urge you to review them and keep them in mind while writing your case notes.

Table 10.2 Examples of Essential Elements That Should Be Included in Counseling Case Notes

- Times that a counseling session starts and stops
- Treatment modalities
- Progress or lack of progress
- Treatment plan made or modified
- Results of clinical tests
- Diagnosis or symptoms
- Functional status
- Danger to self/others
- Child abuse or elder abuse involved
- Actions taken on emergencies
- Consultation or teamwork with other health professionals
- Compliance or lack of compliance from clients
- Recommendations made
- Issues related to fees
- Issues related to informed consent
- Treatment compliance or lack of compliance
- Issues related to termination
- Referral made

3. Use concise language and accurate terminology.

Clarity is key for any documentation, and counseling case notes are not an exception. When writing case notes, counselors need to make good choices of words that are specific, explicit, clear-cut, and precise, because “clear, specific, unambiguous, and precise wording enhances the delivery of services” (Reamer, 2005, p. 330). While taking case notes, you need to do your best to limit words that are vague such as “*something, someone, someplace, nice, soon, late, terrible, miserable, interesting, simple, furniture*” and so forth. For example, instead of saying that *client was late for today’s session*, you may want to make your statement precise, such as *client arrived 20 minutes after the originally scheduled time for today’s session*. Another example can be instead of saying *client looked tired in today’s session*, you may want to state your observation as *client yawned with watery eyes about every half-minute, and each time after he yawned, he said, “I’m so sorry and this is rude.”* When some clients are not as cooperative as you expect, avoid saying *client was very resistant* to describe the client’s behavior while you take your case notes. You may want to be specific in describing his or her behavior, for example, *Client neither responded directly to almost all the questions asked, nor did the homework assignments as agreed in the previous session.*

4. Keep in mind an audience while documenting.

While writing your case notes, keep in mind who, besides yourself, may be reviewing these notes. Generally speaking, people who possibly read your case notes can be

counselors, other health professionals (e.g., nurses, doctors, and psychiatrists), lawyers, judges, auditors, clients, and clients' parents. No matter who is reading your case notes, the person expects the information to be arranged in a consistent and systematic manner. If you use a certain case notes format, strictly follow that format. For example, if you use SOAP format (see the following section on case notes format), you should always follow the format to arrange your case notes in the order of subjective, objective, assessment, and plan. When you write the subjective part, you describe in a consistent manner your client's feelings, concerns, plans, goals, thoughts, and so forth. While writing the objective part, you arrange your observation in the order of appearance, affect, behavior, strengths, weaknesses, and so forth (see Table 10.3).

Because your case notes might be read by other health professionals and professionals from other disciplines, avoid including political, religious, and racial views, as well as avoid using defamatory language about other counselors or health professionals (Cameron & turtle-song, 2002); rather, write your case notes in a constructive, simple, and objective fashion (Baird, 2002).

5. Always ask when you feel uncertain.

The golden rule is, always ask when you feel uncertain. Agencies, institutions, and schools oftentimes cover general situations in their policies and regulations. As an intern, it is common that you may have questions regarding areas and situations that are not specified in the policies of your internship site. Your site supervisor and senior counselors are your resources and assets for things you are unsure about.

The “How,” or Format, of Case Documentation

As we have discussed earlier in this chapter, the purpose of documentation is to give full care to clients, to communicate with other health professionals, to meet professional standards, and to protect clients and counselors themselves legally. Progress notes are an essential portion of clinical documentation, which demonstrate the counselor's day-to-day care for his or her clients. Writing progress notes in a consistent manner in terms of format and content can be crucial in this process of care. As you may know, form always follows the content. So does the form of counseling session notes. Counseling or psychotherapy session note form is designed for the counselor to focus on certain aspects of the counseling process and “to facilitate the formulation of inferences and hypotheses on the basis of clinical data” (Presser & Pfof, 1985, p. 11).

Although there are many systems or methods for taking and recording case notes (e.g., Individual Educational Programs [IEP] and Functional Outcomes Reporting [FOR]), we are going to introduce you to four standard formats of counseling progress notes, (a) SOAP, (b) IPSN, (c) DART, and (d) DAP, for your consideration while you practice at your internship site. You may want to check with your internship site supervisor about the internship site's guidelines regarding record keeping and make sure that you follow those guidelines. If your internship site does not have a requirement for its health professionals to use a specific notes format, you may consider one of these formats based on your personal preference.

SOAP Notes

The first format to be discussed, SOAP notes, is probably the most commonly used standard format across all health professions. SOAP notes originated in the medical field and are part of the problem-oriented medical records (POMR), which are commonly used by medical and other health professionals. SOAP is an acronym that stands for Subjective, Objective, Assessment, and Plan, a system created by Lawrence L. Weed (1964). The counselor's progress notes are structured within the framework of these four components, that is to say, after your individual session is over, you as counselor may follow this structure to write your case notes if you choose to use this case notes system. An excellent review of the use of SOAP notes was written by Susan Cameron and Imani Turtle-Song (2002), and their review serves as the basis for the discussion that follows.

Subjective

In the SOAP notes system, *subjective* means the information from the client and the client's family members, friends, teachers, or anyone who provides information about the client and the client's issues. More specifically, the information may include the client's thoughts, feelings, behaviors, or points of view that negatively or positively affect the client's significant relationships.

Objective

The word *objective* in the SOAP notes system means facts or factual information. This information comes from the observations of the counselor or others. The information in this section may contain the client's appearance, smell, affect, behaviors, thought processing, relationship with the counselor, strengths, weaknesses, response to treatment, compliance with medication, results of physical tests, or observations from other health professionals. The counselor's objective observations must be evidence based instead of personal opinions, judgments, labels, or values-laden language. The wording must be precise and descriptive. Words such as "appear" or "seem" should not be used. If they are used, the counselor needs to provide justification with observational evidence.

Although it may appear useful to include client quotations as part of the "objective" data, such inclusion should be done with caution. As a general rule, the inclusion of client quotes should be kept to a minimum. According to Cameron and Turtle-Song (2002), the inclusion of too many quotes may make it difficult for clinicians to view the client themes and track the therapeutic intervention effectiveness. Moreover, the counselor also needs to be mindful about the appropriateness of the content while writing his or her progress notes. Because your progress notes are read by other professionals, you may not want to repeat the client's inflammatory statements and you may want to omit information about insidious family life, political, religious, and racial views unless these are the focus of therapy, because this information can be interpreted negatively about the client and his or her behaviors. Ultimately, it may risk the client's care from other health professionals. Client quotations or identification of key words or phrases are used to highlight, emphasize, or provide additional support to a notation. This may

be particularly useful when documenting a client's aggressive behaviors and abusive languages, which might suggest potential threat toward the counselor. An additional area in which the use of direct quotation may be of value is when noting client's confusion of time, space, or people.

Assessment

The assessment section is where the counselor summarizes and synthesizes the subjective and objective data. This section also reflects the counselor's clinical impressions concerning the client's presenting issue or issues. Generally the assessment is stated in the form of diagnosis based on DSM-V (American Psychiatric Association, 2013), which is included each time the counselor writes his or her case notes. The authors indicated that some counselors may resist a DSM diagnosis, but third party payers and accrediting bodies have such expectation.

Two major points need to be kept in mind when the counselor writes the assessment section. One is that the assessment must be based on the data collected in the subjective and the objective section. When a diagnosis is made and the counselor is not confident about the diagnosis, insufficient data may have been collected. In this situation, the counselor needs to consult a senior colleague. The other point is the counselor's clinical impression, which is made in the progress notes when there is lack of sufficient data in the subjective and the objective sections to support a particular diagnosis. In such a case, the counselor needs to summarize the existing information in the subjective and the objective sections and make a clear conclusion for future counselors or health professionals to follow his or her reasoning in order to reach a final diagnosis.

Plan

The plan section of the SOAP notes system covers the parameters of counseling interventions that have been used. Specifically, this section includes the action plan as well as the prognosis. In the action plan, the counselor writes about the date of the appointment for the upcoming counseling session, intervention(s) used during the complete session, homework or assignment, treatment progress, consultation, and treatment direction for the upcoming session. The client's prognosis or progress assessment included in this section is a forecast for future gains given what the client has been treated with.

As Cameron and turtle-song (2002) state in their article, the plan brings the SOAP notes and treatment direction full circle. As counselor, you document not only all the interventions used in the session that you have just completed with the client but also possible interventions that may be used by other counselors or health professionals. In addition, you use words such as *poor*, *guarded*, *fair*, *good*, or *excellent* to make the progressive assessment with supportive explanations.

Table 10.3 provides a summary of SOAP definitions and examples as provided by Cameron and turtle-song (2002). Table 10.4 presents guidelines for the creation of progress notes. Finally, we invite you to practice using SOAP notes (see Exercise 10.3).

Table 10.3 A Summarization of SOAP Definitions and Examples

<i>Section</i>	<i>Definitions</i>	<i>Examples</i>
Subjective (S)	<p>What the client tells you</p> <p>What pertinent others tell you about the client</p> <p>Basically, how the client experiences the world</p>	<p>Client's feelings, concerns, plans, goals, and thoughts</p> <p>Intensity of problems and impact on relationships</p> <p>Pertinent comments by family, case managers, behavioral therapists, etc.</p> <p>Client's orientation to time, place, and person</p> <p>Client's verbalized changes toward helping</p>
Objective (O)	<p>Factual</p> <p>What the counselor personally observes/witnesses</p> <p>Quantifiable: what was seen, counted, smelled, heard, or measured</p> <p>Outside written materials received</p>	<p>The client's general appearance, affect, behavior</p> <p>Nature of the helping relationship</p> <p>Client's demonstrated strengths and weaknesses</p> <p>Test results, materials from other agencies, etc., are to be noted and attached</p>
Assessment (A)	<p>Summarizes the counselor's clinical thinking</p> <p>A synthesis and analysis of the subjective and objective portion of the notes</p>	<p>For counselor: Include clinical diagnosis and clinical impressions (if any)</p> <p>For care providers: How would you label the client's behavior and the reasons (if any) for this behavior?</p>
Plan (P)	<p>Describes the parameters of treatment</p> <p>Consists of an action plan and prognosis</p>	<p>Action plan: Include interventions used, treatment progress, and direction</p> <p>Counselors should include the date of next appointment</p> <p>Prognosis: Include the anticipated gains from the interventions</p>

Source: Reprinted from "Learning to Write Case Notes Using the SOAP Format" by S. Cameron and i. turtle-song, 2002, *Journal of Counseling & Development*, 80, p. 290. Reprinted with permission.

Table 10.4 Guidelines for Subjective, Objective, Assessment, Plan (SOAP) Noting

<i>Do</i>	<i>Avoid</i>
<p>Be brief and concise.</p> <p>Keep quotes to a minimum.</p> <p>Use an active voice.</p>	<p>Avoid using names of other clients, family members, or others named by client.</p> <p>Avoid terms like seems, appears.</p>

<i>Do</i>	<i>Avoid</i>
<p>Use precise and descriptive terms.</p> <p>Record immediately after each session.</p> <p>Start each new entry with date and time of session.</p> <p>Write legibly and neatly.</p> <p>Use proper spelling, grammar, and punctuation.</p> <p>Document all contacts or attempted contacts.</p> <p>Use only black ink if notes are handwritten.</p> <p>Sign-off using legal signature, plus your title.</p>	<p>Do not use terminology unless trained to do so.</p> <p>Do not erase, obliterate, use correction fluid, or in any way attempt to obscure mistakes.</p> <p>Do not leave blank spaces between entries.</p> <p>Do not try to squeeze additional commentary between lines or in margins.</p>

Source: Reprinted from "Learning to Write Case Notes Using the SOAP Format" by S. Cameron and i. turtle-song, 2002, *Journal of Counseling & Development*, 80, p. 291. Reprinted with permission.

EXERCISE 10.3

Session Notes (SOAP Notes)

Directions: This exercise offers you an opportunity to practice the SOAP notes format. You are asked to write up a session of one of your cases. After you complete your notes, check to see if you have followed the guidelines offered by Cameron and turtle-song.

Session Notes (SOAP Notes)

Counselor: _____ Session Date: _____ Time: ___ to _____

Client(s) Name: _____ Session #: _____

Client Description:

Subjective Complaint:

Objective Findings:

Assessment of Progress:

Plans for Next Session:

Needs for Supervision:

Counselor Signs:

By now, you may see some advantages of the SOAP notes system, for example, its well-designed structure, consistency across all your documentation, care with a problem focus, a nature of combination of subjective and objective perspectives from both

the counselor and the client with supporting evidence, easy-to-retrieve information, and so forth. However, it also has its disadvantages. These disadvantages include but are not limited to (a) it has a medical background with terminology ambiguity and rigid guidelines (Baird, 2008); (b) the problem focus may reduce the probability of the client's problems being resolved because in many situations clients have no control over the problems they face in their lives; and (c) it categorizes the client with a diagnosis label(s), which is contradictory to the belief of many counselors. Given these advantages and disadvantages, we suggest you choose your progress notes system based on your counseling theoretical orientation and the requirements of your state laws or third party payers if the organization, agency, or school you work for does not require you to follow a specific format.

A number of other systems, which specifically address the needs of counselors and therapists, have been developed, including the Individual Psychotherapy Session Note format (IPSN), described below.

Individual Psychotherapy Session Note (IPSN)

IPSN, or the individual psychotherapy session notes format, was developed by Nan R. Presser and Karen S. Pfof (1985). As these authors described in their article, this format of session notes was especially useful for counseling and counseling psychology novices. Presser and Pfof indicated that they developed this session notes format based on three principles: (a) encouraging counselor attendance to several specific, relevant aspects of the therapeutic process; (b) being atheoretical so it is useful for counselors adhering to most theoretical orientations; and (c) being simple, not time consuming, and user friendly.

IPSN's format includes eight sections: brief summary of session, client, therapist, therapist-client interaction, problem addressed, progress made, plans, and other. The first section includes a narrative overview of the session with a sequential account of major events within the session. In the second section, the counselor objectively records the client's verbal and nonverbal behavior, including the counselor's hypotheses and inferences, with emphasis on the speculative nature of such inferences and desirability of testing of hypotheses later. The third section consists of the counselor's overview of his or her own behavior. This information helps the counselor both to examine and to increase awareness of his or her own behavior with a purpose of altering the counselor's perspective so he or she can be subjective and objective. The information in this section can also be used to evaluate the consistency of the counselor's behavior, correspondence to a theoretical stance, and evolution of the counselor's own style. The fourth section is about the interaction between the counselor and the client. The focus of this section is on the interpersonal dynamics, not on the individuals. The information in this section can be used to evaluate the therapeutic relationship. The fifth section is the place where the problems are addressed. The problems are the ones that are addressed within the session. In the sixth section, the counselor will record the assessment of the progress

that the client has made. This assessment also provides legitimacy for the continuation of the therapy and a need for movement within therapy. The seventh section is about the plans, which include information about the transition from the current session to the future ones. In this section, the counselor may plan therapeutic alternatives and conceptualize issues that the client will work on in the subsequent sessions. The last section includes information that may not logically belong in any of the previous session, such as test data or relevant correspondence. Table 10.5 includes a sample of this format of progress notes as developed by Presser and Pfost.

Table 10.5 Individual Psychotherapy Session Notes (IPSN)

<p>I. BRIEF SUMMARY OF SESSION:</p> <p>Pt. had a recent argument with her parents regarding lack of progress in finding another job led into discussion of pervasive feelings of inadequacy and hopelessness. She feels incapable of attaining the standards which her parents have set for her, but still she refuses to acknowledge any anger toward them. She appears more depressed and reports increased incidence of self-destructive behaviors. Does not appear to be suicidal at this time.</p>	
<p>THERAPIST'S OBSERVATIONS OF:</p>	<p>THERAPIST'S INTERPRETATIONS AND HYPOTHESES:</p>
<p>II. CLIENT:</p> <p>At the beginning of session, pt. talked slowly and softly with infrequent pauses; slumped in chair; rarely made eye contact.</p> <p>Later, many self-deprecating statements as she discussed parents' expectations. Raised voice when discussing these, but denied anger.</p> <p>Reported drinking and contact with ex-boyfriend.</p> <p>Hinted re suicide, but denied intent.</p>	<p>Appears moderately depressed; turning anger inward? May be exacerbated by drinking.</p> <p>Seems threatened by suggestion that she might feel angry toward parents. Overidealization of them is impediment.</p> <p>Presents self as victim and seems stuck in this role; assumes it with ex-boyfriend and parents.</p> <p>Could hints about suicide and drinking be to elicit rescuing by therapist?</p>
<p>III. THERAPIST:</p> <p>Early in session felt tired, looked at watch frequently.</p> <p>Interventions primarily reflective and clarifying.</p> <p>Tone of voice gentle, soothing.</p>	<p>Initially impatient and bored. Am I becoming tired of her helplessness?</p> <p>Approach is relatively client-centered, with only mild confrontations. Is this avoidance of confrontation my issue (helpless behavior annoys me) or is it due to wanting to avoid recapitulation of victimization?</p>

(Continued)

Table 10.5 (Continued)

<p>IV. THERAPIST-CLIENT INTERACTION:</p> <p>When pt. appears helpless or distressed, therapist is still responding supportively rather than confronting.</p> <p>Pt. asked if therapist was disappointed in her lack of progress and reported surprise at the negative reply; this was discussed vis-a-vis her father.</p>	<p>Does pt. typically elicit rescuing, or at times the opposite (frustration and alienating others with her helplessness)?</p> <p>Relationship with therapist is beginning to parallel relationship with father, particularly re projection of negative evaluation onto therapist and expectation of criticism.</p>
<p>V. PROBLEMS ADDRESSED:</p> <ol style="list-style-type: none"> 1. Pt.'s feelings of unworthiness and despair re attaining the standards which she has injected. 2. Relationship with parents. 3. Expectations of negative evaluations. 	<p>VI. PROGRESS MADE:</p> <p>Displays more insight into the connection between internalized standards and her depression.</p> <p>Beginning to express some of the anger that she has heretofore turned inward.</p> <p>Her expectation that therapist would also judge her negatively was examined. Therapeutic alliance solidified by discussion of her reaction to therapist.</p>
<p>VII. PLANS:</p> <p>In supervision, bring up my reaction to her helplessness and consider reacting differently (first explore if this is my issue and, if not, how best to respond to her).</p> <p>Look for more signs of anger and point these out as they occur.</p> <p>Explore idealization of parents.</p> <p>Continue to monitor suicidal ideation.</p>	<p>VIII. OTHER:</p> <p>Will soon need to discuss my absence due to vacation.</p>

Source: Reprinted from "A Format for Individual Psychotherapy Session Notes" by N. R. Presser and K. S. Pfof, 1985, *Professional Psychology: Research and Practice* 16(1), pp. 13–14. Reprinted with permission.

While being particularly useful for novice counselors, IPSN has a number of other advantages. These advantages include (a) clear distinction among all aspects of each counseling session, (b) an atheoretical nature, (c) a focus on interaction or dynamics between counselor and client, (d) minimization of diagnosis, (e) inclusion of counselor behaviors, and (f) a process orientation. However, there are major disadvantages with IPSN. One is that the format seems lengthy (although the authors claimed it is not time

consuming), and the counselor may not be able to complete it within 10 minutes before he or she starts the next session. When a counselor has a full schedule for the day, accumulation of unfinished session notes can be cumbersome. The other disadvantage is that logging counselor behaviors such as being tired or not being able to concentrate in session in the client's permanent file may not be desirable. Counselors may be concerned that in any legal action, such notes may suggest that they were ill-prepared or in some way unable to provide the best care. Perhaps the best way to assess any system is to employ it. As such, you are invited to complete Exercise 10.4, which offers you an opportunity to use IPSN to write one of your cases.

EXERCISE 10.4

Session Notes (IPSN notes)

Directions: This exercise offers you an opportunity to practice the IPSN format. You are asked to write up a session of one of your cases with IPSN format. After you complete your notes, check to see if you have followed the guidelines offered by Presser and Pfost.

Counselor: _____ Session Date: _____ Time: ____ to ____

Client(s) Name: _____ Session #: _____

Brief Summary of Session:

Client:

Therapist:

Therapist-Client Interaction:

Problems Addressed:

Progress Made:

Plans:

Others:

Counselor Sign:

Data, Assessment, and Plan (DAP)

DAP is another session notes format commonly used by health professionals at agencies and institutions. DAP, which is the acronym for Data, Assessment, and Plan (or sometimes Description, Analysis, and Plan) has been found to be useful for mental health providers.

Data (Description)

Data (or Description) refers to the section in which factual information or data collected by the counselor during the session is presented. This factual information or data contains what the client and the counselor said on specific topics about the client's concerns or issues. The descriptions included may target the client's emotions, thoughts expressed, behaviors, experiences or observations, points of view, and reactions to any treatment, as well as the counselor's perception and impression of what happened in the session. In other words, this section includes both objective findings and subjective impressions. The subjective data is the information (verbal or nonverbal) provided by the client, whereas the objective data is the information about the client observed by the counselor during the session, which may include the client's appearance, affect, mood, speech, attitude, behaviors, or reaction to homework or activities. This section may further comprise the information about the general content and process of the session, which include interventions (goals and objectives worked on), education, review of homework if there is any, or consultation.

Assessment (Analysis)

In the Assessment (Analysis) section, the counselor records his or her understanding of the client's problem(s) along with the hypotheses that the counselor has developed. Information from initial screening, test results, and any other forms of assessments are included in this section. Also included within this section would be the client's current response to the treatment plan, the client's progress or stage of change, and how this particular session relates to the overall treatment.

Plan

The final section is the Plan. In this section, the counselor documents any need for revision of the treatment plan that may be necessary as a result of the client's response to the initial plan. The counselor would likely make adjustment to the established goals and objectives and/or the strategies and techniques to be used. Additional information included in this section would be a recording of the goals and objectives that were addressed in the session, along with any action steps that will be taken following the session. Finally, the counselor would list the date of the next session and the client's commitment to any homework assignment or action step to take, as well as any referral made during the session. Again, as a way of helping you get a "feel" for this system, we invite you to engage in Exercise 10.5, which provides a demonstration of DAP session notes.

EXERCISE 10.5**DAP Session Notes**

Directions: For this exercise, you are asked to write up the case notes for one of your cases with DAP session notes format. You may use the following questions as a guideline for your session documentation.

Data:

What are your client's thoughts, observations, experiences, or direct quotes?

What have you observed during the session about the client's mood, feelings, appearance, attitude, behaviors, and reaction to homework or activities?

What interventions have you used and what goals and objectives have you worked on?

Have you reviewed homework or consulted anyone?

Assessment:

What are your hypotheses?

What is your understanding of the client's presenting issue(s)?

What are the results of the assessment (e.g., testing results), if there are any?

What are your client's responses to the current treatment plan?

Plan:

What goals and objectives have been addressed during this session?

What adjustment is needed based on your client's reaction to the treatment plan?

What are you going to do with the client in the coming session?

What is the date of this client's next session?

Counselor: _____ Session Date: _____ Time: ____ to _____

Client(s) Name: _____ Session #: _____

Data (Description):

Assessment (Analysis):

Plan:

Counselor signs:

Description, Assessment, Response, and Treatment Plan (DART)

DART is a progress notes system created for mental health professionals by Brian N. Baird (2002). The author created the DART system because he felt that other systems, specifically SOAP, with its use of medical terminologies, were problematic for those working in psychological settings.

Description

The first section of this system is a detailing of the client and client situation. To develop a good description, the clinician should answer the four "W" questions: when, where, who, and what. The question of when refers to the date and time that the event

occurred; where indicates the location of the event; who is the person who played a significant role in or observed the event; and the what is the event that was observed. The sequence of the clinician's progress notes would be the presentation of time, location, people, and event or incident. Among the four Ws, the event or incident is the most flexible part, which means "the more significant the event, the more space will be dedicated to the corresponding progress notes" (Baird, 2002, p. 115).

Assessment

Assessment is the section in which you as the clinician need to answer the "why" question and document what you have observed and the meaning you have subscribed to those observations. Although it is not necessary to give elaborate explanations or offer profound insights about the event, the clinician needs to provide his or her understanding of the client's response (e.g., client's behaviors and emotions) to the event. Any client behavior or response that does not immediately seem interpretable should also be documented for later consideration or in the event the counselor seeks to consult about the case. In this section, the clinician uses his or her knowledge of the client to develop hypotheses about the events and the best way to assist the client in addressing these events.

Response

In the Response section, clinicians record how they respond to what they have observed based on their understanding or assessment of what they have observed. In other words, this is what the clinician did when he or she heard what the client did and said. As Baird suggests, "In this process, the clinician is recording not only the action taken but the reasons for taking or not taking an action" (pp. 115–116). It is suggested (Baird, 2002) that the clinician document accurately, including important details, in a way that supports a well-founded and rational treatment approach and counseling decisions. In this section, include data such as descriptions of rationale for referral; types of test or measures employed and why; consultations and their results; and, in terms of clients who present at risk, specific measures taken to ensure the safety of all. The rationale for the clinician's responses is important to have articulated, especially in the event of future legal action where the clinical judgment may be under question.

Treatment Plan

The final section includes an articulation of the treatment plan. This may be as specific as stating when the next follow-up session will be along with the "homework" assigned to the client (e.g., the clinician invites the client to bring artwork to the next session for discussion). The description of the plan moving forward might also include the rationale for including other service providers or even preparing the client for referral to another clinician. In all cases, the "what" needs to be described, as does the rationale behind the counselor's decisions. Case Illustration 10.2, Jeff Gates, is a demonstration of the DART notes system.

CASE ILLUSTRATION 10.2

Jeff Gates

D (description): 10 a.m. to 10:50 a.m., Monday, 8/11/2014; Individual Therapy: Jeff came to session on time and began speaking about his insomnia, caused by the conflict between him and his wife. According to Jeff, he felt very bad on the weekend and last night in particular. He remarked that he kept thinking about why his wife was doing this to him—allowing her three adult children to ruin their life and his life. Jeff stated that all his wife's three adult children don't have jobs and are dependent on his wife and him. "We not only give them money but feed them as well; the more I was thinking about it, the angrier I became," said Jeff. Client indicated that while he was angry, he had butterflies in his stomach and then felt terrible and could not fall asleep. He added that he did not have any other problems with his wife but the problem of her children, whom she could not let go. When asked about other areas of life, Jeff reported he had a hard time concentrating on his work, had less appetite than before, and did not want to see anybody but drank by himself.

A (assessment): Client appears to have mild depression due to conflict between him and his wife over her adult children. Symptoms of depression include insomnia, reduced appetite, problems with concentration at work, and diminished interest in social life. Though client reports no suicidal or homicidal thoughts, he has been using alcohol to cope with his frustration and depression.

R (response): During the session, client was asked to verbalize his anger and his depressed mood. He was further helped to become aware of the relationship between these two feelings, which in turn affected his thoughts and behaviors, his drinking behavior in particular. Through sharing his feelings, Jeff gained some insights on how the value differences between him and his wife on raising children have caused him to feel angry and depressed.

T (treatment): Homework of listing pros and cons of client's marriage was assigned. BDI and AUDIT will be used to make a further assessment on client's depression and alcohol consumption in the session on Monday, 8/18/2014, which has been scheduled with client.

Signed, Gordon Wood, M.A., Date, 8/11/2014

Concluding Thoughts

We hope, as you read through the chapter, you were able to see and embrace both the need and the very practical value of good documentation and clinical records. Documentation is more than an administrative function. Record keeping and documentation safeguard ethical and legal practice and, perhaps most important, are useful in the provision of best practice standard of care.

It is important to become familiar with the various systems of documentation while familiarizing yourself with the system employed at your field setting. In this chapter, we have introduced four formats of progress notes systems for your consideration. Each format has its advantages and disadvantages. You may want to try all of them to see which one fits your style and your work environment. Of course, you may have no choice if you are required to use a certain format by your agency, institution, or school. No matter which system you use, it is important to be clear and legible and avoid spelling and grammatical errors. Not only do these errors detract from the validity of the session notes, but present a less-than-professional image of the clinician. To avoid these problems, you want to develop a good habit of notes taking from the very beginning of your practice.

KEYSTONES

- The purposes of clinical documentation and record keeping are to ensure standard of care, enable effective communication between health professionals, and provide a desirable defense for litigation.
- The ethical practice of documentation and record keeping facilitates the counselor's clinical choices and reflects the dignity and integrity of the counseling profession.
- All mental health professions have developed ethical guidelines for their members to follow in the aspect of clinical documentation and record keeping.
- HIPAA regulations, as well as any other state, local, or organizational requirements, need to be considered when establishing a system of record keeping and maintenance.
- Most case notes formats share more commonalities than differences, and counselors may choose the one that best fits their style and organizational needs.

ADDITIONAL RESOURCES

Web Based

Documentation Tips and Guidelines: <http://www.school-counseling-zone.com/documentation.html>
Healthcare Providers Service Organization (HPSO): <http://www.hpso.com/resources/article/233.jsp>

Print Based

Mitchell, R. W. (2007). *Documentation in counseling records: An overview of ethical, legal, and clinical issues* (3rd ed.). Alexandria, VA: American Counseling Association.
Wheeler, A., & Bertram, B. (2012). *The counselor and the law: A guide to legal and ethical practice* (6th ed.). Alexandria, VA: American Counseling Association.
Zukerman, E. L. (2010). *The clinician's thesaurus: The guide to conducting interviews and writing psychological reports* (7th ed.). New York, NY: Guilford.

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