



The notes of our profession: Documentation

Some time ago, I received a call from an attorney representing a professional counselor who was working through the disciplinary process with a state licensing board. (Note: Names and issues have been changed according to Standard F.7.f., Use of Case Examples, in the 2014 *ACA Code of Ethics*.) The attorney wanted me to meet with his client and review her case to see if I could offer any support or expertise concerning the charges leveled against her.

Among the concerns the licensing board identified was the counselor's insufficient creation and storage of client notes. Apparently, if the counselor saw a client only once, she would keep the associated notes for a maximum of six months and then shred them. She was not using electronic medical records and had some physical space limitations. As fate would have it, one of those "one-session clients" filed a complaint about the treatment she had received, and the counselor did not have any records to defend herself.

It seems the state in which I practice has a law on the books requiring mental health practitioners to maintain the patient's full record for a minimum of seven years. This law was buried deep within the larger mental health code; it was not contained within the specific codes governing each individual mental health profession (e.g., counseling, social work). Although the counselor did her best to defend her position of disposing of the records of one-session clients after six months, the state held that *all* records were to be kept for a period of at least seven years. All I could do at this point was listen as she complained about the state's response. I did, however, politely but firmly remind her of the purpose of client records.

The many purposes of case notes

Most of us have heard the old refrain, "If you don't write it down, it didn't happen." This reminds us that creating and maintaining client case notes is a necessity of practice. Yet case notes are about more than just ensuring that we have an accurate account of what went on in a session. They support our primary responsibility to our clients, which, as outlined in the *ACA Code of Ethics*, is to "respect the dignity and promote the welfare of the client" (Standard A.1.a.). It's interesting to note that the standard addressing records and documentation (A.1.b.) immediately follows the standard concerning our primary responsibility as counselors.

The fundamental purpose of a case note (also known as a progress note) is to create a record of the clinical management of the overall case. The process and content of a counseling session generally do not follow a straight path to new growth or healing for a client. Instead, we travel along a winding road of the client's issues and stories that relate, sometimes tangentially, to the overall issues that brought the client into our consultation room. And, simply put, as counselors, we cannot always remember which side road or path the client took at what time in a session that led to a breakthrough or roadblock. Taking the time to develop a good case note allows us to reflect and consider what took place in session, how it relates to the overall goals of the client in counseling and what direction to take during the next session. As part of preparing to see a continuing client, a counselor will want to revisit previous session notes, reviewing the treatment plan to facilitate the delivery and continuity of care to the client.

This careful recording of session notes is especially important when the content of a client's session reveals thoughts or

behaviors that demonstrate the intention to harm one's self or others (i.e., suicide or homicide). The counselor will want to be able to record what was said, how it was evaluated and what action was taken on the part of the counselor. This more extensive case note records not only the process and content of the session but also how the counselor determined what action to take: Why did the counselor take this action with the client rather than going down another path? What did the client say or do that prompted the counselor's clinical response? Why did the counselor decide not to take any action in the face of what was shared in session?

Although this level of detail is more time-consuming to create, it connects what took place in the session and the counselor's *careful* decision-making process to the implementation of the clinical intervention. In following this process, counselors support a practice that is clinically beneficial to the client, meets their ethical obligation for the continuity of care and provides them with a record that is legally defensible.

Good clinical case notes can follow one of several formats, often identified by their acronyms, including:

- ❖ S.O.A.P. (Subjective, Objective, Assessment, Plan)
- ❖ B.A.R. (Behavior, Action, Response)
- ❖ D.A.P. (Data, Assessment, Plan)
- ❖ S.T.I.P.S. (Signs and Symptoms, Topics of Discussion, Interventions, Progress and Plan, Special Issues)

Although the layout of these case notes may differ, the content is common across all formats. This content includes:

- ❖ Topics discussed during the session
- ❖ How the session related to the treatment plan
- ❖ How the treatment plan goals and objectives are being met

- ❖ Interventions and techniques used during the session and their effectiveness
- ❖ Clinical observations
- ❖ Progress or setbacks
- ❖ Signs, symptoms and any increase or decrease in the severity of behaviors as they relate to any diagnosis used
- ❖ Homework assigned, results and compliance
- ❖ The client's current strengths and challenges

Many counselors work in clinics or agencies that are required to comply with the Health Insurance Portability and Accountability Act (HIPAA). Additionally, if counselors do any billing through electronic means, they are required to maintain HIPAA regulations regarding records and confidentiality. This presents another layer of complexity to managing client records.

As HIPAA rules and regulations were developed, they affected the standards of practice for counseling records. Counseling records for a HIPAA case note include demographic information, diagnosis (if necessary), prognosis, treatment plan, progress to date, dates of service, who attended the sessions and any financial issues (billing, costs, payments, etc.).

HIPAA also identifies another type of note, commonly called a psychotherapy note. It is defined as a note (recorded in any medium) by the counselor that documents or analyzes the contents of the session (conversations) during individual, joint, group or family counseling that is separate from the medical record of the client. This excludes prescriptions for medication, start and stop dates of sessions, frequency of the treatment or sessions, and any summary of symptoms, prognosis, diagnosis, functional status, treatment plan and progress. Counselors must decide if they want two sets of notes (HIPAA notes and psychotherapy notes) and how they will store them.

A well-written case note also serves another purpose. It protects the counselor if a complaint is filed with the licensing board or if a client initiates a lawsuit. As the story of the counselor at the beginning of this article illustrates, not having a record of the session places the therapist in an untenable position. The

rationale for any decisions made based on what the client did or said cannot be supported if you have no record to call on to refresh your memory. You have no notes that describe the issues the client shared that caused your concern and directed your future actions. You have no way of accurately demonstrating that your actions were measured and clinically appropriate. It now becomes a case of your word against the word of an aggrieved client.

There are several situations other than issues involving client harm to self or others that call for counselors to maintain more extensive case notes. These include cases in which:

- ❖ Concerns about the possible abuse of a child, older adult or person who is disabled are raised or reported
- ❖ The client is involved in illegal actions or behaviors
- ❖ A minor child is involved in illicit drug use
- ❖ A minor child is involved in sexual activity
- ❖ There are discussions related to pregnancy and abortion
- ❖ Custody issues are involved

More extensive case notes are also called for when counselors need to document the ongoing process of informed consent (see Standard A.2.a.). For example, should a counselor decide to introduce a new technique or determine a major shift in how counseling will be offered, the counselor is responsible for obtaining the consent of the client before initiation of the new treatment. This is especially important when the counselor is using a developing or innovative modality (see Standard C.7.b.). In addition to explaining in detail the potential risks and benefits of using a developing modality to the client, the counselor must obtain consent from the client and document this in the case note.

Another instance in which documentation is necessary is in the area of roles and relationships with clients. The 2005 version of the ethics code addressed the issue of potentially beneficial nonprofessional relationships with clients (e.g., attending a wedding or graduation). The 2014 *ACA Code of Ethics* added clarity to the necessity to “officially document, prior to the

interaction (when feasible), the rationale for such an interaction” (see Standard A.6.c.). This extension of the therapeutic boundary for nontherapeutic purposes must be thoroughly discussed with the client. The potential risks and benefits of the boundary extension should be weighed and documented carefully in the case notes. The same holds true when the counselor's professional role changes with the client, such as when moving from individual to family therapy (see Standard A.6.d.). The process of ongoing informed consent must be documented.

Finally, it must be mentioned that altering a client's record after the fact or when treatment has been called into question is fraught with serious consequences. Others who may be required to read the record might question the veracity of the documentation or take it as a sign that you are seeking to protect yourself or hide something that could be considered an error. Focusing on accuracy and clarity during the construction of a case note will prevent any need to expound on or clear up the information after the fact or when treatment is called into question.

The client record is the story of the client's relationship with you and the treatment that you offered. It is a nonfiction account of the process of therapy — the path you and your client took toward resolution and an accurate map for others to see should that be required. Properly maintaining case notes is part of our obligation as counselors to respect the dignity and worth of our clients and a reflection of our work to promote their growth and development. ❖

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