Beyond Therapy: The Basics of Clinical Documentation

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Faculty

Lisa Kathryn Jackson, MA, LPCC, MPH, received her Master's of Arts degree with a dual emphasis in Community and School Counseling from the University of New Mexico, Albuquerque, in 2006. After graduating, Ms. Jackson practiced as an outpatient psychotherapist providing treatment to children, adolescents, couples, families, and adults. In 2007, she relocated to Durango, Colorado, where, as a triage clinician, she provided mental health assessments and diagnoses for a multi-access behavioral health facility (inpatient, outpatient, and substance abuse services). Ms. Jackson returned to Albuquerque, New Mexico, in 2008, where she started and maintained a private practice, earned certification in Wholistic Kinesiology, and was the Clinical Supervisor for a crisis intervention program in the local school district. Ms. Jackson went on to become the interim Clinical Director for a community mental health agency, managing clinical and case management staff, developing staff trainings, and overseeing the administration of clinical processes required by the state of New Mexico.

In her eight years of clinical work, Ms. Jackson has written more than 2,500 mental health assessments and reviewed hundreds of clinical records for medical necessity. She continues her clinical work as a Behavioral Health Care Manager in a managed care setting reviewing clinical documentation from mental health providers throughout the state of New Mexico. In 2017, Ms. Jackson received a Master of Public Health degree with a concentration in Healthcare management and Policy from Benedictine University (Illinois). She continues her work in behavioral health as the CEO and Senior Clinical Advisor with ENVIVE Solutions, LLC.

Faculty Disclosure

Contributing faculty, Lisa Kathryn Jackson, MA, LPCC, NCC, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all licensed behavioral healthcare professionals, including social workers, counselors, and therapists.

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Course Objective

The purpose of this course is to provide clinicians with a broader understanding of documentation and its relationship to the standards of practice governed by regulatory bodies in order to fully support client care.

Learning Objectives

Upon completion of this course, you should be able to:

1. Outline the regulatory requirements affecting clinical documentation.
2. Describe the necessary components of mental health assessments.
3. Evaluate the role of documentation in treatment planning.
4. Discuss the proper creation of progress notes.
5. Identify the necessary parts of discharge summaries.

INTRODUCTION

Throughout the course of training as behavioral health providers, one learns to be a clinician —to engage clients, understand the theoretical basis for treatment, develop an understanding of mental illnesses, and become an advocate for clients' well-being. Unfortunately, behavioral health providers are rarely adequately trained in the administrative and regulatory aspects that impact their work—a significant aspect of which is documentation.

Clinical documentation is a cornerstone in the regulatory process. It serves as evidence of treatment, can be a focus of chart audits, and is part of the client's legal medical record. Clinical documentation also serves to support the treatment process, giving credence to the effectiveness of the treatment being provided.

Whether in an agency or private practice, all practicing behavioral health providers are required to meet regulatory standards of practice including appropriate documentation. Under healthcare reform, these standards will become increasingly stringent. To meet the demands of regulatory standards, clinicians should develop a working knowledge of the process and an understanding of the requirements to which they are expected to adhere.

This course will provide an overview of common regulatory standards, breakdown the essential clinical documents typically required by practicing clinicians, and offer documentation examples that support regulatory guidelines. Upon completion, you will be able to define medical necessity, have a working knowledge of the role of regulatory bodies, and identify and define parts of a mental health assessment, progress note, treatment plan, and discharge summary.

AN OVERVIEW OF CLINICAL DOCUMENTATION AND THE MEDICAL RECORD

What therapist, at some point, has not spent uncounted hours writing and re-writing clinical notes? Or worse, writing notes detailing every nuance of a session. Notes like these are time consuming, and critical information gets lost in the minutia.

Ideally, clinical notes provide a clear accounting of time with a client. Anyone reviewing documentation, including an auditor, should be able to assess what occurred during a session, have an idea of the general treatment plan, know the status of the client's state of mind, and determine the next course of action in the treatment.

Clinical documentation serves two primary roles. Foremost, clinical documentation is a tool that guides the clinical process and aids in measuring outcomes; secondly, it provides the content required for clients' clinical chart, also known as the medical record. Medical records are legal documents and are protected under the Health Insurance Portability and Accountability Act (HIPAA). As such, great care should be taken in the format and content of each and every note or document. The American Medical Association describes the medical record as a "key instrument used in planning, evaluating, and coordinating patient care in both the inpatient and the outpatient settings. The content of the medical record is essential for patient care, accreditation (if applicable to the practitioner), and reimbursement purposes. Medical records (charts) should detail information pertinent to the care of the patient, document the performance of billable services, and serve as a legal document that describes a course of treatment" [1]. Although behavioral health professionals are not physicians, they are providers of care and are subject to the same kind of guidelines and scrutiny to which physicians have grown accustomed.

Those working for a behavioral health agency or large facility are probably familiar with the requirements of record keeping, especially as it pertains to billing and compliancy. But private practice clinicians with little experience working in other care settings may be less familiar with the regulatory guidelines that describe the requirements of documentation. Terms like "medical necessity" may be foreign to many working clinicians in the field.

Every facility, agency, organization, and practitioner will, to some extent, have different documentation requirements based on the treatment setting and based on the regulatory guidelines they are required to adhere to, which is dependent on the governing bodies to which they are beholden. That said, most regulatory guidelines share common themes. Learning documentation skills that hold up to even the most stringent of regulations serves the clinician and ultimately serves the client as well.

REGULATORY AND GOVERNING BODIES

For the general practice therapist, the most applicable regulatory governing bodies are the insurance companies with whom they are contracted to provide services. Providers participating in an insurance network (e.g., managed care organizations [MCOs] and health maintenance organizations [HMOs]) are contractually obligated to comply with specific standards and regulations, usually outlined in the contract. Some of these standards may incorporate the relevant requirements set forth by the applicable licensing board as well. Standards and regulations, while administered and monitored through the insurance company, are derived from much higher levels of governance, including federal, state, and local governments and accreditation agencies.

Agencies such as the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS) are responsible for the development and oversight of guidelines based on policy, law, and standards of practice. In turn, state levels of governance, such as State Departments of Health and Human Services, Public Regulation Commissions, Departments of Insurance (DOIs), and Behavioral Health Services Departments (BHSDs) are responsible for administering these guidelines at the state and local levels and ensuring compliance with the federal guidelines.

Insurance companies are regulated under federal and state guidelines and regulate their providers under the same standards. In addition, most MCOs/HMOs as well as large behavioral health facilities are accredited by national agencies (e.g., the National Committee on Quality Assurance [NCQA], The Joint Commission [TJC], the Commission on Accreditation of Rehabilitation Facilities [CARF]) that require strict adherence to their standards as well. Best practice dictates if there is a conflict between the requirements of the accreditation agency and statutory regulations or codes, the stricter should take precedence.

To varying degrees, these regulatory and governing bodies serve a similar purpose: to ensure efficacy of treatment, fiscal accountability, and that proper protocols are employed at all levels of care. As a general rule, providers are responsible for reviewing any and all state administrative codes, regulations, policy manuals, best practices, contracts, and other requirements applicable to the services provided.

CLINICAL CHART AUDITS

Clinical chart audits are one way regulatory and governing bodies monitor adherence to the standards they set forth. Chart audits typically occur at the service level and are usually conducted by the quality and compliancy departments within the MCO/HMO. When an audit is conducted, the organization will measure how well the standards have been met using an audit tool. Audit tools specify the areas an audit will address, including assessment of the physical environment of a facility or office; quality of documentation, including thoroughness, adherence to HIPAA standards, organization of the chart, format of documentation, and whether or not the specific treatment reported in the clinical documentation meets medical necessity guidelines; and finally, financial and billing information.

One example is from the Department of Health Care Services (DHCS), the single entity responsible for the management of Medicaid funds for behavioral health in the state of California. DHCS states that [2]:

- Providers must keep, maintain, and have available records that fully disclose the type and extent of services provided to Medi-Cal recipients. The required records must be made at or near the time the service was rendered.
- Provider records must document the meeting of Code I restrictions for medical supplies.
- Records of services rendered by Non-Physician Medical Practitioners (NMPs) must include the signature of the NMP and the countersignature of the supervising physician.
- Every practitioner who issues prescriptions for Medi-Cal recipients must maintain, as part of the recipient's chart, records concerning each prescription and records concerning medical transportation.
- Records of psychiatric and psychological services must include recipient logs, appointment books, or similar documents showing the date and time allotted for recipient appointments and the time actually spent with each recipient.
- Providers must make available all pertinent financial books and records concerning health care services provided to Medi-Cal recipients to any authorized DHCS or Department of Justice representative.

MEDICAL NECESSITY

Medical necessity is a guideline developed by the quality and compliancy department within an MCO/HMO and is often referred to as a level-of-care guideline. Although there is no federal definition, and only slightly more than one-third of states have any regulatory definition of medical necessity, it is most commonly found in individual insurance contracts that are defined by the insurer and hold primacy in most determinations [3]. These guidelines are developed as tools to assess whether or not the treatment provided is in accordance with the treatment need for a specific level of care.

For example, in the level-of-care guidelines for acute behavioral health (inpatient) clients, medical necessity is present if a client is determined to be at imminent risk of harm to self or others. The medical record in this example must clearly support evidence of the client's "risk." At lower levels of care, such as outpatient therapy, medical necessity is much broader, and the treatment plan and progress of treatment is typically a measure of medical necessity.

Nonetheless, whatever treatment is implemented, documentation should support the clinical rationale for the type of service and the care setting in which the care is being provided. It is recommended that clinicians and facilities request the level-of-care guidelines, documentation standards, and any other quality and compliancy templates available from the insurance companies for which they are doing work.

A NOTE ABOUT HIPAA

There are several guiding rules or principles under HIPAA. The most familiar of these are regarding privacy, security, and breach. An important principle under the Privacy Rule is that of "minimum necessary," a term that applies to various aspects of disclosure. According to the U.S. Department of Health and Human Services, "The Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, protected health information to the minimum necessary to accomplish the intended purpose" [4].

Although this statement does not specifically discuss the content of clinical documentation as part of its definition, it is reasonable to assume the principle extends to content as well. While regulatory bodies define the general content areas required in clinical documentation, the specifics of the content should adhere to the "minimum necessary" principle in order to comply with HIPAA principles. Clinicians should write chart notes that they would feel

comfortable sharing with the client. Conversely, information referring to risk of any kind must be well documented. The key is to state facts and to write in an objective and neutral manner. A few guidelines to keep in mind: only keep one set of notes, avoid subjective statements/opinions, and use clients' own words whenever possible.

MENTAL HEALTH ASSESSMENTS

Mental health assessments are usually the first clinical document resulting from an initial session with a client. A thorough mental health assessment gives the clinician a global perspective of the problem and provides the basis for formulation of diagnoses or a hypothesis of dysfunction. It is a tool used to collect information about a client's presenting symptoms and complaints and a method for identifying early treatment needs and creating a treatment plan. It can also aid in rapport building and assessing a client's history and current level of risk. The mental health assessment is an important part of the medical record and the basis from which all other clinical documentation will develop. In some cases, an initial assessment is required by the MCO/HMO for prior authorization of services, depending on the care setting.

Moving forward, emphasis will be placed on developing documentation that meets medical necessity guidelines and regulatory standards regardless of treatment setting. This will include examining the structure of an assessment, identifying important language that supports medical necessity, reviewing how to complete and integrate a mental status exam (MSE), discussing the development of diagnoses, exploring conceptualization of a treatment plan, and finally, reviewing how to write evidence-based progress notes and discharge summaries that link to the initial assessment and treatment goals.

Engaging a client in a mental health assessment requires therapeutic skill, but it also requires a clinician to have a grasp of mental illnesses and of specific diagnostic criteria. Without this knowledge, it is difficult to guide the interview and capture the details needed to make an appropriate assessment of the client's clinical needs.

Some screening tools may be useful to home in on specific symptoms and their severity, but they are usually symptom-specific. If screening tools are used or collateral information is collected from outside sources, such as psychological testing, this information should be integrated into the assessment.

INFORMATION GATHERING AND DIAGNOSES

The structure of the assessment tool guides clinicians to ensure key areas are evaluated. Information may be gathered from a variety of sources: a referral source, the client during the interview, collateral information received from other providers, and family members, when appropriate. Observations of a client's appearance, emotional expression, and affect, and his or her reactions or interaction with the therapist during the interview should be noted as well.

Diagnoses are generally developed based on presenting symptoms (problems); duration, frequency, and intensity of symptoms; and level of functionality/impact of symptoms across all environments. A comprehensive assessment and accurate diagnosis are critical for appropriate treatment planning, identifying potential referrals to other providers, and assurance that the client can benefit from the treatment being offered.

BUILDING RAPPORT IN THE ASSESSMENT INTERVIEW

Building rapport is the key to successful engagement and therapeutic gains for the client. When attempting to complete an initial mental health assessment, the process can feel awkward and cumbersome. It can be difficult to be fully present for a client when trying to gather specific information. The first few sessions require the therapist to take control and give direction to the session, which can feel counterintuitive in rapport building and can prove even more challenging depending on the client's level of functionality.

Building trust in these first sessions is critical. To encourage engagement in the assessment and maintain a focus on building rapport, consider addressing the assessment process before starting the session. Give a thorough explanation of the process and what the client can expect. Acknowledge the need for note taking and the possibility of reading questions from a list. Reassure the client that his or her purpose for attending the session is important. Give good eye contact and allow for any questions the client may have. Most clients are understanding and appreciate the forthrightness.

IDENTIFYING IMMINENT RISK OF HARM

During any session, but especially in the initial assessment interview, a heavy burden rests on the clinician to assess for risk and have a willingness to act on behalf of clients who are in imminent danger of harming themselves or others. Assessing for risk in the initial sessions allows the clinician to ensure the immediate safety of the client but also to obtain a baseline of risk behaviors, triggering events or situations, and level of coping.

A risk assessment should take into account past behaviors, such as self-harming, previous suicidal ideation or attempts (including methods), previous threats or acts of harm toward others, and a general review of the circumstances surrounding the harm behaviors. Those who are new to the field, work alone, or have little experience in risk assessment or crisis intervention should seek additional training and support in this area. There are different levels of risk, and being able to assess them respectfully and appropriately is important not only to the relationship between clinician and client, but more specifically for the safety of the client and possibly others.

IDENTIFYING TREATMENT NEEDS

A comprehensive assessment reveals areas of clinical focus for treatment and identifies barriers to treatment. Treatment needs are typically symptom- or behavior-based and are the seedlings that eventually become the treatment plan. Barriers to treatment are equally important when evaluating treatment needs. If a client has transportation problems, is unable to make his/her co-payment, has a cognitive impairment, or is from a vastly different culture than the therapist, these factors may impede treatment progress. While therapists cannot be responsible for the immediate needs of their clients (such as transportation), the identification of these barriers can be treatment opportunities, allowing clients to develop the skills needed to locate, access, and utilize supports. By identifying and addressing these barriers early, and strategizing with the client on ways to address them, the potential for positive therapeutic outcomes is dramatically improved.

TREATMENT PLANNING

Treatment planning is the ability to develop a comprehensive understanding of a client's situation, needs, barriers, and ability to make therapeutic gains and applying this information to measurable outcomes. The level of complexity in treatment planning varies based on the treatment setting and client needs.

A primary goal is to conceptualize the plan as early in treatment as possible. While the plan may change over time, it provides the initial structure to the care being provided. Most treatment planning is done directly with clients, and in some states, client involvement in the development of the treatment plan is a requirement of regulatory or governing bodies, as mandated by Medicaid.

Engaging clients in their treatment planning encourages commitment to the treatment and shows transparency, which aids in trust building. It also helps the client and therapist to have a clear and mutual understanding of expectations and the direction of therapy. Clients are more apt to make progress and feel successful in therapy when they know what they are working toward and can see it in measurable terms. As a document, the treatment plan is the guide from which treatment is measured.

INSURANCE AND PRIOR AUTHORIZATION

Prior authorization is required by most MCOs/HMOs when a client is admitted to a higher level of care, which may include, but is not limited to, psychiatric hospitalization, residential treatment centers, substance abuse rehabilitation, partial hospitalization programs, and inpatient eating disorder treatment. To request prior authorization for treatment, the admitting facility or program must provide clinically relevant information to the MCO/HMO responsible for reimbursement of services.

Specialized staff at the MCO/HMO called utilization managers or care managers are licensed clinicians who compare the clinical information to medical necessity guidelines. If medical necessity is met, a determination to authorize the service is made. This process can be equated to a chart audit occurring at the time of service as opposed to after the service has been delivered.

When a client requires a higher level of care for an extended amount of time, the facility must provide ongoing clinical information to the insurance company, in some cases on a daily basis. This is called the utilization review.

MENTAL HEALTH ASSESSMENT CONTENT AREAS

MCOs often have a protocol or guideline regarding the content areas of clinical documentation. Guidelines and requirements for content areas are typically modeled after the guidelines set forth by Medicare and Medicaid. While not consistent among all states, MCOs, or providers, the content areas are very similar. The following content areas are the most common categories included in a mental health assessment. Each section will describe the relevant information addressed and, in some cases, provide brief examples.

Source of Information

When recording information in a mental health assessment, indicate the source of the information; information that does not have a context or identified source may be confusing to the reader. If additional or collateral information is obtained from an outside source, this should be integrated into the assessment and the source identified. Examples include:

- "Client states she feels down once in a while."
- "Client's father states [she] has been down and depressed every day for the past year."
- "According to the client's school psychologist, the client has been very angry and depressed at school."

Presenting Problems

This section provides an overview of the current issues and gives the first clues about symptoms, precipitants, or circumstances; why the client came to therapy; and what he/she hopes to gain from therapy. Asking questions like "What brought you to therapy at this time?" and listening for key issues like "I'm not sleeping well" will support treatment planning and diagnostic formulation.

Specific Symptoms

From the initial presenting problems, start to develop an idea about which symptoms need clarification. For example, initial complaints of poor sleep might indicate symptoms of anxiety or depression. It is important to clarify the symptom category and determine which symptoms are the most distressing to the client; this becomes a starting point for diagnostic formulation and treatment planning. After the primary symptom(s) are identified, gathering measurable information about each symptom is helpful. These will be used later in treatment planning, but it also gives more insight into the level of distress the client feels in relation to the symptom. Measurable data includes duration, frequency, and intensity of symptoms. Assess for triggering events/situations and impact to functional areas (e.g. relationships, school, work, etc.). For example: *Client reports feeling anxious for the past year with symptoms of rapid heartbeat, sweating, feeling fearful that something bad is going to happen, feeling faint, and racing thoughts. Client reports this occurs at least three times per week, typically at home, and when it occurs, she is unable to leave the house. Client states the symptoms seem to be triggered when her spouse goes out to drink with friends. On a scale of 1 to 10, symptoms at their worst are rated a 9.* In this case, measurable goals may be to reduce anxiety/panic symptoms from a 9 to a 5 in intensity and from three times per week to not more than one time per week. Subjective goals may include increasing the client's insight into the triggering event and improving coping with mindfulness techniques.

Communication and Cognitive History

Communication is fundamental to the therapy process. Without it, engagement and therapeutic impact/change can be difficult to measure or assess. Noting any organic, cultural, or language barriers to communication helps to identify any potential impediments to treatment. If a communication or cognitive barrier is identified, this should be included in the treatment plan with an appropriate intervention. For example, a deaf client may require an interpreter or a referral to a therapist who can communicate via sign language. Cognitive history might include head trauma, dementia, learning disabilities, or other processing issues. If collateral information has been received from other providers about the clients' cognitive history, include this as well.

Social History

A thorough social history provides good insight into a client's ability to interact with others. It may also identify possible social supports available to the client. How clients see themselves is often reflected in their social circles. Social history is also an important component when assessing for possible personality disorders.

Personal and Family History

Personal history will generally include marital status, children, and information about clients' own childhood. Clients may be asked where they grew up, if their parents are living and married/separated, how many siblings they have, and what the family relationships or dynamics are like now and when the client was younger.

Medical History

The client should be assessed for any current or past medical issues that may be a focus of treatment or that may impact treatment. This includes previous motor vehicle accidents, head traumas, chronic pain conditions, physical disabilities, and previous surgeries.

Trauma History

Note any client reports of traumatic events in their lives. This can range from the divorce of parents to sustaining or witnessing abuse. Obtaining a trauma history and assessing for the requisite symptoms may help to substantiate as well as differentiate between diagnoses, such as PTSD and depressive or anxiety disorders. A thorough trauma history may also give further insight into client behaviors. As with any category, but especially for trauma history, be specific, use neutral language (or preferably the client's own words), and record as much factual information as possible. For example:

- Client states, "My mom and dad fight all the time."
- Client reports parents' fight at least three times per week, "mostly yelling at each other and calling each other bad names."
- "Sometimes they start hitting each other."

Substance Use

The revised fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR) updated the definition and some of the criteria in the substance use disorder category, now referred to as Substance-Related and Addictive Disorders. In addition to assessing for substance use using these criteria, assess for other kinds of addictions as well. When substance use or addictive behaviors are identified, treat them similarly to symptoms by collecting data that includes measurable content. At a minimum, gather data for the following items:

- Age of first use/behavior
- Frequency
- Duration
- Quantity/amount
- Method (e.g., smoking, snorting, injection, oral)
- Last use
- Impact areas
- Environmental factors leading to use

This information supports diagnostic formulation, identifies possible treatment goals, points to a client's risk behaviors, and gives insight into a client's coping skills and strategies.

Educational and Employment History

A factual accounting of a client's academic and work history can reveal insights regarding situational problems, attitude toward authority, and ability to achieve goals. Current status of employment and education may speak to a client's motivation and/or ability to make therapeutic gains.

Legal History

Assess for a client's past and current legal issues. Identify offenses, applicable charges, and any additional consequences. Assess the client's attitude about the situation. Is the client on probation or court ordered for treatment?

Treatment History (Substance Abuse and Mental Health)

Determine if the client has engaged in mental health treatment in the past. What has been helpful or not helpful? Elicit specific ways former treatment was or was not helpful. Note any higher levels of care used, such as psychiatric hospitalization, including dates and facilities. If applicable, attempt to obtain a release of information (ROI) to collect collateral information from the previous provider(s). If the client has previous diagnoses, document these as well. Does the client agree or disagree with previous diagnoses?

Strengths

Asking clients about their strengths and reflecting on observable ways in which their strengths can build trust in the therapeutic relationship. It also helps to reveal clients' coping strategies, which can be built into the treatment plan. If a client is unable to identify strengths, this may in itself be an aspect of treatment and built into the treatment plan.

Leisure and Recreational Preferences

Not unlike strengths, identifying ways in which clients spend their free time can give insight into their coping strategies. Because loss of interest in pleasurable activities may be part of a depressive diagnosis, clients who are unable to identify leisure or recreational interests may require additional assessment to determine an appropriate diagnosis.

Nontraditional and Natural Supports

Assess clients for their use of complementary/alternative medicine. This can include, but is not limited to, anything from yoga to herbal supplements. In some cases, a client may express an interest in a specific type of healing practice or routine he or she feels is a positive force. If the client believes it is helpful, this can be another strength. When working with clients from other cultures or who have a preference for "nontraditional" practices, attempt to assess to what degree the client is engaged. Can these supports be integrated into the therapy process in some way?

Cultural and Spiritual/Religious Preferences that May Impact Treatment

Assessing for cultural and spiritual/religious preferences is a category that appears to hold a higher importance in some regions than others. That said, it is important to understand how the client sees him/herself in the environment. An example note in this content area may be: *Client self-identifies as lesbian. Client states she grew up in a religious family of devout Catholics and reports she has attempted to engage with her family and the church but feels "unaccepted and misunderstood" both by her family and the church. Client states, "I feel very conflicted over my sexual orientation and my desire to be close to my family and the church."* While the client's sexual orientation may or may not be the focus of treatment, this example speaks to the cultural/religious issues that may impact the client's treatment, including loss of family support, loss of religious community support, and internalized conflict. Another example would be a Native American client who is deeply involved in his cultural and religious practices, including working with a Medicine Man. Understanding each client's involvement with and ascribed level of importance of cultural and religious preferences can vastly alter the therapy approach and process.

Risk Behaviors

The primary risk factors assessed for in the initial session usually include suicidal ideation, suicide attempts, self-harming behaviors, and threats to harm others. Additional risk behaviors can include engagement in dangerous or illegal activities, such as drinking and driving or going to a hotel with a stranger to buy drugs. Risk behaviors are almost always a focus of treatment when they are identified, more so when behaviors are active and pose a risk to the client or others. Gather and record as much data about the risk behaviors as possible, including, but not limited to, age of onset, frequency, duration, intensity, method(s), interventions/consequences, and triggering event or circumstances. For example: *Client reports, "I cut myself when I am feeling really stressed out." Client states cutting behaviors began at 12 years of age, following her parents' separation. Client has engaged in cutting with a razor on upper arms and inner thighs for the past five years at least three times per week and states, "I just can't stop now…It helps me feel better." Client denies any medical interventions and states that her parents are unaware of the behavior because she hides it well.* Further assessment can determine current stressors/triggers leading to self-harming behaviors.

Medications

Although Master's level clinicians are not trained in psychopharmaceuticals or other medical treatments, being able to, at a minimum, document medications is an important part of the behavioral health medical record, particularly as integration of care becomes a primary focus in both behavioral and primary care settings. Whenever possible, collect the names, dosages, prescriber, dates of first use, and purposes of medications. Collateral information from the client's medical provider(s) is usually the most accurate source of medication information. If

the client is unable to provide this information in the initial session or the clinician is unable to obtain the collateral information, request the client review medications and provide a list at the next visit. Note whether or not there have been adverse reactions or allergies to medications.

DSM-5-TR Diagnosis

Always include initial diagnoses on the mental health assessment. In 2013, the a new version of the DSM was released, resulting in changes to diagnostic criteria. The five-axis structure has been eliminated. The Global Assessment of Functioning (GAF) scores have been replaced by more specific scales built into the diagnostic criteria. For example, a depressive diagnosis is now rated as mild, moderate, or severe based on the number of symptoms presented or identified. In addition, Z-codes are integrated into the diagnosis when the code identifies a specific factor that is either the focus of treatment or has an impact on treatment. The basic format for documentation of the diagnoses may be structured as follows: primary diagnosis as focus of treatment, personality factors, medical factors, and psychosocial factors (Z-codes). For example, a diagnostic formulation might be written as: *F32.1 Major Depressive Disorder, single episode, moderate; F11.20 Opioid Use Disorder (moderate); F60.3 Borderline Personality Disorder; E11 Type 2 Diabetes; T74.11XD Spouse or Partner Violence, physical, confirmed, subsequent encounter.* Also, note that diagnostic codes have also changed and are now congruent with ICD-10-CM codes typically used by medical practitioners. To ensure the most up-to-date diagnostic information, the DSM-5-TR should be used.

Mental Status Exam

An MSE is a structured assessment tool that allows clinicians to record observations of client presentations, such as mood and affect, thought processes, appearance, cognition, perceptions, orientation, and level of insight and judgment. Areas of the MSE support diagnostic formulation and reveal aspects of functionality. A completed MSE can be written as a narrative, but it is often in the form of a checklist that can be quickly completed during an assessment as signs emerge. The MSE will be discussed in greater detail in the next session of this course.

Clinical Analysis

Some best practices call for the inclusion of a clinical analysis that summarizes the findings of the mental health assessment indicating the specific relational aspects between symptoms and impact to functionality.

Signature and Licensure

The clinician completing the assessment should include his or her signature, licensure level, and date the assessment was completed. Remember, the mental health assessment is a legal document.

MENTAL STATUS EXAM

Completing an accurate MSE relies on two factors: knowing the categories and definitions of the MSE language and the ability to observe and identify signs aligning with those categories. The purpose of the MSE is to "evaluate, quantitatively and qualitatively, a range of mental functions and behaviors at a specific point in time. The MSE provides important information for diagnosis and for assessment of the disorder's course and response to treatment" [5].

The MSE should support the clinical findings of a mental health assessment and add dimension or further clarification of a client's presentation. When an MSE is included with the mental health assessment or progress notes, the information documented in narrative form should be congruent with indicators on the MSE. For example, if a client is unable to sit still throughout the session and the clinician indicates poor impulse control on the MSE, it is important to document the specific reason poor impulse control was indicated (i.e., "poor impulse control as evidenced by inability to sit still during session").

Areas included in an MSE may vary depending upon treatment setting. However, there are nine generally accepted categories of assessment on the MSE: appearance, motor activity, speech, affect, thought content, thought process, perception, intellect, and insight. Additional categories may include mood, cognition, judgment, impulse control, activities of daily living, ambulation, appetite, and sleep. Points to consider in each of these categories include [5]:

- Appearance: Overall appearance, including age, race, gender, and hygiene/grooming
- Motor activity/ambulation/movement and behavior: Psychomotor agitation or retardation, ambulation status (e.g., wheelchair, walker, cane, independent), manner of walking (gait), coordination, eye contact, facial expressions
- Speech: Volume, rate, tone, coherency, focus, spontaneity
- Mood and affect: Mood is related to the overall presentation of the client (e.g., anxious, depressed), while affect is related to the expression of mood. Affect can be mood congruent, mood incongruent, or more descriptive (e.g., flat/blunted, grimacing). Some terms related to affect are linked with specific diagnoses in the DSM-5-TR and may be described here.
- Thought content: The overarching theme of a client's informational focus, such as suicidal/homicidal ideation, cognitive dissonances, paranoid/magical ideations, ideas of reference, obsessions, ruminations
- Thought process: The logical connections between thoughts as well as relatedness to the conversation (e.g., logical, linear, concrete, blocking, concentration/attention, associations)
- Perceptions: Hallucinations (e.g., auditory, visual, tactile, olfactory), déjà vu, jamais vu, derealization, depersonalization
- Intellect: General observation that a client's intellectual capabilities are below average, average, or above average
- Insight: The client's level of awareness about his or her illness and/or circumstances leading to treatment
- Cognition: The client's general orientation to person, place, time, circumstance, and long- and short-term memory. In some cases, a Mini-Mental Status Exam will be conducted to assess for impairments of thinking or processing.
- Judgment: A client's ability to consider circumstances and make reasonable decisions, typically noted as impaired, poor, fair, or good/intact
- Impulsivity/impulse control: The client's ability to self-regulate across most environments and in most situations. This speaks to risk behaviors, and ratings are noted as low, medium, high, or affected by substances. When impulse control is the specifier, the rating is noted as impaired, poor, limited, or within normal limits. Is typically considered poor in most adolescents based on developmental stage.

- Activities of daily living: The client's level of functionality, such as being able to bathe, groom, and attend to one's toileting needs without assistance. This is especially important when working with disabled clients or the elderly to determine if there are additional needs that should be addressed to aid in the client's well-being.
- Appetite: When noted to be irregular in some way, requires further inquiry to rule out eating disorders or other conditions that may impact appetite. Noted as decreased/poor, increased/excessive, within normal limits, or fair. May also be noted as a percentage of meals consumed. When indicated, document weight changes, duration of weight changes, and cause of change, if known.
- Sleep: When sleep is noted to be irregular, further inquiry is needed to rule out problems such as a primary sleep disorder or to support a preliminary diagnosis where sleep is a factor, such as hypersomnolence in some cases of depression.

FORMULATION OF DIAGNOSES

Diagnostic formulation refers to the analysis of presenting information applied to a set of specific criteria that allows a working supposition to emerge and thus treatment to begin. For the midlevel clinician, it is not uncommon for little attention to be given to the process of diagnostic formulation in the academic setting. It is an egregious misrepresentation to presume the only purpose of developing diagnoses is to bill insurance. While it is true that to bill for a therapeutic session/interaction, a diagnosis must be included, this is, of course, not the ultimate goal of diagnosis. Without a working theory or hypothesis of the presenting issues, there is no basis for treatment to occur.

The field is changing rapidly, and midlevel clinicians are expected to step up to the treatment standards to which medical practitioners currently adhere. Evidence of this lies in the DSM-5-TR, the diagnosis codes of which are congruent with codes in the ICD-10, which are used by medical practitioners.

Developing a diagnostic picture requires more than identifying a set of symptoms, although this is a starting point. Understanding the full diagnostic picture requires an ability to identify important factors impacting symptoms, which is why there are so many assessment categories in a mental health assessment.

That said, there is no denying that diagnostic formulation is complex; a foundational understanding of the mechanics/technical aspects is required to be successful. Although studying the DSM-5-TR is recommended, the following will give a foundation to the process of diagnostic formulation.

Start with the identified objective information collected from the mental health assessment. This includes specific symptoms and their onset, duration, frequency, and intensity; the results of the MSE; and collateral information from other providers. After the primary symptoms are known, the DSM-5-TR will aid to further home in on a primary diagnosis. Other information from the assessment may be used to support or disprove a diagnostic theory based on the criteria noted for the proposed diagnosis. Always take into account culture, areas impacted, overall level of functioning, medical factors, and other psychosocial factors. A combination of objective and subjective factors can be the difference between a diagnosis of major depressive disorder versus an adjustment disorder with depression, each of which has different treatment plans or approaches.

TREATMENT PLANNING

Treatment planning begins at the first encounter with the client. During the initial mental health assessment and diagnostic formulation, identifying symptoms and a focus for treatment emerges. To some degree, treatment planning does not vary significantly from one level of care to another, but the specific interventions are dependent on the level of care and the practitioner. In other words, the treatment plan in an inpatient setting will attempt to reduce symptoms of acuity and the underlying cause, such as depression or anxiety. However, in this case, the intervention will be one of a short duration with a focus primarily on stabilization. In an outpatient setting, when acuity is stable and the duration of engagement is expected to be longer, the treatment plan, while also focused on symptom reduction, will focus on developing coping skills.

The conceptualization of treatment planning refers to the process of seeing the treatment and subsequent steps throughout treatment from a global perspective. While in long-term therapy the actual treatment plan may shift over time, the idea is to develop a conceptualization of the entirety of treatment long before treatment ends.

In general, treatment planning (in some cases referred to as a "client plan") will include client input. Treatment plans provide a guideline for treatment to occur and notably allow all involved parties, specifically the client and clinician, to work together toward identified goals. Treatment plans are living documents, and goals may change over the course of treatment. Some goals may be achieved, and new ones emerge. The focus always remains on helping clients alleviate symptoms or improve their quality of life. Treatment plans are typically updated a minimum of twice a year.

According to the *Clinical Record Documentation Standards*, treatment plans are developed from the initial assessment and must substantiate ongoing medical necessity and be consistent with the diagnosis(es) that is the focus of mental health treatment; the plans serve as a record of clients' progress [6]. Aside from the primary diagnosis, which is required to establish medical necessity, common content areas to document in the treatment plan/client plan include, but are not limited to:

- 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."
- Mental health goals/objectives: From the identified symptoms and diagnostic formulation, specify the clinical goals/objectives for specific symptoms. For example, if a client presents with symptoms of generalized anxiety, 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 six times per day at least five times per week at an intensity level of 5/6, the goal may be to reduce the frequency to three times per day not more than three times per week and to reduce intensity to not more than a three.
- Interventions and their focus: How the clinician plans to reduce symptoms should be noted. Using the example of generalized 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.

PROGRESS NOTES

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, 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 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.

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 DISCHARGE SUMMARY

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.

CONCLUSION

Clinical notes are 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.

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.

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