CHAPTER 1

Introduction

WE ARE LIVING in the age of professional accountability. In addition to mental health workers, professionals such as politicians, executives, clergy, educators, and people from most walks of life have increasing demands placed on them to demonstrate that they have practiced their profession effectively and ethically. In the past few years an increasing number of well-known public figures have filled the headlines and court dockets due to compromising their professional standards. Colleges and professional schools have increased their required ethics courses. Many mental health licensing boards require ongoing ethics training as part of their mandatory continuing education.

Standards of accountability in the mental health profession come from a number of sources. State boards, such as those for psychology, social work, professional counselors, and marriage and family therapy, have specific guidelines for licensees. Accrediting agencies, such as the Commission of Accreditation for Rehabilitation Facilities and The Joint Commission, and third-party payers, such as insurance companies and managed care organizations, maintain specific documentation requirements to assure accountability.

Such regulations help curtail the rising costs of mental health services, which have skyrocketed due to factors such as inflation and increased mental health insurance benefits available to consumers. Current standards of third-party payers hold that services must be medically necessary in order to be covered for payment. Both third-party payers and regulatory agencies impose strict requirements in which each step of the clinical process must be clearly documented. Therefore, appropriate documentation and communicating evidence of clients' needs for services are crucial for a clinic's financial and professional survival.

Learning appropriate documentation procedures goes far beyond meeting professional regulations or requirements for payment of services.

Accurate recording procedures provide clear evidence of what takes place in mental health sessions. Without accurate documentation, there is not a clear record of what takes place in therapy; thus, it is difficult to evaluate therapeutic effectiveness. Sloppy clinical procedures are not only unfair to the client but may border on malpractice. During third-party audits or clinical reviews, among others, proper documentation validates that appropriate treatment took place. When sound documentation procedures are followed, a written record of treatment will be available for review of (1) therapeutic effectiveness, (2) appropriateness of services, (3) continuity of services, and (4) evaluation of therapeutic outcomes, setting a high standard for mental health treatment.

When documentation is poor, there is no clear written evidence of the course of therapy. With or without documentation requirements, responsible clinicians will continue to provide clients with valuable services.

Documentation procedures can affect the financial condition of a clinic. It is not uncommon for an insurance provider to audit records. When records do not adequately demonstrate that services were necessary, on target, or concordant with the presenting problem or diagnosis, it is possible that the clinic will have to pay back money received from the insurance company. Such audits have put some clinics out of business.

In the past, third-party payers simply paid therapists when an insurance claim was made. Due to escalating costs, managed care was necessary and subsequently flourished. Today, third-party payers no longer blindly accept billing for any psychotherapy services. They require specific types of evidence demonstrating the client's need for services and the therapeutic effectiveness in order to pay for the treatment. Without knowing proper documentation procedures and how to present a case on paper, the therapist is vulnerable to appearing to be ''out of compliance'' or providing ''unnecessary services,'' even if the treatment is exceptional. If it isn't written down, it doesn't exist.

Although most mental health professionals are properly schooled in conducting psychotherapy, few receive any training in documenting the evidence of their treatment. It is not uncommon for therapists new to the field to become discouraged when exposed to the ''other responsibility'' of treatment: documentation. However, when properly trained, therapists soon realize the benefits of documentation. Not only do they become more confident in meeting third-party requirements, but they also become more aware of their clients' progress. Learning documentation procedures is a win-win situation.

Documentation is atheoretical. It is not psychotherapy. That is, it does not follow a certain theoretical school of thought. It is presented as *behavioral*

evidence, in measurable terms; however, it has nothing to do with behavioral therapy. The clinician may conduct psychotherapy from any effective type of treatment (e.g., cognitive, behavioral, dynamic, rational-emotive, solutions focused, etc.). Managed care companies, along with other third-party payers and accrediting organizations, are open to this variation, provided that the improvements in client functioning are documented in behavioral terms. The evidence is presented in terms of objective client behaviors, not opinions or speculation. Evidence of alleviation of specific client impairments is required. Third-party payers ask: ''What changes in behavior are taking place as the result of therapy?''

Regulatory agencies require that the same measuring stick is used to assess the effects of therapy regardless of the treatment modality employed. The current measurement standards in mental health require that clinical documentation be observable and measurable and provide behavioral evidence of therapeutic progress.

Documentation begins at the first interview. The several documentation procedures conducted throughout therapy are interrelated. The information collected in the initial interview is necessary for writing the treatment plan. The treatment plan provides a guideline for the course of therapy, which is documented in the progress notes. Progress notes are necessary for writing a revised treatment plan. All of the information collected is needed in writing the discharge summary and assessing outcomes as outlined in Figure 1.1.

The documentation procedure examples provided in this text represent a course of treatment for a client with depression. In addition, Appendix A provides documentation examples for a client with panic disorder with agoraphobia.

This text begins by teaching the rationale and examples of documentation for each step of the therapeutic process. It also provides training as to what documentation is required for third-party payers and accreditation agencies.

Initial	Diagnostic Interview
	Treatment Plan
	Progress Notes
Cycles of	Treatment Plan Revisions/Updates
	Progress Notes
End	Discharge Summary

Figure 1.1 Course of Documentation

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HIGHLIGHTS OF CHAPTER 1

- Accurate and specific documentation procedures are necessary for ethical, professional, and financial reasons.
- Third-party payers and accrediting agencies are becoming more stringent in documentation procedures.
- The intake, treatment plan, progress notes, revised treatment plan, and discharge summary are interrelated. Although they are independent documents, they represent a continuous process in therapy and documentation.
- Each step in the counseling procedures has specific documentation procedures. Not following them could be detrimental to the client, the therapist, and the clinic. Likewise, all can benefit when appropriate procedures are followed.

QUESTIONS

1. In the medical model of documentation, the means by which a therapist documents therapy
   a. depends on the theoretical school of thought.
   b. is atheoretical.
   c. is not important.
   d. incorporates documenting impairments rather than strengths.
2. A current requirement by most third-party payers to cover mental health services is documenting
   a. that personal growth will take place in therapy.
   b. that a preexisting condition was not present.
   c. proof of insurability.
   d. medical necessity.
3. When audited by a third-party payer, client files that are found not to be compliant with documentation standards
   a. typically result in loss of licensure.
   b. are a minor concern to most clinicians.
   c. may be subject to repaying funds to the third-party payer.
   d. are clear violations of confidentiality.
4. Typically, the evidence a third-party case manager uses to determine that the treatment plan has been followed is found
   a. in the progress notes.
   b. by interviewing the client.
   c. through determining the number of sessions that have been conducted, to date.
   d. in the initial summary report.

   Answers: 1b, 2d, 3c, 4a