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## CHAPTER 1

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# Introduction

**D**ocumentation of all aspects of mental health treatment is crucial in this age of accountability. It is the only evidence demonstrating the need and effects of treatment. Simply stating that a client has a certain diagnosis or claiming that therapy has been helpful to the client is an opinion but not evidence. Empirical evidence demonstrating that treatment was necessary and effective is essential. It is possible, and even compulsory, to document the outcomes of psychotherapy in objective, measurable terms without mechanizing or dehumanizing the process.

The clinical skills employed in psychological treatment are unrelated to documentation skills. It is possible to be an excellent therapist but have poor documentation skills. And, vice versa, one can be quite adept in documentation but not very helpful as a therapist. Of course, the goal is to be proficient in each of these realms.

It is not the purpose of this text to teach a particular mode of therapy that is easily documented, but rather, it is to teach documentation methods and skills that are useful for any school of thought. Therefore, the focus of this text is not on the “how to’s” of mental health treatment, but on documenting the necessity, goals, and effects of therapy. If the examples used in the documentation training appear to reflect a particular school of thought, it is not intentional.

We are living in the age of both personal and 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. Reading the newspaper or watching the news on just about any given day substantiates the point of widespread ethical concerns. Modern political debates have emphasized ethical issues as much as political issues. An increasing number of well-known public figures have

filled the headlines and court dockets by compromising their professional standards. Colleges, universities, and professional schools have increased their required ethics courses over the past several years. Most mental health licensing boards require ongoing ethics training as part of their mandatory continuing education. Insurance premiums for mental health professions are often discounted when they provide evidence that they have taken ongoing continuing education credits in ethics.

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

Such regulations are designed to both increase clinical effectiveness and help curtail the rising costs of mental health services, which have skyrocketed over the years. 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, providing appropriate documentation and communicating evidence of clients' needs for services is crucial for a clinic's financial and professional survival and growth. As an added bonus, many mental health professionals have commented that after they have learned sound documentation skills, their therapy became more on target rather than vague or unfocused.

Learning on-target documentation procedures is much more than simply 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, it is not possible to evaluate therapeutic effectiveness because there is not a clear record of what took place in therapy. Sloppy clinical procedures are not only unfair to the client but can border on malpractice. During times such as a third-party audit or a clinical review, proper documentation validates course of the therapy. When sound documentation procedures are followed, a written record of treatment will be available for review of (a) validation of the correct diagnosis, (b) the medical necessity of services, (c) therapeutic effectiveness, (d) appropriateness of services performed, (e) continuity of services, and (f) evaluation of therapeutic outcomes. The result is setting a high standard for mental health treatment.

In the past, third-party payers simply paid therapists when an insurance claim was made. Costs escalated, and thus managed care 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.*

Many therapists have claimed that they were unaware that most third-party payers do not cover counseling that is intended solely for "personal growth," rather than treating psychopathology. This is not to say that counseling for personal growth is not helpful, but it is typically not covered by insurance. Thus, it is usually an out-of-pocket expense. Such counseling likely fits under the category of the services a life coach offers. Please be aware that insurance companies do not pay for services without adequate documentation and a definite mental health diagnosis and related impairments. It can be quite tempting to assign a diagnosis to a client, whose symptoms do not meet the *Diagnostic and Statistical Manual of Mental Disorders (DSM)-5* criteria for the diagnosis, in order to receive payment. Avoid this practice at all costs. Your reputation is on the line! Always explain to each client both the benefits and risks of having a record of mental health treatment as in Box 1.1.

There are certainly other risks to clients when receiving mental health treatment. Most of them are unfair to the client, who simply wants to get better. A few of these risks include the following:

1. Being labeled as having a mental illness can lead to stereotypes by both the client and others involved in the client's life.
2. Poor therapy can lead to a decline in the client's condition or a feeling that there is no hope. I have seen too many clients who apply for disability benefits when they are convinced that they will never get better because their previous counseling did not help, thus believing that they will never improve.
3. Some types of counseling are inappropriate for certain clients. For example, if for some reason a client can attend only 10 sessions (e.g., insurance benefits restrictions, cost, other timing factors), and the client has a severe mental illness that requires long-term therapy, the effects of brief treatment could be harmful if not conducted properly. That is, there is only time to "open the can of worms" but no resolution.

**Box 1.1** Realistic Example of the Benefits and Risks of Receiving Mental Health Treatment

For the past 5 years John Doe has been under an increasing amount of stress. He had been promoted on his job to a very stressful position that required being on call at work 24/7. Although he was doing well career-wise, the stress of his job took a toll on his mental health. Gradually, it affected his marriage and attendance at work. For relief, he spent increasingly more time at a local bar. He spent large amounts of money unwisely, leading to significant debt. He often came home intoxicated and would miss work the next day. Eventually he lost his marriage, children, and his job. He felt empty inside and became severely depressed. His parents convinced him to see a therapist and receive substance abuse treatment. In treatment, he was diagnosed with both Major Depressive Disorder and Alcohol Use Disorder. Over time, he recovered and was quite thankful for the treatment he received. His compliance with professional treatment was a life changer. He was overjoyed when he reunited with his wife and children. Without this necessary treatment, he likely would have gone into deeper depression and perhaps harder drugs. When he disclosed to potential employers that his lapses of employment were due to mental health and chemical dependency treatment, he soon realized that his history of both mental health treatment and substance abuse affected that type of employment available to him. He eventually found work but at a much lower level of responsibility and pay. Yes, there are both benefits and risks of receiving mental health treatment.

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 providing mental health treatment: documentation. However, when properly trained, therapists soon realize the benefits of documentation by not only becoming more confident in meeting third-party requirements but also becoming more aware of their client’s progresses and setbacks; they are also more proficient at staying on task. Learning documentation procedures is a win-win situation.

Documentation for psychotherapy is atheoretical. It does not follow a certain school of thought. It is presented as *behavioral evidence*, in observable and

measurable terms; that have nothing to do with *behavioral* therapy. The clinician may conduct psychotherapy from any effective type of treatment (e.g., cognitive, behavioral, dynamic, gestalt, rational-emotive, solutions focused, etc.). Managed care companies, along with other third-party payers and accrediting organizations, are open to this variation, provided that there is written evidence of the course of therapy, not just a narrative. The evidence is presented in terms of objective client behaviors, not opinions or speculation. Evidence of alleviation of specific client impairments, which are secondary to the mental health symptoms, is required. They question, “What improvements in mental health or behavioral functioning are taking place as the result of the present therapy?” It is our job to provide this evidence by means of written documentation throughout the treatment.

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, 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.

Initial	Diagnostic Interview Treatment Plan Progress Notes
Ongoing During Course of Treatment	Treatment Plan Revisions/Updates  Progress Notes
End	Discharge Summary

**Figure 1.1** Course of documentation

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This text begins with teaching the rationale and examples of documentation for each step of the therapeutic process. In addition, it provides training as to what documentation is required for third-party payers and accreditation agencies.

### 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 their required 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, if not followed, could be detrimental to the client, therapist, and the clinic. Likewise, all can benefit with appropriate procedures.
- Documentation procedures are atheoretical. They do not represent a form of treatment, but rather, they demonstrate the effects of treatment in objective, measurable terms.

### 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. Client files that are audited by a third-party payer that not found to be compliant with documentation standards
  - a. typically leads to loss of licensure.
  - b. is a minor concern to most clinicians.
  - c. may be subject to repaying funds back to the third-party payer.
  - d. is a clear violation 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.
5. Why might counseling for the sole purpose of “personal growth” not be covered by an insurance company?
  - a. It isn’t necessarily medically necessary.
  - b. It does not have a *DSM-5* diagnosis.
  - c. It is too vague of a concept.
  - d. all of these.

Answers: 1b, 2d, 3c, 4a, 5d

