

DOCUMENTATION IN COUNSELLING

Darebin Community Health

The background of the slide is a solid teal color. In the lower half, there are several faint, concentric circles of varying sizes, resembling ripples in water, which are centered horizontally and positioned towards the bottom right.

D.S.M & The Clinical Report Format

- **THE DSM IS THE STANDARD CLASSIFICATORY SYSTEM USED IN MENTAL HEALTH PRACTICE AUSTRALIA:**
- **BENCHMARK AS SET BY THE A.P.A FOR PSYCHOLOGY & PSYCHIATRY**
- **THE CLINICAL REPORT FORMAT IS BASED ON THIS.**
- **FORMS THE BASIS OF SESSION DOCUMENTATION PRACTICES AT D.C.H**

SO WHAT DOES THIS LOOK LIKE

AT

DAREBIN COMMUNITY HEALTH?

DCH CASE-NOTE FORMAT

- DATE, NAME OF PRACTITIONER and all other record keeping requirements as per departmental/privacy act standards
- GENOGRAM (the standard is for 3 generations if possible or more if considered relevant).

DCH CASE-NOTE FORMAT

- **PRESENTING ISSUE(S)/ REFERRAL SOURCE(S)**: a brief summary of what has brought the client to the service (precipitating event).
- **Who has driven the referral – provides systemic context around the “identified patient”**
- **Any accompanying information from referral sources should be signaled here.**

DCH CASE-NOTE FORMAT

- **SIGNIFICANT HISTORY:** this could include anything you consider relevant:
 - family of origin history/significant events (deaths)
 - client's developmental history (trauma history)
 - other significant relationships and social support system
 - history around the presenting issue and any other related issues (predisposing, precipitating perpetuating and protective factors)
 - history around any help sought in the past and other services currently involved.
 - drug taking history: illicit & prescribed
 - physical health issues

DCH CASE-NOTE FORMAT

- **FORMULATION**: an attempt to hypothesize/summarize/"snap-shot" the therapeutic themes which reflect the clients psychological, emotional and social well-being.
- **DIAGNOSIS**: (depends on qualification of worker & organization's 'scope of practice')
 - consists of a provisional and differential diagnosis.
 - or can include a diagnosis that has been made by another clinician but you must state it as such – and have written confirmation of it from that clinician.

DCH CASE-NOTE FORMAT

- **CLIENT SERVICE PLAN**: a brief and concise summary of what work will be undertaken with the client, therapeutic goals, the terms of contact and a basis for formally reviewing the work.
- It is strongly recommended that you document this section separately as well, and sign along with the client and give them a copy. This can be in point form or whatever form makes most sense to you and the client.
- This can be a difficult task in our field, but it needs to be done – even if you are simply stating that you are agreeing to spend some sessions with the client to support them through a difficult period

DCH CASE-NOTE FORMAT

- **LIST OF SIGNIFICANT CONTACT PEOPLE:** names & numbers, and who is responsible for what.
- **SAFETY PLAN:** especially around self-harm/suicidality, issues of domestic violence or child protection issues
- **MEDICATION:** what has been prescribed, dosage and administration regime. Who is the prescribing practitioner– useful to know because this practitioner ultimately holds the ‘duty of care’ in the event of crisis/acute episode

ONGOING/PROGRESS NOTES

- **CONTENT:** what was explored in the session. Client incidents (like self-harm) or anything around which our duty of care may become relevant needs to be documented.
- **THEMES/SIGNIFICANT DEVELOPMENTS:** what stood out about this for you and the client. Comments on progress or direction of the work. Identify anything impeding the work, conflict around agreed service-plan.
- **HOMEWORK/FOLLOW-UP:** nature of homework tasks if applicable or what will be attended to next session.

REVIEW SESSION NOTES

- Occur periodically as agreed with client – need to document the content and outcomes of the review.
- Can be an informal discussion, guided by a structured pro-forma, or may involve a client reflection facilitated by another worker (and may involve other significant parties/service providers as well).
- The Review should identify whether issues have been substantially addressed, or whether more/new work needs to occur. Any other key reflections/feedback from the client
- Identify new client service-plan and terms of contact and new review date for this.
- Is work complete? How does finishing need to be attended too

CLOSING (DISCHARGE) SUMMARY

- **A SUMMARY OF THE WORK THAT HAS TAKEN PLACE**
- **IDENTIFY OUTCOMES - SUCCESSFUL OR ADVERSE**
- **INFORMATION THAT MAY BE PERTINENT TO FUTURE CARE EPISODES - HELPS AVOID REPITITION & TO FOCUS NEW WORK**

ISSUES

- **REGARDLESS OF THE FORMAT, HAND-WRITTEN NOTES CAN BE DIFFICULT TO READ – DCH HAS DEVELOPED A FORMATED CASE-NOTE TEMPLATE SO MOST CASE-NOTES ARE NOW TYPED**
- **STYLE OF WRITING ACROSS THE TEAM CAN VARY (POINT FORM VS PROSE) – REQUIRES TRAINING & SUPERVISION**
- **COMPETENCY OF DOCUMENTATION - DISTINGUISHING BETWEEN FACTS, CONJECTURE AND WHO ACTUALLY SAID WHAT (QUOTATIONS)**
- **GENERALLY WRITING NOTES THAT WILL WITHSTAND RIGOROUS EXAMINATION IN COURT IS A PROBLEM FOR THE FIELD GENERALLY**