A case in point

A Queensland guide to alcohol and other drug clinical documentation and case formulation

insight

Centre for alcohol and other drug training and workforce development

Insight is a Queensland Health initiative, proudly delivered by Metro North Mental Health – Alcohol and Drug Service.

Queensland Government

Insight are specialist providers of alcohol and other drug training, education, clinical resources and practice advice for workers and services.

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Disclaimer
Interchangeable language is used throughout "A case in point – A Queensland guide to alcohol and drug clinical documentation" with "case note," "file note," "treatment note" and "progress note" all be represented by the term "clinical documentation."

Why is clinical documentation important?

Clinical documentation is an essential feature of all aspects of alcohol and drug treatment. It is recommended that alcohol and other drug (AOD) services document their clinical activity well to enhance their ability to provide better, more consistent and more accountable healthcare.

The primary purpose of clinical documentation is to record the care that a worker has provided to a client. This documentation usually contains a chronological summary of what was discussed between the client and the worker, along with information about any intervention that was provided during the contact and the goal for ongoing treatment.

Other reasons for maintaining good case notes include:

- It allows for the identification of the presenting concern/s, and records interventions provided within the episode of treatment.
- To support the therapeutic relationship.
- To establish a longitudinal history of client contact, interventions and treatment over time.
- To communicate progress towards treatment goals and treatment outcomes.
- It facilities communication and care within a treating team or service, and assists with continuity of care, allowing for another worker to assume care of the client with minimum disruption to treatment.
- Allows us to reflect if the client is making progress or not and to change treatment if necessary, ensuring the best treatment is always offered (Cameron, 2013).
- To support good client outcomes, with evidence suggesting that workers who are skilled in writing case notes support better client outcomes (Preston-Shoot, 2003).
- Allows for ongoing assessment and identification of risk.
- Promotes the opportunity for reflective practice processes when recording and reviewing clients progress in treatment.
- Provides a system of accountability and evidence for the provision of safe and quality healthcare.

Worker Tip: *Organisational requirements can have significant bearing on how clinical documentation is recorded. Workers are always encouraged to ensure that documentation is recorded both within their scope of practice, and is done so in accordance with the policy/procedure of their local work environment.*

Rules for clinical documentation

Who can record?

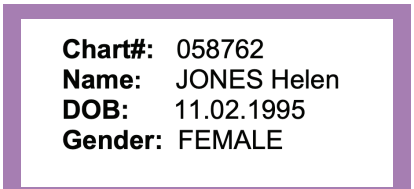
In the majority of AOD treatment settings, clinical documentation relating to a client will be completed by the treating worker, or alternative worker who may have had contact with the client. In some organisations, administration officers may add entries into a clinical record, but these would be limited to noting cancellation or rescheduling of appointments or updating basic demographic data.

If a student makes an entry in a clinical record, it is a common requirement that the student's supervisor review the clinical documentation and counter sign the entry.

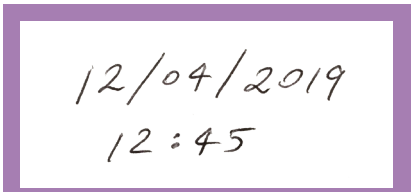
Under no circumstances should a worker make an entry in the clinical record under the name of another worker. In the extenuating circumstances where you are asked to update or add notes on behalf of another worker, it must clearly state in the notes that the entry is being made at request of another worker.

Client identification

All clinical documentation should enable ease of identification of the client. In many settings it is often mandatory that the client's full name, date of birth and unit record number/identification number be recorded as a minimum on the top of every page of the record.



Pictured: Client ID example



Pictured: Date stamped example

Date stamped

All clinical documentation should be recorded with date of entry and time of entry (recommended in 24-hour format) and should be filed in chronological order.

The date and time of contact with a client also needs to be stated in the entry.

Timely

It is recommended that contact with a client be recorded as soon as possible. Organisational requirements and contact context (such as outreach) should be considered in these timeframes. It is recommended, where possible, that documentation occurs within 24 hours.

If you are recording clinical documentation in retrospect, this should be specified in the notes. The date and time of contact with the client must be stated in the entry.

Worker Tip: *What shouldn't I record?*

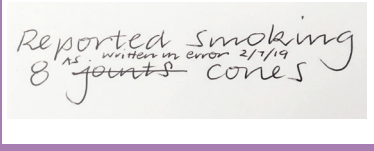
Worker emotions, opinions and judgements, unsubstantiated suspicions, or false or untrue information should not be included in clinical documentation.

Legibility and use of writing instruments

Handwritten notes should be written in a legible manner and in black ink. Recording notes in black ink allows for ease of photocopying. It is recommended that typed notes/digital records be subject to spell checking. All entries should have appropriate punctuation and grammar.

Correction of errors & changing/ amending case notes

Mistakes sometimes occur during the writing of clinical documentation. Mistakes should be correctly dealt with, and not be omitted. As the permanency of documentation needs to be preserved, do not black out or use liquid paper on any mistakes within the notes.

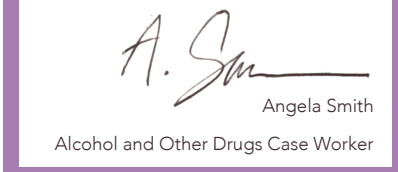


Pictured: Error correction

If clinical documentation is hand written, it is a practice option to put a single strike through the error, with the words "written in error" to be recorded, along with the initials of the worker and the date. For an amendment to a digital record, check local policy for further information and management instructions.

If a change or addition needs to be made to a case note, it is recommended that a completely new entry be added, with reference to the date and time of the previous entry that you need to amend. You must sign and date the additional information, as you would with a standard case note entry.

Signing and designating each entry



Pictured: Signing each entry

All entries in a clinical record must contain the signature, name and designation of the staff member making the entry. Stamps are acceptable to record the staff members name and designation, and must be directly beside or underneath the signature. This identifies who made the entry in the clinical record.

Worker Tip: *Should I discuss abstinence?*

Whilst the Queensland AOD sector operates from a harm minimisation framework, it is recommended that you discuss the option of abstinence from substance use with your client. Even if this is declined, it is important to record this interaction in your case notes, to demonstrate that abstinence was offered as a treatment option, as evidence that the client understands their choice and has made an informed decision.

Use of abbreviations

Abbreviations are used widely in AOD treatment settings, and can be used when the full meaning of the acronym or abbreviation is written elsewhere in the case note if they are not expected to be known to any other staff who need to interpret the entry.

It is also recommended that AOD treatment setting consider the use of The Australian Dictionary of Clinical Abbreviations, Acronyms & Symbols to assist with further standardisation of abbreviations.

Greatest meaning with the fewest words

Clear, brief and succinct notes that cover what has occurred in the contact is desired and makes it easier for others when reviewing your notes.

Worker Tip: *Should I do anything differently when working with under 18-year-old clients?*

As this population are considered minors in Queensland, family involvement in treatment should always be offered and evidenced in your clinical documentation – even if this is declined.

Methods for clinical documentation

There are many methods used to write case notes. Using a standardised format can assist you to learn how to structure information about a contact you have with a client in a logical and sequential format. It can also assist you to improve how you write your case notes over time. Additionally, a standardised format can highlight key information quickly and can also assist with care collaboration within an organisation.

Local work area guidelines should be reviewed to see if there is a standardised case note template or case note method that is endorsed for use within your organisation. It is recommended that you use your organisational tool if one exists. If your organisation does not have an endorsed approach or tool, the following methods may provide guidance.

The SOAP and DAP methods are two ways of organising your clinical case note entries.

Worker Tip: *Entering collateral information about your client that has been provided by a significant other or another service provider may not fit within the SOAP and DAP models, but is still important to record this information in the clinical record.*

The SOAP Method

S

Subjective data

Information that the client provides or states - client subjective feelings only. The subjective portion of case notes written in this style should start with "The client reported…" or "Client says..."

e.g. The client reported that they feel anxious.

Client says "I feel anxious".

O

Objective data

Factual data, anything that can be measured or observed. The objective portion of case notes written in this style would have common phrases such as "It appears…" or "Client presented with…"

e.g. Client smells of an odour that could be consistent with alcohol.

Client presented crying.

Client's clothes were visibly dirty.

A

Assessment

The conclusions reached from the subjective and the objective data obtained from the client. This may be:

- problems or potential problems which can be identified from the subjective and objective data and
- certain assessments from your specific professional knowledge base.

All information pertaining to the assessment of the client's problem, client's goals for treatment, progress on their treatment plan and any diagnosis.

P

Plan

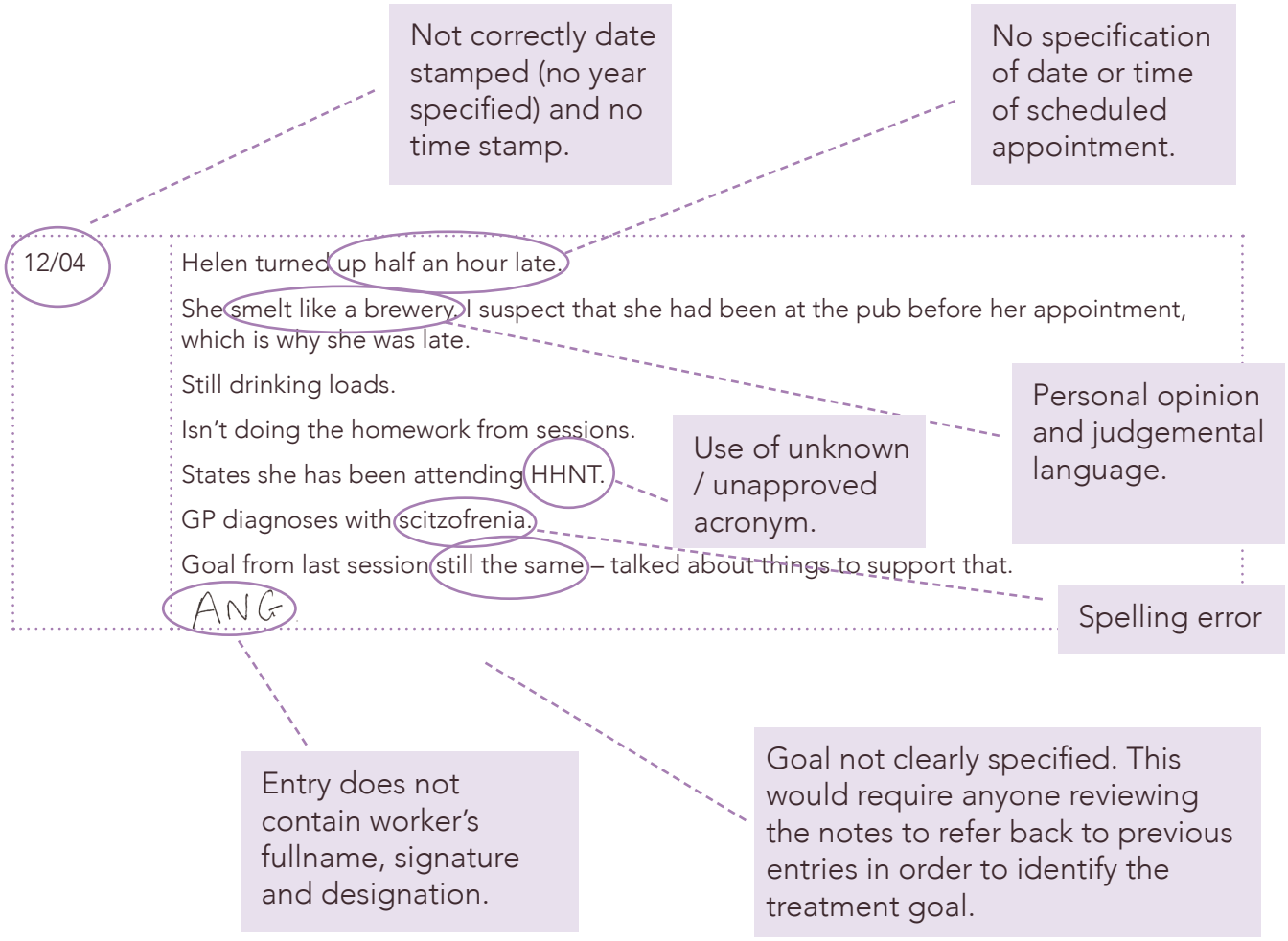
Ideally, it should be a plan based on bringing together all the information that has been gathered. The plan should include the interventions or advice suggested for the problem or the potential problem after discussion of the option with the client. Specify treatment options you presented to the client and what they decided upon or agreed to.

e.g. Discussed abstinence from drinking, controlled drinking and pharmacological interventions including acamprosate. Client reported they were unwilling to abstain from alcohol use at this time, and was seeking to attempt controlled drinking.

A good example of the SOAP method

12/04/2019 12:45	Helen presented for appointment with Alcohol Treatment Service at 11:30 on 12/04/2019 – 30 mins late.
Subjective (Information the client provides)	Helen stated "I am feeling overwhelmed", disclosing difficulties reaching goal she set at last appointment (controlled drinking, 5 standard drinks (SD), 2 days/week) and reported increase in symptoms that could be associated mild anxiety (sleep disturbance, rumination).
Objective (Factual, observable data)	Helen presented with odour consistent with alcohol intoxication but denied use when discussed. Helen continues to present well-groomed to sessions in neat, casual clothing, brushed hair and engages well in session, maintaining appropriate eye contact.
Assessment (Bringing together the conclusions from the subjective and objective)	Helen stated she had drank daily since last contact, consuming approx. 5-8 SD (white wine) on each occasion. Explored use since last session, focusing on triggers to her alcohol use. Helen identified stressful evening routine with two young children (5 and 7 yrs) and minimal alternative coping strategies as primary trigger. Denies engagement in other substance use. Able to confirm that husband does not use substances – able to be primary carer for children when Helen is unable, minimising risk to children. Poor sleep reported (sleeping approx. 5 hrs/night, difficulties with sleep initiation due to night time rumination) and stated this has been occurring for approx. 6 months. Denied any thoughts, feelings of self harm or suicide. Nil concerns with physical health reported. Continues to engage in full time employment as a Disability Support Carer – reports high employment satisfaction. Session focused on further exploring treatment options with Helen – Helen identified that because previous attempt to drink in a controlled manner (stated above) has not been achievable she would like to consider abstinence.
Plan (Interventions)	Discussed with Helen various strategies to support abstinence – inpatient detox, outpatient detox, residential rehab, counselling. Helen indicated preference for outpatient detox, followed by ongoing counselling (with focus on alternative coping and anxiety management strategies), to manage child care arrangements. Supported Helen to call to Alcohol Ambulatory Detoxification Service and scheduled an assessment 16/04/2019 at 1000. Next session scheduled 19/04/2019 at 1100 to focus on further strategies for anxiety management.  Angela Smith Alcohol and Other Drugs Case Worker

A less good example



The DAP Method

D

Data

The objective description of factual information provided by the client. It should contain observable and identifiable characteristics and behaviours that the worker sees. This may include what occurred in the session, clinical observations, diagnosis, current psychosocial concerns, what interventions were provided.

This section responds to the question: "What did I see/observe?"

A

Assessment

An assessment on how the client is presenting and progressing towards their treatment goal. This may include information such as reviewing treatment progression over sessions, client's insights towards their own treatment goal/s, specifying any areas for further intervention, treatment plans and how the goals are being met.

This section responds to the question: "What does it mean to me?"

P

Plan

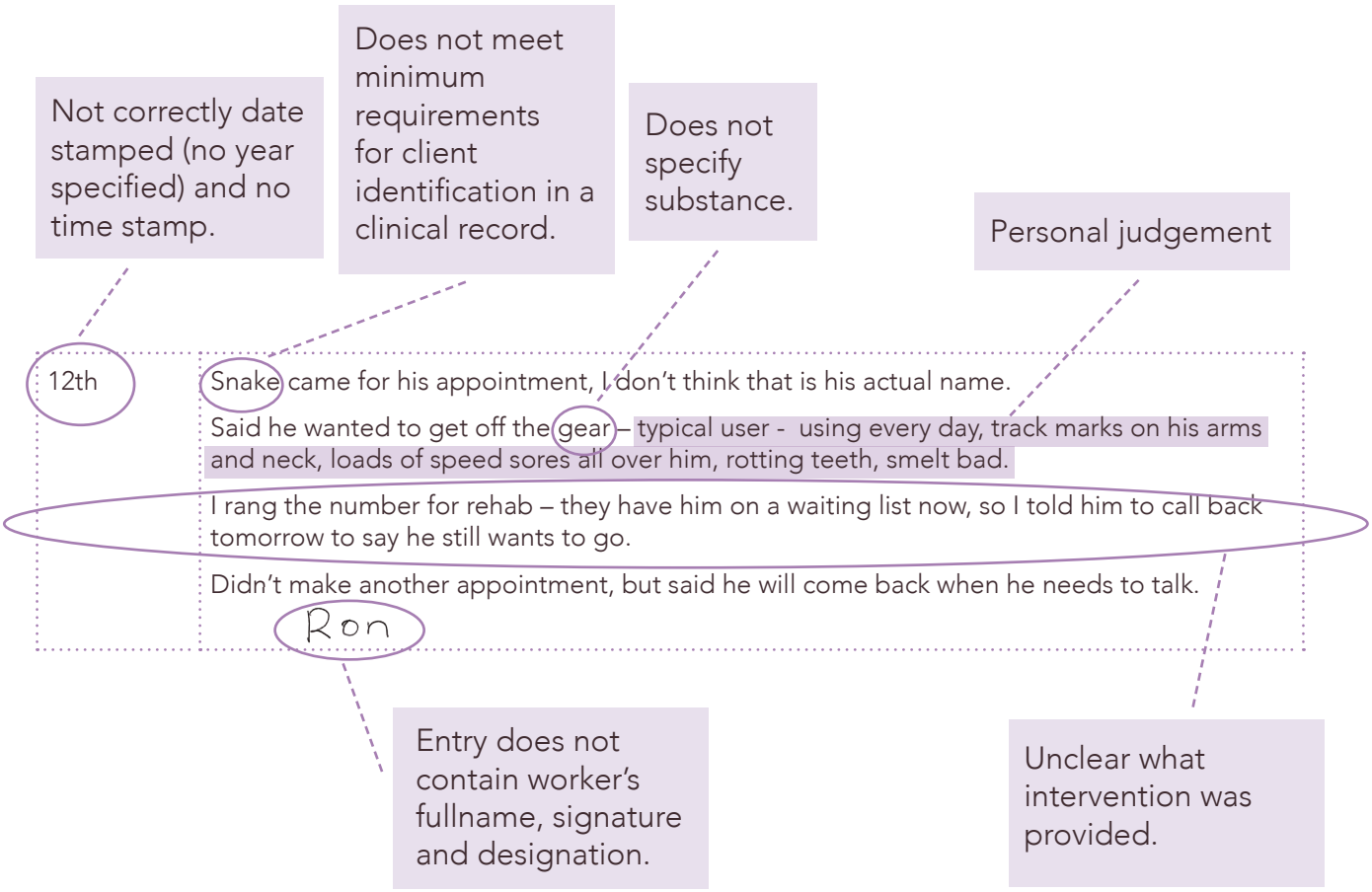
The plan is based on the assessment information from the current or past sessions, and states what is required or any changes needed that have been identified to assist in meeting the client's set treatment goal/s. It can also include planning for what interventions will be provided in the next session and any homework to be completed.

This section responds to the question: "What are we going to do about it?"

A good example of the DAP method

12 April 2019 1400	Mark (aka "Snake") presented for appointment at 1500 on 12 April 2019 at the Alcohol and Other Drug Service.
Data "What did I see?"	Mark stated he continues to have challenges controlling use of methamphetamine due to influence of peers and family. Mark disclosed use of 2 points/day over past 2 weeks, intravenous drug use (IVDU), with injection sites noted on left forearm and left side of neck. Nil periods of abstinence reported over the last two weeks. Mark reported his tolerance is increasing, stating he needs almost double the amount to achieve desired state (has gone from 1 to 2 points over the past fortnight). Poor sleep hygiene reported, (approx. 1 – 3 hours/night, with periods of "crashing" reported where he could sleep for 12-24 hrs). Agitation and irritability reported when withdrawing from methamphetamine "I just get so pissed off at everything and everyone".
Assessment "What does it mean to me?"	Current IVDU methamphetamine use suggests Stimulant Use Disorder – Severe (according to the Diagnostic and Statistical Manual of Mental Disorders - 5) with increased tolerance and marked withdrawal state, preoccupation with substance, desire to engage in use and decline in relationships. Mark expressed preference to cease use but struggling to achieve this in the community. Continued engagement in dependant use perpetuated by trauma symptoms associated with physical assault that occurred in early adolescence by an unknown person. Mark presents with good insight into correlation between trauma and substance use to manage intrusive thoughts and memories of the event. Mark has good awareness that withdrawal from is causing significant agitation and irritability – denies any perceptual disturbances, thoughts of self harm or suicide. Mark demonstrates significant insight into role of substance use in the deterioration in the relationship with his parents and (now) ex-girlfriend. These insights play a significant role in Mark's motivation to make changes to his life, and presents in Preparation Stage of Change.
Plan "What am I going to do about it?"	Explored further treatment options and Mark expressed preference for inpatient detox and residential treatment. Mark declined option of abstinence at present, but agreed to referral to Hospital Inpatient Detoxification Service to start assessment process – written referral complete and faxed within session (phone call required to confirm referral received). Mark was willing for treatment plan to be updated to reflect today's discussions. Future plan for treatment to focus on supporting Mark to explore residential rehab options, appointment scheduled 19 April 2019 at 1400. Ronald Smith Social Worker

A less good example



Case Formulation

Case formulation is a theoretically-based explanation or conceptualisation of the information obtained from a clinical assessment. A case formulation usually includes a summary of the presenting issues, an examination of these presenting issues in terms of their development and maintenance within the context of the client's life, as well as a summary of the client's strengths.

A case formulation will differ according to the theoretical approach and model of therapy being provided, and according to someone's professional discipline and scope of practice.

What are the advantages of case formulation?

- It helps to clarify information relevant to treatment.
- It provides structure to organise and integrate information provided by the client.
- Having this structure results in treatment being more focused.
- It may be easier for the client to understand than a long clinical document.
- It helps to interpret information.
- It helps to direct and develop the treatment plan.

There are many documented approaches to formulation. One of the most popular is the Five Ps approach. (Weerasekera, 1996).

The following pages contain three ways in which you can present your case formulation information using the Five Ps model. If you are required to share your formulation with others, you may wish to consider the most appropriate format to use.

Worker Tip: *Developing a case formulation is about collaborating with your client – you should involve them in the development, discuss your hypothesis and allow your client to provide feedback on what you have developed.*

Method 1: The Five Ps Narrative Approach

Let's review the Five P's in more detail.

Presenting issues	Briefly summarise the problems the client identifies as bringing them into treatment, as well as any other problems that are identified during the assessment. Presenting issues are usually broader than just AOD problems, such as psychological, social, health, legal, accommodation and financial problems.
Predisposing (or background) factors	These are issues in the client's childhood, adolescence and adulthood that predispose them towards experiencing AOD, mental health and other difficulties. Includes historical events and biopsychosocial factors that increases the likelihood (or risk) of the client developing social, emotional or behavioural difficulties.
Precipitating factors (or triggers)	These are the factors or key onset events that have brought the client's difficulties to the surface and resulted in them accessing treatment.
Perpetuating (or maintaining) factors	These are the factors in the client's life, behaviour, beliefs and psychological state that maintain the presenting issues or cycles of behaviour.
Protective factors	Captures both individual and systemic strengths that exists alongside the presenting issue. These are the client's strengths and resources that offer hope and promote resilience.

Worker Tip: *A case formulation is a working hypothesis – the hypothesis will change as your client makes changes, and therefore should be regularly updated.*

The Five Ps Narrative - Example

Presenting issues	Colin is a 45yo single male, seeking support to cease 30-year history of daily cannabis use. Cooccurrence of anxiety. Nil vocational engagement, with Colin stating that he is "too anxious to get a job." Rental accommodation is currently at risk – income has been spent on purchasing cannabis and has subsequently fallen behind in his rental payments. Reported difficulties with social interaction, with limited peer network and family support.
Predisposing (or background) factors	Colin reported growing up in a community where substance use was accepted as "normal". Experienced social disadvantage throughout early childhood, with father passing away when Colin was 4yo. Nil positive male role model. Report that mother did not cope with father's death, and used alcohol a way to cope. Attachment issues with mother reported, stating she was "cold" to him as he was growing up, and that family was disorganised through childhood and adolescence. Has difficulties with educational obtainment, and left school at 14 years old. Presented with an anxious predisposition and observed low self-esteem.
Precipitating factors (or triggers)	Cannabis use has been easily accessible for Colin throughout his life, and he has regularly used cannabis to manage symptoms consistent with anxiety.
Perpetuating (or maintaining) factors	Colin's engagement in cannabis use is maintained by a longstanding history of psychological dependence to cannabis use. The ongoing ease of availability to cannabis, accompanied by Colin's history of social disadvantage, and limited/poor social support networks perpetuates his cannabis use. A long history of dysfunctional coping strategies, such as engagement in cannabis use has seen Colin's cannabis use span 30 years. Anxiety symptoms have resulted in Colin having difficulties both seeking gainful employment and building/sustaining social relationships.
Protective factors	Colin presents with good insight and understanding regarding the role the cannabis plays within his daily coping and functioning. He acknowledges that there is a problem, and is voluntarily seeking treatment to make changes to his cannabis use. Colin accepts this formulation and plan for treatment to achieve abstinence from cannabis use.

Method 2: The Five Ps Formulation Matrix

(Adapted from: Psych-Lite: Psychiatry that's easy to read. Selzer and Ellen, 2010, Sydney, page 22, table 4.1)

	Biological/Medical (physical disease / illness)	**Behavioural**	**Psychological** (cognitive style, emotional regulation, self esteem)	**Social**
Presenting Information				
Predisposing Factors	Family history Genetics Pre/Post Natal Developmental Temperament Birth trauma	History of reinforcement & punishment Dysfunctional coping strategies Modelling Learned helplessness	Distorted / dysfunctional thinking / faulty patterns of thinking Conduct / emotional problems Learning difficulties. Positive beliefs about substance use Low self esteem External locus of control Expectations	Poor social support Geographical isolation Poor housing Race, gender, class Limited social skills
Precipitating Factors	Acute/Recent Trauma Acute Injury / Illness / Infection	Decrease / change of reinforcement or punishment Regulating negative mood states with drugs Risk taking / sensation seeking	Low self esteem Stage of life Loss/grief Life stressors	Acute life stressor Peer pressure / bullying Availability / curiosity about drugs Lifecycle change / transition – school, employment status, housing, financial, relationship Immigration
Perpetuating Factors	Past Trauma Injury / Illness / Infection	Chronic low reinforcement Accessing reinforcement Reinforcement of illness behaviour Poor variety of reinforcement Poor impulse control	Low self efficacy Poor coping strategies	Social isolation / poor social support / loyal member of substance using peer group Social disadvantage Social Anxiety / shyness Availability of substances Lack of meaningful engagement / activity
Protective Factors	Good Health Medication Intelligence	Variety of reinforcement Wide behavioural repertoire Ability to self regulate Absence of punishment	Easy temperament High self-esteem / self-efficacy Internal locus of control Optimistic attribution style Functional coping strategies	Good social supports Good social skills Stable social role

The Five Ps Formulation Matrix - Example

	Biological/Medical (physical disease / illness)	**Behavioural**	**Psychological** (cognitive style, emotional regulation, self esteem)	**Social**
Presenting Information	30-year history cannabis dependence.	Nil identified	Anxiety diagnosis. Believes that cannabis use a problem, and demonstrates insight into use of cannabis to manage anxiety symptoms.	Limited peer network. Limited family support. Nil vocational engagement
Predisposing Factors	May have genetic vulnerability – mother engaged in alcohol use as a way to "cope."	Mother role modelled use of substances as a coping strategy.	History of poor coping strategies Low self esteem. Query learning difficulties	Grew up in a community that accepted substance use as norm. Poor social support. Rental accommodation is currently at risk – behind on rental payments. Limited social skills
Precipitating Factors	Nil identified	Nil identified	Low self-esteem. Historical use of cannabis to management anxiety-symptoms.	Risk of loss of current accommodation / rental. Strain of his current financial situation.
Perpetuating Factors	Cannabis use Possible withdrawal symptoms – with inclusion of anxiety-symptoms.	Copes by engaging in cannabis use to manage anxiety symptoms.	Experiences anxiety symptoms Has poor coping skills / minimal functional coping strategies Longstanding history of psychological dependence to cannabis	Ease of availability to access cannabis use Longstanding history of social disadvantage Limited/poor social support network. Lack of engagement in meaningful activity / vocational engagement.
Protective Factors	Physical health is reported as "okay"	Voluntarily seeking treatment to support abstinence from cannabis	Good insight and understanding into use of cannabis to manage anxiety symptoms. Well engaged, friendly demeanour.	Nil identified

Method 3: The Five Ps Flowchart

Predisposing Factors

Psychological Factors

- Conduct problems
- Emotional problems
- Specific learning disabilities
- Positive beliefs about drug abuse
- Risk taking and sensation seeking
- Difficult temperament
- Low self-esteem
- External locus of control

Parent-child factors in early life

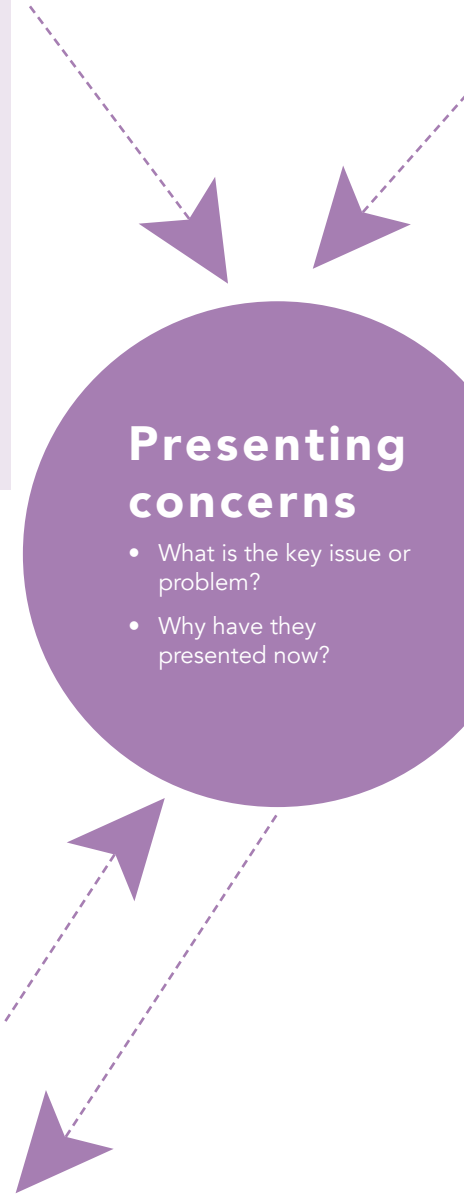
- Attachment problems
- Inconsistent parental discipline
- Lack of intellectual stimulation
- Authoritarian parenting
- Permissive parenting
- Neglectful parenting

Exposure to family problems in early life

- Parental alcohol and substance abuse
- Parental psychological problems
- Parental criminality
- Marital discord or violence
- Family disorganisation
- Deviant siblings

Stresses in early life

- Bereavements
- Separations
- Child abuse
- Social disadvantage
- Institutional upbringing
- Trauma



Perpetuating Factors

Biological factors

- Physiological dependence

Behavioural factors

- Academic and vocational problems
- Involvement in justice system
- Positive beliefs about substance use
- Sensation seeking and risk-taking
- Low self-efficacy
- Dysfunctional coping strategies

Family / Parental factors

- Family denies problems
- Chaotic family organisation
- Family is ambivalent about resolving the problem / never coped with similar problems before
- Parents / family model or reinforce drug use by using drugs, expressing positive attitudes to drug use and tolerating drug use
- Disengaged interaction and neglectful parenting
- Father absence
- Marital discord
- Inaccurate knowledge about drug use
- Depressive or negative attribution style
- Family history of dysfunctional coping strategies

Social network factors

- Ongoing availability of drugs
- Loyal member of drug using peer group
- Educational placement where there is lax supervision
- Poor social support network
- High family stress
- Social disadvantage
- High crime rate
- Few employment opportunities
- Lack of coordination among involved professionals

Precipitating Factors

- Availability and curiosity about drugs
- Peer pressure
- Regulating negative mood states with drugs
- Acute life stresses
- Illness or injury
- Child abuse
- Bullying
- Births or bereavements
- Lifecycle transitions
- Changing school
- Loss of peer friendships
- Separation or divorce
- Parental unemployment
- Moving house
- Financial difficulties

Protective Factors

Biological factors

- Good physical health

Psychological factors

- High IQ
- Easy temperament
- High self-esteem and self-efficacy
- Internal locus of control
- Mature defence mechanisms
- Functional coping strategies

Family / Parental factors

- Family accepts there is a problem
- Family is committed to resolving the problem
- Family has coped with similar problems before
- Secure parent-child attachment
- Clear family communication and flexible family organisation
- High marital satisfaction
- Good parental adjustment
- Accurate knowledge about drug use
- High parental self-efficacy and self-esteem
- Functional coping strategies

Social network factors

- Good social support network
- Low family stress
- Positive educational placement
- High socioeconomic status
- Good coordination among involved professionals

The Five Ps Flowchart - Example

Predisposing Factors

- Grew up in community where AOD use was accepted
- Social disadvantage in childhood
- Father died when Colin was 4yo, mother unable to cope.
- Attachment issues with mother
- Family disorganisation in childhood/adolescence
- Difficulties with educational obtainment
- Anxious predisposition
- Low self-esteem.

Precipitating Factors

- Ease of access to cannabis
- Use of cannabis to manage symptoms of anxiety
- Difficulties obtaining vocational activities
- Difficulties building/sustaining social relationships,
- Financial difficulties and risk to accommodation

Perpetuating Factors

- Psychological dependence. History of social disadvantage
- Limited/poor social support networks
- Dysfunctional coping strategies

Protective Factors

- Good insight and understanding re: cannabis and daily coping/functioning. Acknowledges the problem.
- Voluntarily Treatment seeking.
- Accepts this formulation and treatment plan.

Using 5 P's to formulate a care plan

Once you have completed your case formulation, the next step is to develop a corresponding care (or treatment) plan which addresses the issues and concerns presented. Ideally this is undertaken in collaboration with the client (and family or significant others where appropriate) to ensure that that the plan is client owned and directed, and that there is clear agreement and understanding of the plan moving forward.

The plan should include:

- Overarching treatment goals
- Any assessment / reassessment of risk
- Agreed priorities and next steps
- General health and wellbeing strategies
- Referral to other services or specialists where required

The plan should also include any other items, actions, decisions or process agreements deemed necessary or relevant through the formulation process.

Many services use a template or proforma for documenting care plans so we recommend that you consult with your line manager or organisational policy and procedure manual on how to best approach this task.

Legal and Ethical Considerations

It is important to consider legal and ethical issues that can impact on documentation. Issues of consent (implied and explicit), confidentiality and consideration of medicolegal issues and assessing issues of risk are important components of the treatment provided to a client, and should be carefully documented in the clinical record. (Documentation Handbook, Alcohol and Drug Service 2005)

The maintenance of good case notes and clinical documentation has the potential to offer legal protection for both you and the client you are working with.

Consent

It is best practice to obtain consent to share information from a client. Consent and the sharing of client information should be discussed at initial assessment and be an ongoing subject for discussion throughout treatment.

When a client provides consent to share their information, it is the responsibility of the worker to document this on their organisation's template or form and consider the relevant legislation and information sharing provisions applicable to the situation. Staff are also encouraged to engage in a transparent conversation with the client regarding the uploading of clinical notes and information onto any other related systems (e.g. My Health Record).

When seeking consent it is important for workers to:

- explain the purpose, benefits and risks of sharing specific information
- communicate in a way the client will understand, using clear and concise language
- inform the client that they can withdraw their consent at any time
- close the discussion by clarifying the shared understanding of what has been agreed
- document the agreed outcome of the discussion in the client's clinical record.

Some forms of treatment require "explicit" consent. This is where the client clearly states their agreement to healthcare or access to treatment – either verbally or in writing (such as Medically Assisted Treatment for Opioid Dependence).

Other forms of healthcare may have more "implied" consent. This consent is implied where the client indicated their consent through their actions or by complying with the healthcare providers recommendations (such as attendance at voluntary counselling). It is recommended that you refer to local organisational policy about consent for further guidance.

Worker Tip: *It is recommended that you talk with your client early on about which pieces of information about their treatment can be shared with who – e.g. they may want their family to know they are coming along to appointments, but not to know the details of their treatment plan.*

Confidentiality and information sharing

All staff who are working in a government health service (such as a state health department), are bound by the Hospital and Health Boards Act 2011 (HHB Act). The HHB Act allows for information sharing in a range of circumstances, from those in which workers are required by law to disclose information to protect the health, safety and well-being of clients, significant others or the community, and to those in which clinical judgement is required in deciding what information should be shared and with whom.

The client's preferences regarding sharing of information should be respected, however there may be times in which confidential client information needs to be provided. These exceptions are specified in the HHB Act (Part 7 Confidentiality) and may include circumstances such as threats to harm self/others, child protection risk, disclosure of engagement in criminal behaviours that may impact on the community (such as driving under the influence of alcohol or other substance) or the disclosure of other serious criminal offences.

It is important that discussions around confidentiality and circumstances when information may be shared without consent occurs early on within treatment with a client, so the client is aware of what you may be professionally, legally or ethically required to share.

For staff working in AOD treatment services who are not bound by the HHB Act, it is recommended that you consult local procedures and policy pertaining to confidentiality and sharing of client information for further guidance.

Medicolegal considerations

Workers working in the AOD sector need to be aware that any clinical documentation that is recorded can be openly scrutinised in a case where a client claims the treatment that they have received is negligent or suboptimal. Clinical documentation can also be requested where there are investigations by the State Coroner or by an entity with the capacity to take evidence such as the Medical Board or Queensland Nursing Council (Legal Factsheet, QLD Health, Legal and Administrative Law Unit: Good Clinical Documentation: Its importance from a legal perspective, October 2004)

Documentation as evidence

When recording interactions with a client, it is important to ensure that what is being recorded is a clear, complete and accurate record of what occurred. Consideration needs to be given to the notion that "if it was not recorded in the clinical record, it was not done." Gaps in clinical documentation may imply poor treatment, or that the treatment was not provided.

AOD clinical records are often subject to subpoena from the State Coroner, Police or Family Court, and when this information is requested, there is no time for workers to "catch up" on writing comprehensive notes or assessments.

Worker Tip: *If you are ever in doubt about disclosing confidential client information, check with your line management first. Document the rationale for disclosure of the confidential information, as well as the discussion with line management in the clinical record.*

Clients accessing clinical documentation/case notes (Freedom Of Information)

Clients who access AOD treatment services are within their rights to request access to their clinical record and case notes.

All staff who are working for government agencies are bound by state legislation about right to information and right to privacy (e.g. Right to Information Act 2009 and Information Privacy Act 2009), which allows the community (the client) greater access to information. It is recommended that you refer to your local work unit guidelines for processes for how a client can request and access their clinical record.

Auditing Clinical Records

Auditing of clinical documentation should be undertaken as a quality and service improvement activity. It allows an organisation to demonstrate that clinical record maintenance is an important activity, enables organisations to clearly set benchmark standards for documentation and can also serve as an opportunity for supervision and professional development with staff members.

Worker Tip: *The following are examples of questions used in a clinical documentation audit of physical/hand written charts.*

(Please note that these questions are an example only and services should consider their own organisation specifications regarding clinical documentation and how compliance could be monitored/audited.)

Is there a client identification label on every page?

Are the following items recorded accurately in the chart?

- *Corrections are dealt with correctly (single strike through, initial and date)*
- *Legible*
- *Written in black ink*
- *Every entry is signed, surname printed and designation recorded*
- *Time entry is recorded in 24-hour formal for every entry*

Are the case notes recorded in an approved format (SOAP, DAP)?

Is there a case formulation recorded in the 5 P's format?

Security and Retention of Clinical Records

Consideration needs to be given about how clinical records are secured within an organisation. It is recommended that at a minimum, any written clinical record, or information relating to a client is stored in a lockable and secured location. Additional measures need to be taken within organisations regarding online security and the sharing or retaining of electronic data relating to a client. It is recommended that you refer to local work unit policies about the security, retention and destruction of clinical records within your organisation.

Issues of Risk

Working in the AOD treatment sector we often are informed about issues of significant risk or are disclosed information about issues that are particularly sensitive in nature. These issues may include:

- Child Protection
- Family and Domestic Violence
- Suicide / Self Harm
- Operating a motor vehicle under the influence of substances
- Homicidal / Violent ideations
- Disclosure of a significant criminal offence

If a worker identifies any of these issues of risk when working with a client, it is important to document in the clinical record:

- facts about the issue disclosed
- any interventions offered to the client
- actions to be undertaken or that have been undertaken
- the clients' comments/responses to the actions offered (eg accepted referral, refused referral)
- decisions and guidance provided by team and/or line management.

It is recommended that any risk screening tools that may be endorsed for use by your organisation be additionally completed and retained in the clinical record (eg risk screening tool, suicide risk screen, child protection notification tool etc).

For accountability reasons, if you consult with your line manager, supervisor or team regarding a risk disclosed by your client, it is recommended that the who, when, what was discussed and any outcomes are clearly documented in the clinical record.

Worker Tip: *Be conscious of identifying details of a third party within your clinical notes. Consideration needs to be given to the use of a person's name, using initials or referring to them by their role in the client's life e.g. "partner". If you are unclear of how to record or reference a third party, speak with your line manager.*

References

Cameron, J & Murray, J, Turning Point Alcohol & Drug Centre, 2012, Take Note! A practical guide to writing case notes: A quick reference guide for alcohol and other drug workers

Weeraseckera, P 1996, Multiperspective case formulation: A step towards treatment integration.

Clinical Issues Working Party, Alcohol and Drug Service, The Prince Charles Hospital Health Service District, 2005, Documentation Handbook

New South Wales, Family & Community Services, 2017, Clinical Formulation Practice Guide: A collaborative approach

Queensland Health, Legal and Administrative Law Unit, 2004, Good Clinical Documentation: Its importance from a legal perspective

DAP Notes, SOAP Notes and Therapist Confidential Notes, https://www.maretwebproject.com/users/docs/session_notes.pdf

Metro North Mental Health – Alcohol and Drug Service, 2019, Procedure: Requests for Client Information.

The Australian dictionary of clinical abbreviations, acronyms & symbols

Queensland Health Guide to Informed Decision-making in Healthcare, 2010 https://qheps.health.qld.gov.au/__data/assets/pdf_file/0031/693148/qh-guide-id.pdf

Selzer, R & Ellen, S 2010 Psych-lite: psychiatry that's easy to read, McGraw-Hill Australia Pty Ltd, North Ryde

Hospital and Health Boards Act 2011, State of Queensland https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2011-032

Cameron, J (2013) Take Note! Case notes and the AOD sector, Of Substance, Vol 11(1) 20-21

Preston-Shoot, M (2003) A Matter of record? Practice: Social Work in Action, Vol 15(3) 31-50

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