YOUTH CONSULTATION SERVICE

3.1 Policy and Procedure for Progress Notes

Applicability: All YCS programs

Policy:

YCS shall document all client sessions and progress through progress notes as consistent with all state regulations, including Division of Developmental Disabilities-Division Circular #52.

Procedure:

A. Required Counseling

1. Clients’ will be seen consistently, as indicated on the treatment plan, for Individual, Group, or Family Counseling.
2. Individual counseling shall include any meeting between the clinician and client for the purpose of exchanging substantive information with the explicit intention of addressing a treatment goal.
3. Group counseling shall include any meeting between the clinician and more than one additional client for the purpose of addressing the goals of all clients in the group. Group therapy is the intervention that focuses on life skills, anger management, interpersonal skills, team building, or any other area of need for those clients.
4. Family counseling shall include any meeting between the client and his or her self-defined or legal family and/or support system members in which the client’s treatment and treatment goals are discussed.

B. Required Documentation

1. The purpose of a progress note is to document the treatment and issues addressed during counseling.
2. After meeting with the clinician for Individual, Group, or Family Counseling, the clinician will document the treatment through a progress note (Attachment A).
   i. Each treatment session shall involve at least one treatment (plan) goal. This goal will be documented under Treatment Goal addressed.
   ii. Each treatment session shall have at least one objective. This short-term, measurable target will be documented under Objectives.
   iii. The intention of each treatment session is to obtain some progress in addressing the goal and objective. This progress will be documented under Progress.
   iv. Each treatment session will have content. This is the actual situation occurring and information exchanged during the session. This session content will be documented under Session Content.
v. After meeting for a session, the clinician will have a plan for future sessions. This could include follow up needed, a future meeting date, a future topic area, etc. This plan will be documented under Plan.

vi. The clinician will then sign the progress note and write his or her credentials. The clinician will also print his or her name on the progress note.

vii. The progress note shall be filed in the chart within 7 days.

3. Regarding writing an Individual counseling progress note, see #1.

4. Regarding writing a Group counseling progress note, see #1. In addition, general group information and specific client information shall be included on each note.

   i. General Information
      The clinician can note a date, treatment modality, goal, objective, session content, and plan that is general for the entire group.

   ii. Specific Information
       Each note shall then include the specific clients’ name, progress that he or she made in attaining the goal or objective, and the clinician’s original signature.

5. Regarding writing a Family counseling progress note, see #1. In addition, this note and session will focus on the client’s goal, objective and progress while noting what occurred with all members in the session content section.

Regulatory Reference: *DDD Circular #52, Page 8, Section J #4; NJAC10:128-6.1(e)12; 10:37B-4.7

Attachment A- Progress Note

Date Effective: February 1, 2006

1Counseling refers to counseling, therapy or psychotherapy depending on the clinicians license.