Golden Thread

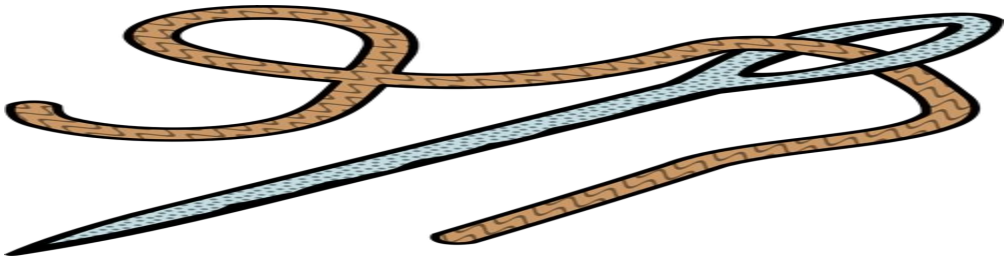
The Golden Thread is a concept in mental health that refers to the consistent presentation of relevant clinical information throughout a client's documentation. It's a best practice in healthcare that helps create a cohesive narrative of a client's experience and provides clear evidence of medical necessity. **AI Definition**

Golden Thread

The Golden Thread is a concept in mental health that refers to the consistent presentation of relevant clinical information throughout a client's documentation. It's a best practice in healthcare that helps create a cohesive narrative of a client's experience and provides clear evidence of medical necessity. **AI Definition**

Assessment-Service Plan-Service Note

Stitching it all together



GOBHI

Assessment ⇨ Service Plan ⇨ Service Note

Assessment - *Symptoms, impairments history*; **Service plan** **-** *Goals, objectives, enhance skill, decrease symptoms;*

Service note - *describe the service, how did the client respond, progress*

GOBHI

Assessment

A biopsychosocial assessment helps counselors, social workers, and other behavioral health professionals learn about their clients on multiple levels and better understand their subjective viewpoints. As a result, biopsychosocial assessments enable therapists to diagnose and effectively treat their clients.

They conceptualized a way to look at clients and their problems, systematically and holistically taking into consideration the (1) Presenting problem, (2) Predisposing factors, (3) Precipitating factors, (4) Perpetuating factors, and (5) Protective factors.

GOBHI

Presenting Problem

Primary Complaint what are the symptoms when did they start how long do they last, what is the intensity and frequency of the symptoms? How do the symptoms impair daily functioning?

Predisposing Factors

History of previous mental health symptoms

- History of trauma or family history of trauma
- Family history of medical issues, mental illness and addiction
- Living situation, who lives with them, number of dependents they care for, socioeconomic status
- Problems related to work or school

Precipitation Factors

What events led to the individual's presenting problems?

- Job change
- Illness
- Death of a loved one
- Car Accident
- School - Peer pressure, bullying, homework, teacher pressure, poor grades

Perpetuating Factors

- Ongoing stressors
- Addiction
- Abusive Relationships
- School
- Social platforms
- Caretaking for a loved one

Protective Factors

- Strengths
- Coping skills
- Supportive family
- Hobbies
- School successes - sports. Friendships

Clinical Formulation

Medical Necessity - Three things can inform medical necessity: ICD-10 (DSM-V) diagnosis, impairments as a result of the said diagnosis, and what interventions you're providing to alleviate symptoms and improve functioning.

Pulling all of the information together to form a clinical formulation, symptoms, history of symptoms, impairments, stressors, strengths

Diagnosis Why is it this and not this, evidenced by…

Assessment Template

Full Name: John Smith

Actual Start and Stop Time: 2:02-2:59pm

Service Location: Greenwood Office

Billing Diagnosis: F43.89 Other Specified Trauma and Stressor Related Disorder

Data: This writer and the individual completed a collaborative and comprehensive behavioral health assessment and initial treatment plan on this date (see copy of both the assessment and tx plan dated today's date in the individual's chart for additional information). Based on the individual's reports, individual was provided a diagnosis of Other Specified Trauma and Stressor Related Disorder (F43.89). The individual was provided with information regarding the Agency, signed an informed consent, received information on advanced directive, voters rights, declaration of mental health and reviewed confidentiality. The individual completed a PHQ-9 or CSSR (present in chart). No safety plan was completed at this time based on responses to these tools, however, this will continue to be monitored and if necessary, a safety plan will be created in the future. Individual wishes to engage in treatment to improve feelings of self-worth, resolve past trauma and decrease anxiety.

GOBHI

Assessment Template cont..

Reason for Seeking Services (age, referral source, brief introduction into reason for seeking services): John is a 45 year old male referred to this writer by a friend. John is seeking mental health treatment due to an increase in feelings of worry and “emotional outbursts”, a decrease in his feelings of “connectedness” in his marriage and with his children and a difficulty sleeping due to recurrent bad dreams.

History of Presenting Problem (Events, precipitating factors, or incidents leading to the need for services): John reports that for the past year, he has noticed a change in his mood and emotions. He describes that he and his wife, of 15 years, have been arguing more often than they ever have before, he feels less connected in their relationship and he has less patience with his two children, ages 10 and 12. John describes that about 9 months ago his father passed away, who he was not “close” with but that since his death, he noticed a recurrence of “bad dreams” from situations that occurred during childhood, making it difficult to stay asleep. John works as an Emergency Room nurse and has for the past 20 years and describes that he is having more “emotional outbursts” at work in the past three months. Working in the emergency department, John has experienced countless traumatic cases including treating suicides, deaths of children, fatal car accidents and more.

GOBHI

Assessment Template Cont…

Functional Impairments- specifically identify all areas where symptoms are negatively impacting individual's life, include frequency and duration of symptoms): John reports that his relationship with his wife and children has been more challenging over the past year but more specifically over the past six months. He describes feeling less connected to his wife, having less patience with his children when he gets home from work or on days off and feels overall less inclined to engage in family activities. He also describes thoughts of worry and concern about his family throughout most days that, while have occurred mildly for years, have increased more recently and are distracting. These are not worries or concerns that he shares with his wife. John describes the disruption in his sleep, due to the bad dreams at least three times a week, are causing him to feel more tired and more irritable. John describes having "emotional outbursts" at work at least once a month in the past four months that include him having to go into the bathroom to "cry a lot out of nowhere", something that has never happened to him before and something that is making him worry will affect his ability to do his job.

Brief Family Childhood History (Pertinent social or developmental history, Family history of mental health and/or SUD concerns): John describes his childhood as "fine", describing that he did well in school, had friends, and engaged in sports. John has an older sister and an older brother. He describes his parents fighting often but they remained married until his father's passing 9 months ago. His mother lives in Washington, he sees her several times a year and speaks to her about twice a month. John reports his father drank "a lot of alcohol" and he believes his uncle struggled with depression and his sister has anxiety.

GOBHI

Assessment Template Cont…

Trauma/Abuse/Domestic Violence History: John reports that his father provided “a lot of physical discipline” that in “today’s world” would likely be considered physical abuse. He described that this would occur more often when his father was drinking. As a emergency room nurse, John reports that he has seen and experienced “a lot of messed up things” which likely would be considered traumatic.

Pertinent Education or Employment Considerations: John has a Bachelor’s degree in nursing and has worked as an emergency room nurse for 20 years.

Mental Health Treatment History: John has never sought out mental health treatment before.

Medical History, Current Medical Conditions, Current Medications: John has high blood pressure and is currently taking Enalapril 5mg once a day prescribed by his primary care physician Dr. Jones.

Client’s Strengths: This was difficult for John to answer. He described himself as loyal and hard-working.

Client’s recreational/leisure activities: John enjoys hiking, camping and playing video games with his family.

Gambling Use History/Current use: John denies any current or past gambling

GOBHI

Assessment Template Cont…

Substance Use History/Current Use (Include Summary of Use, History of Treatment, Specific question surrounding history of chronic use/abuse of opioids and if yes, was information provided regarding risks of overdose): John drinks 2-4 alcoholic drinks per week, mostly with dinner or socially when out. He denies having any present or historical difficulties with alcohol and denies any other substance use, past or present.

History of non-lethal self-injury: John denies any current or past non-lethal self-injury

Current Suicidal Ideation and was a safety plan created? John denies any current or past thoughts of suicide. **If no, why not?** Individual denied any current or past thoughts of suicide. This will continue to be assessed ongoing and if a safety plan is warranted, one will be created and put into chart.

Current Homicidal Ideation and was a safety plan created? John denied any current or past homicidal thoughts. No Safety plan was created at this time due to denial of thoughts.

GOBHI

Assessment Template Cont…

Mental Status Exam (General Appearance/Behavior, Orientation, Speech, Mood, Thought Content: Judgment and presence of delusions): Neat and clean appearance, behavior was anxious, oriented X4, speech was normal, mood was appropriate for session, thought content was appropriate and oriented to reality, no presence of delusions.

Recommended Level of Care: This writer is recommending the individual engage in up to 24 sessions of individual therapy with the option to increase and/or decrease frequency and duration based on stability. This writer will further assess individual's need for group therapy, family sessions, peer support and/or case management.

Clinical Formulation: Individual meets criteria for Other Specified Trauma and Stressor Related Disorders (F43.89) as evidenced by individual has been exposed to various traumas as a result of his nursing career in the emergency department as well as during childhood, experiencing a father who struggled with alcohol abuse and was physically abusive. John's father passed away 9 months ago and since that time he has been experiencing symptoms of difficulty sleeping as a result of "bad dreams", discord in his relationship with his wife and children, "emotional outbursts" at work, and overall feeling disconnected from his family. At this time John does not meet criteria for a more specific diagnosis like Post Traumatic Stress Disorder, however, this will continue to be assessed and the diagnosis will be updated if criteria is met.

Diagnosis: Other Specified Trauma and Stressor Related Disorders (F43.89)

GOBHI

Assessment Template Cont…

Any other appropriate referrals made: N/A

Does Clinician feel individual is able to access resources to meet their needs and is self-reliant: Yes

Original Clinical Signature (Name, Credentials, date and time of completion) Melissa Thompson, MA LPC CADC-I 8.12.24 3:13pm

Assessment leads to Service Plan

The treatment plan should reflect a clear series of goals and objectives for helping the client through the identified problem. Each goal and objective should have specific interventions prescribed that reflect best practices and evidenced-based treatments to help guide the client along the path to recovery.

Goal - What is wanted

Objective - how the goal is met

Service Plan Template

Goal - What does the individual want? In their own words and quotes

Objective - How will they reach their goal? What is the baseline? What symptom will be decreased and what skill will be increased?

Intervention- What service will be rendered? How often will it offered? How long will each session be? What credential will be providing this service?

Projected end date - When will plan end or be evaluated? Should be reviewed at min every 90 days

Date and Time assigned to Plan

Signature - Therapist sign and date

GOBHI

How do the symptoms impair daily living?

Goal - Enhance the skills and decrease the symptomatology.

Baseline - where is the individual in this skill or symptom - starting point. Measurable objectives

Individual will increase their coping skills from 2 to 4 within 90 days.

Individual states that on a scale of 1 - 5 with 5 being high they are feeling symptoms of depression at a level 4. Individual will reduce feeling symptoms of depression from 4 to 2 within 90 days.

GOBHI

Smart Objectives

- Specific: Clearly defined objectives that state what you want to achieve and who will do it
- Measurable: Quantifiable objectives that allow you to track individual's progress
- Achievable: Objectives that are challenging but still possible to complete within the set time frame
- Relevant: Objectives that align with individual's values, long-term objectives.
- Time-bound: Objectives that have a deadline to promote effective time management

GOBHI

Why S.M.A.R.T. Objectives?

- Provides direction and focus: Client will know and understand what they are working on.
- Tracks Progress: Client will know how far they have come in their treatment. Will encourage motivation.
- Creates a sense of accomplishment: Client will feel more confident and self-esteem will be boosted.
- Builds Resilience: When goals are attainable the client can develop a sense of resilience and perseverance. Can help them bounce back from setbacks and challenges.
- Improves Mental Health: Enhancing the skill and decreasing the symptomology.

GOBHI

Examples

- Client will reduce anxiety attacks from 7 times a week to three times a week or less by using anxiety management techniques learned in therapy when feeling anxious.
- Client will be able to get out of bed, get dressed, and brush teeth 3 times per week up from 0 times per week.
- Client will learn three coping skill within 90 days to decrease feelings of depression from daily to only 2 times per week.

SMART Template

Specific:

Measurable:

Relevant:

Time Bound:

Service Note

Finally, the Golden Thread includes service notes that demonstrate that the services you deliver match what was prescribed in the service plan. Each note should lead into the next, creating a comprehensive story of the individual's progress through treatment.

DAP Service Note: Data, Assessment, Plan

Data (D): What you did: 1-2 key words (ex. processed through, educated), 1-2 interventions (ex. motivational interviewing decisional balance), Depending on if this is a mental health or SUD note (what diagnosis and treatment objective are in the note), 1 thing to connect to MH OR SUD, and clear, direct connection to the objective pulled in from the service plan (to do this, mention the main thing the objective is measuring in the content in the data or assessment section of the note).

Assessment (A): Client response to intervention provided (were they receptive/closed off?), and/or their progress in treatment, and, if SUD, stage of change.

Plan (P): Plan for future which can include: upcoming appointments with peer, therapist, med providers, court, p.o., etc. and any "homework" or things they plan to work (ex. skills) on or complete (ex. contacting people to set up appointments, housing, etc.) prior to next appointment.

GOBHI

Interventions to Specific Treatment Modalities

MI Intervention Ideas:

- reflective listening
- expressed empathy through reflective listening
- affirmations
- asked open ended questions
- utilized reflective statements
- attempted to elicit change talk
- worked to assess motivation by identifying target behavior and state of change.
- assisted client in differentiating between different areas of motivation
- normalized and explored ambivalence
- reframed ambivalence
- utilized decisional balance
- explored pros and cons of change
- Attempted to promote internal motivation through exploring values underlying motivation for change
- attempted to elicit change talk through reflective listening and asking open ended questions
- explored client values as they relate to change
- explored pros and cons

Interventions to Specific Treatment Modalities

CBT Intervention Prompts/Ideas:

- challenged beliefs
- utilized CBT to assist individual in identifying cognitive dissertations. In an attempt to unravel negative cognitive distortions, this reporter challenged harmful automatic thoughts.
- cognitive restructuring
- functional analysis (A,B,C chart) to assist individual to learn about what factors lead to specific behaviors and what consequences resulted from those behaviors. (helps individual identified what behaviors are adaptive and helpful in striving towards goals or destructive and self defeating)
- utilized successive approximation (break up large task into small steps to make it easier to accomplish) to assist individual in achieving goal of…….
- utilized longitudinal formulation (5 p factors) to help individual identify what drives behavior or thoughts and what results from it.
- assist individual in reframing negative thoughts
  - thinking in shades of grey
  - cost/benefit analysis
- educated on ways to change thoughts
  - the survey method
  - reattribution
  - identify the distortion
  - define terms
  - the double standard method
  - examine the evidence
  - the semantic method
- automatic thoughts (identifying trigger, automatic thought, and replacement thought)
- practiced creating rational counter statements for identified negative thoughts

GOBHI

Interventions to Specific Treatment Modalities

CBT Intervention Prompts/Ideas:

- Socratic Questions

1. Examine the validity of the thought
    - "What evidence do you have that your thought is true? What evidence do you have on the other side, that your thought isn't true, or isn't completely true?"
2. See if there is a different perspective
    - "Is there another way of looking at this situation?"
3. De-catastrophize the situation
    - "If the worst happens, how could you cope?" "What's the best that could happen if you _____?" "What is the most realistic outcome, something in between?"
4. Look at the utility of the thought
    - "What's the effect of telling yourself _____?" What could be the effect of changing your thinking?"
5. Get some distance from the thought
    - "If _____ were in this situation and had this thought, what advice would you give them?"
6. "What would be good to do about this?"

GOBHI

Interventions to Specific Treatment Modalities

EMDR

-Brief description of memory that is being processed, Negative Cognition and Positive Cognition

-Initial score of Validity of Cognition VOC, SUD Level of Disturbance

-Post session score of VOC and SUD

Service Note Template

Service type:

Date:

Actual Time:

Location:

Objective:

Progress or lack there of towards objective _____As evidence by..

Narrative (DAP or SOAP).

What was the intervention (tx modality), how did client respond (connecting back to objective).

Signature and credentials

Assessment - Service Plan- Service Notes

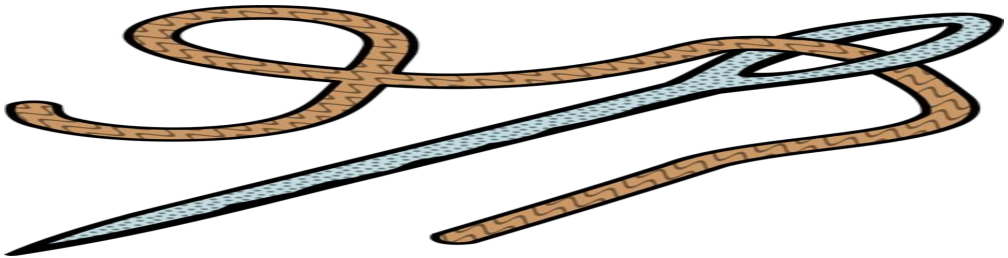
All coming together

- Document Medical Necessity - presenting problem symptoms, Skills.
- The plan for reducing symptoms and enhancing skill. Frequency, duration of each service
- The service rendered, what objective (symptom, skill) were you working on? Progress?
- Conclusion - Summary of services and progress.


Questions?

Assessment-Service Plan-Service Note

Stitching it all together



GOBHI

Assessment ⇨ Service Plan ⇨ Service Note

Assessment - *Symptoms, impairments history*; **Service plan** **-** *Goals, objectives, enhance skill, decrease symptoms;*

Service note - *describe the service, how did the client respond, progress*

GOBHI

Assessment

A biopsychosocial assessment helps counselors, social workers, and other behavioral health professionals learn about their clients on multiple levels and better understand their subjective viewpoints. As a result, biopsychosocial assessments enable therapists to diagnose and effectively treat their clients.

They conceptualized a way to look at clients and their problems, systematically and holistically taking into consideration the (1) Presenting problem, (2) Predisposing factors, (3) Precipitating factors, (4) Perpetuating factors, and (5) Protective factors.

GOBHI

Presenting Problem

Primary Complaint what are the symptoms when did they start how long do they last, what is the intensity and frequency of the symptoms? How do the symptoms impair daily functioning?

Predisposing Factors

History of previous mental health symptoms

- History of trauma or family history of trauma
- Family history of medical issues, mental illness and addiction
- Living situation, who lives with them, number of dependents they care for, socioeconomic status
- Problems related to work or school

Precipitation Factors

What events led to the individual's presenting problems?

- Job change
- Illness
- Death of a loved one
- Car Accident
- School - Peer pressure, bullying, homework, teacher pressure, poor grades

Perpetuating Factors

- Ongoing stressors
- Addiction
- Abusive Relationships
- School
- Social platforms
- Caretaking for a loved one

Protective Factors

- Strengths
- Coping skills
- Supportive family
- Hobbies
- School successes - sports. Friendships

Clinical Formulation

Medical Necessity - Three things can inform medical necessity: ICD-10 (DSM-V) diagnosis, impairments as a result of the said diagnosis, and what interventions you're providing to alleviate symptoms and improve functioning.

Pulling all of the information together to form a clinical formulation, symptoms, history of symptoms, impairments, stressors, strengths

Diagnosis Why is it this and not this, evidenced by…

Assessment Template

Full Name: John Smith

Actual Start and Stop Time: 2:02-2:59pm

Service Location: Greenwood Office

Billing Diagnosis: F43.89 Other Specified Trauma and Stressor Related Disorder

Data: This writer and the individual completed a collaborative and comprehensive behavioral health assessment and initial treatment plan on this date (see copy of both the assessment and tx plan dated today's date in the individual's chart for additional information). Based on the individual's reports, individual was provided a diagnosis of Other Specified Trauma and Stressor Related Disorder (F43.89). The individual was provided with information regarding the Agency, signed an informed consent, received information on advanced directive, voters rights, declaration of mental health and reviewed confidentiality. The individual completed a PHQ-9 or CSSR (present in chart). No safety plan was completed at this time based on responses to these tools, however, this will continue to be monitored and if necessary, a safety plan will be created in the future. Individual wishes to engage in treatment to improve feelings of self-worth, resolve past trauma and decrease anxiety.

GOBHI

Assessment Template cont..

Reason for Seeking Services (age, referral source, brief introduction into reason for seeking services): John is a 45 year old male referred to this writer by a friend. John is seeking mental health treatment due to an increase in feelings of worry and “emotional outbursts”, a decrease in his feelings of “connectedness” in his marriage and with his children and a difficulty sleeping due to recurrent bad dreams.

History of Presenting Problem (Events, precipitating factors, or incidents leading to the need for services): John reports that for the past year, he has noticed a change in his mood and emotions. He describes that he and his wife, of 15 years, have been arguing more often than they ever have before, he feels less connected in their relationship and he has less patience with his two children, ages 10 and 12. John describes that about 9 months ago his father passed away, who he was not “close” with but that since his death, he noticed a recurrence of “bad dreams” from situations that occurred during childhood, making it difficult to stay asleep. John works as an Emergency Room nurse and has for the past 20 years and describes that he is having more “emotional outbursts” at work in the past three months. Working in the emergency department, John has experienced countless traumatic cases including treating suicides, deaths of children, fatal car accidents and more.

Assessment Template Cont…

Functional Impairments- specifically identify all areas where symptoms are negatively impacting individual's life, include frequency and duration of symptoms): John reports that his relationship with his wife and children has been more challenging over the past year but more specifically over the past six months. He describes feeling less connected to his wife, having less patience with his children when he gets home from work or on days off and feels overall less inclined to engage in family activities. He also describes thoughts of worry and concern about his family throughout most days that, while have occurred mildly for years, have increased more recently and are distracting. These are not worries or concerns that he shares with his wife. John describes the disruption in his sleep, due to the bad dreams at least three times a week, are causing him to feel more tired and more irritable. John describes having "emotional outbursts" at work at least once a month in the past four months that include him having to go into the bathroom to "cry a lot out of nowhere", something that has never happened to him before and something that is making him worry will affect his ability to do his job.

Brief Family Childhood History (Pertinent social or developmental history, Family history of mental health and/or SUD concerns): John describes his childhood as "fine", describing that he did well in school, had friends, and engaged in sports. John has an older sister and an older brother. He describes his parents fighting often but they remained married until his father's passing 9 months ago. His mother lives in Washington, he sees her several times a year and speaks to her about twice a month. John reports his father drank "a lot of alcohol" and he believes his uncle struggled with depression and his sister has anxiety.

GOBHI

Assessment Template Cont…

Trauma/Abuse/Domestic Violence History: John reports that his father provided “a lot of physical discipline” that in “today’s world” would likely be considered physical abuse. He described that this would occur more often when his father was drinking. As a emergency room nurse, John reports that he has seen and experienced “a lot of messed up things” which likely would be considered traumatic.

Pertinent Education or Employment Considerations: John has a Bachelor’s degree in nursing and has worked as an emergency room nurse for 20 years.

Mental Health Treatment History: John has never sought out mental health treatment before.

Medical History, Current Medical Conditions, Current Medications: John has high blood pressure and is currently taking Enalapril 5mg once a day prescribed by his primary care physician Dr. Jones.

Client’s Strengths: This was difficult for John to answer. He described himself as loyal and hard-working.

Client’s recreational/leisure activities: John enjoys hiking, camping and playing video games with his family.

Gambling Use History/Current use: John denies any current or past gambling

GOBHI

Assessment Template Cont…

Substance Use History/Current Use (Include Summary of Use, History of Treatment, Specific question surrounding history of chronic use/abuse of opioids and if yes, was information provided regarding risks of overdose): John drinks 2-4 alcoholic drinks per week, mostly with dinner or socially when out. He denies having any present or historical difficulties with alcohol and denies any other substance use, past or present.

History of non-lethal self-injury: John denies any current or past non-lethal self-injury

Current Suicidal Ideation and was a safety plan created? John denies any current or past thoughts of suicide. **If no, why not?** Individual denied any current or past thoughts of suicide. This will continue to be assessed ongoing and if a safety plan is warranted, one will be created and put into chart.

Current Homicidal Ideation and was a safety plan created? John denied any current or past homicidal thoughts. No Safety plan was created at this time due to denial of thoughts.

Assessment Template Cont…

Mental Status Exam (General Appearance/Behavior, Orientation, Speech, Mood, Thought Content: Judgment and presence of delusions): Neat and clean appearance, behavior was anxious, oriented X4, speech was normal, mood was appropriate for session, thought content was appropriate and oriented to reality, no presence of delusions.

Recommended Level of Care: This writer is recommending the individual engage in up to 24 sessions of individual therapy with the option to increase and/or decrease frequency and duration based on stability. This writer will further assess individual's need for group therapy, family sessions, peer support and/or case management.

Clinical Formulation: Individual meets criteria for Other Specified Trauma and Stressor Related Disorders (F43.89) as evidenced by individual has been exposed to various traumas as a result of his nursing career in the emergency department as well as during childhood, experiencing a father who struggled with alcohol abuse and was physically abusive. John's father passed away 9 months ago and since that time he has been experiencing symptoms of difficulty sleeping as a result of "bad dreams", discord in his relationship with his wife and children, "emotional outbursts" at work, and overall feeling disconnected from his family. At this time John does not meet criteria for a more specific diagnosis like Post Traumatic Stress Disorder, however, this will continue to be assessed and the diagnosis will be updated if criteria is met.

Diagnosis: Other Specified Trauma and Stressor Related Disorders (F43.89)

GOBHI

Assessment Template Cont…

Any other appropriate referrals made: N/A

Does Clinician feel individual is able to access resources to meet their needs and is self-reliant: Yes

Original Clinical Signature (Name, Credentials, date and time of completion) Melissa Thompson, MA LPC CADC-I 8.12.24 3:13pm

Assessment leads to Service Plan

The treatment plan should reflect a clear series of goals and objectives for helping the client through the identified problem. Each goal and objective should have specific interventions prescribed that reflect best practices and evidenced-based treatments to help guide the client along the path to recovery.

Goal - What is wanted

Objective - how the goal is met

Service Plan Template

Goal - What does the individual want? In their own words and quotes

Objective - How will they reach their goal? What is the baseline? What symptom will be decreased and what skill will be increased?

Intervention- What service will be rendered? How often will it offered? How long will each session be? What credential will be providing this service?

Projected end date - When will plan end or be evaluated? Should be reviewed at min every 90 days

Date and Time assigned to Plan

Signature - Therapist sign and date

GOBHI

How do the symptoms impair daily living?

Goal - Enhance the skills and decrease the symptomatology.

Baseline - where is the individual in this skill or symptom - starting point. Measurable objectives

Individual will increase their coping skills from 2 to 4 within 90 days.

Individual states that on a scale of 1 - 5 with 5 being high they are feeling symptoms of depression at a level 4. Individual will reduce feeling symptoms of depression from 4 to 2 within 90 days.

GOBHI

Smart Objectives

- Specific: Clearly defined objectives that state what you want to achieve and who will do it
- Measurable: Quantifiable objectives that allow you to track individual's progress
- Achievable: Objectives that are challenging but still possible to complete within the set time frame
- Relevant: Objectives that align with individual's values, long-term objectives.
- Time-bound: Objectives that have a deadline to promote effective time management

GOBHI

Why S.M.A.R.T. Objectives?

- Provides direction and focus: Client will know and understand what they are working on.
- Tracks Progress: Client will know how far they have come in their treatment. Will encourage motivation.
- Creates a sense of accomplishment: Client will feel more confident and self-esteem will be boosted.
- Builds Resilience: When goals are attainable the client can develop a sense of resilience and perseverance. Can help them bounce back from setbacks and challenges.
- Improves Mental Health: Enhancing the skill and decreasing the symptomology.

GOBHI

Examples

- Client will reduce anxiety attacks from 7 times a week to three times a week or less by using anxiety management techniques learned in therapy when feeling anxious.
- Client will be able to get out of bed, get dressed, and brush teeth 3 times per week up from 0 times per week.
- Client will learn three coping skill within 90 days to decrease feelings of depression from daily to only 2 times per week.

SMART Template

Specific:

Measurable:

Relevant:

Time Bound:

Service Note

Finally, the Golden Thread includes service notes that demonstrate that the services you deliver match what was prescribed in the service plan. Each note should lead into the next, creating a comprehensive story of the individual's progress through treatment.

DAP Service Note: Data, Assessment, Plan

Data (D): What you did: 1-2 key words (ex. processed through, educated), 1-2 interventions (ex. motivational interviewing decisional balance), Depending on if this is a mental health or SUD note (what diagnosis and treatment objective are in the note), 1 thing to connect to MH OR SUD, and clear, direct connection to the objective pulled in from the service plan (to do this, mention the main thing the objective is measuring in the content in the data or assessment section of the note).

Assessment (A): Client response to intervention provided (were they receptive/closed off?), and/or their progress in treatment, and, if SUD, stage of change.

Plan (P): Plan for future which can include: upcoming appointments with peer, therapist, med providers, court, p.o., etc. and any "homework" or things they plan to work (ex. skills) on or complete (ex. contacting people to set up appointments, housing, etc.) prior to next appointment.

GOBHI

Interventions to Specific Treatment Modalities

MI Intervention Ideas:

- reflective listening
- expressed empathy through reflective listening
- affirmations
- asked open ended questions
- utilized reflective statements
- attempted to elicit change talk
- worked to assess motivation by identifying target behavior and state of change.
- assisted client in differentiating between different areas of motivation
- normalized and explored ambivalence
- reframed ambivalence
- utilized decisional balance
- explored pros and cons of change
- Attempted to promote internal motivation through exploring values underlying motivation for change
- attempted to elicit change talk through reflective listening and asking open ended questions
- explored client values as they relate to change
- explored pros and cons

Interventions to Specific Treatment Modalities

CBT Intervention Prompts/Ideas:

- challenged beliefs
- utilized CBT to assist individual in identifying cognitive dissertations. In an attempt to unravel negative cognitive distortions, this reporter challenged harmful automatic thoughts.
- cognitive restructuring
- functional analysis (A,B,C chart) to assist individual to learn about what factors lead to specific behaviors and what consequences resulted from those behaviors. (helps individual identified what behaviors are adaptive and helpful in striving towards goals or destructive and self defeating)
- utilized successive approximation (break up large task into small steps to make it easier to accomplish) to assist individual in achieving goal of…….
- utilized longitudinal formulation (5 p factors) to help individual identify what drives behavior or thoughts and what results from it.
- assist individual in reframing negative thoughts
  - thinking in shades of grey
  - cost/benefit analysis
- educated on ways to change thoughts
  - the survey method
  - reattribution
  - identify the distortion
  - define terms
  - the double standard method
  - examine the evidence
  - the semantic method
- automatic thoughts (identifying trigger, automatic thought, and replacement thought)
- practiced creating rational counter statements for identified negative thoughts

GOBHI

Interventions to Specific Treatment Modalities

CBT Intervention Prompts/Ideas:

- Socratic Questions

1. Examine the validity of the thought
    - "What evidence do you have that your thought is true? What evidence do you have on the other side, that your thought isn't true, or isn't completely true?"
2. See if there is a different perspective
    - "Is there another way of looking at this situation?"
3. De-catastrophize the situation
    - "If the worst happens, how could you cope?" "What's the best that could happen if you _____?" "What is the most realistic outcome, something in between?"
4. Look at the utility of the thought
    - "What's the effect of telling yourself _____?" What could be the effect of changing your thinking?"
5. Get some distance from the thought
    - "If _____ were in this situation and had this thought, what advice would you give them?"
6. "What would be good to do about this?"

Interventions to Specific Treatment Modalities

EMDR

-Brief description of memory that is being processed, Negative Cognition and Positive Cognition

-Initial score of Validity of Cognition VOC, SUD Level of Disturbance

-Post session score of VOC and SUD

Service Note Template

Service type:

Date:

Actual Time:

Location:

Objective:

Progress or lack there of towards objective _____As evidence by..

Narrative (DAP or SOAP).

What was the intervention (tx modality), how did client respond (connecting back to objective).

Signature and credentials

Assessment - Service Plan- Service Notes

All coming together

- Document Medical Necessity - presenting problem symptoms, Skills.
- The plan for reducing symptoms and enhancing skill. Frequency, duration of each service
- The service rendered, what objective (symptom, skill) were you working on? Progress?
- Conclusion - Summary of services and progress.


Questions?