

CASE MANAGEMENT IN COUNSELING

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INTRODUCTION

In Malaysia, counseling is becoming more acceptable by the population. Counseling services are offered in schools, institutions and community. Thus the role of a counselor is more towards providing individual and group counseling. In this service, the process of meeting the client's needs includes assessment, developing an action plan, consulting and liaising with other community service providers, information sharing and client confidentiality, information and referral, and client's progress tracking. This paper provides practical information on the case management of counseling starting from entry, assessment and diagnosis; treatment plan; case note management; referral and multi-disciplinary cooperation; and case closure or termination.

BASIC REQUIREMENTS IN COUSELING

All counselors need to have the necessary credential before they can start off in their career as a professional counselor. In most countries, the minimum credential requirement is a Master Degree in Counseling but there are some countries where the minimum credential is a first Degree in Counseling. There are three additional requirements that are critical to ensure effective helping service to our clients. The three requirements are competence, informed consent and confidentiality. These are not comprehensive requirements but are seen as critical for counselors.

Competence

Competence according to Pope and Brown (1996) requires “intellectual” and “emotional” competence. Intellectual competence refers to knowledge and skill, and emotional competence refers to one’s internal emotional stability and ability to manage the emotional challenges of working with different clients.

The first and most important principle in the ethics code is to operate within one’s level of competence. Consistent with the principle of Do No Harm, knowing our limits means that no matter how much we may want to help others, we must recognize the extent and limitations of our abilities and seek assistance or supervision when we need it. The fundamental importance of this principle is demonstrated by the fact that **competence** is the first of the general principles in the American Psychological Association’s code of ethics (Fisher & Younggren, 1997).

The idea, that anyone can do human service work without any training, is not only wrong, it is dangerous. Good intentions cannot substitute for competence. One of the purposes of ethics is to remind us that we are not always the best judges of our own abilities and conduct. Simply because you want to believe you can help someone does not mean you are justified in proceeding. In all your clinical work, make it a practice to ask yourself as objectively and honestly as possible if you have any real training or experience in the skills required to work with a given individual or situation. Then, go a step further and ask yourself how you would provide objective evidence of your competence if required to do so by an ethics review board or a court of law.

Informed Consent

The ethical principle of informed consent means that clients have a right to be informed about the treatment, assessment, or other services they will receive before they agree to participate in or receive those services. When applied in practice, this principle dictates that, in order to ensure informed consent, clients must be given certain information in a manner and language that they can understand. At the minimum, clients should be informed about each of the following subjects (Harris, 1995):

- a. The qualifications of the person providing counseling. This includes the degrees, clinical experience, specialized training, and licenses the person has received.
- b. The nature of the counseling or assessment to be provided. This includes a brief description of the approach to counseling or the purpose of an assessment and the instruments that will be used.
- c. The frequency and duration of counseling sessions, as well as a reasonable estimate of the typical number of sessions involved in handling a given concern.

- d. The client's responsibilities for participating in counseling must be made clear. For example, the client should be expected to attend scheduled appointments, notify the counselor in advance if appointments must be cancelled or changed, and follow through with any assignments.
- e. The fees such as the costs per session or per assessment and whether or not there are charges for missed sessions. How and when are payments to be made and the procedures that will be followed if payment is not made. This discussion should also cover insurance charges and its impact on confidentiality.
- f. The nature and limitations of confidentiality, including a specific discussion of any limitations to confidentiality.

The counselor needs to provide an opportunity to answer questions before the start of the counseling or at any time during the counseling process to ensure that the client feels comfortable and safe.

Confidentiality

Openness and honesty are essential ingredients of counseling. Confidentiality is considered a necessary condition for effective counseling (Swenson, 1993). Along with competence and informed consent, many counselors consider confidentiality to be their primary ethical responsibility (Crowe, Grogan, Jacobs, Lindsey & Mark, 1985). The essence of confidentiality is the principle that clients have the right to determine who will have access to information about them and their treatment in counseling. In the clinical settings, clients need to feel that the information they share will stay with the professional and not be released without their permission. Without assurance, clients are less likely to explore and express their thoughts and feelings freely. This, in turn, is likely to inhibit the client's willingness to share certain information and may distort the treatment process (Nowell & Spruill, 1993). At the same time, however, clients must be aware of limits to confidentiality so they can make informed choices. Under confidentiality, two areas need to be mentioned. They are release of information and safeguarding records.

To protect confidentiality, certain standards and guidelines must be followed carefully. First, no one should be given any information in written or verbal form about the client without explicit written and signed permission from the client. In most settings, standard "Release of Information" forms are used. In the form are space to identify the person(s) who will receive the information, the purpose for the release, the specific information to be released, the form in which the information will be communicated, the date of the release, the time period for which the release is to be valid, the name of the person authorized to release the information, the name of the client, and the signature of the client and the primary counselor or other professional (Bennett et.al, 1999). In practice, their

requirement for written permission means that if someone calls or comes into an office claiming to have the client's permission to see records or discuss the case, one must not agree to this request unless there is written permission authorizing such disclosure to the individual asking for the information. You can cope with insistent or demanding people by saying something like, "I'm sorry, but I cannot share any information unless I have a signed release of information form. I'm sure you understand how important confidentiality is, and I'll be glad to provide you with whatever information I can as soon as a signed release of information is available." Note that this statement does not acknowledge that the individual in question is a client. It merely says a release is necessary for any information to be shared.

To ensure the confidentiality of records, all case notes, records, and other written or recorded information about the client should be kept in locked file cabinets. You should not leave notes, files or other material with client names out in the open where others might see them inadvertently. As a further precaution, the words "PRIVATE AND CONFIDENTIAL" can be printed or stamped on all files. If case notes are kept in computers, access to the files should be restricted in some way and the computer screen with notes should not be left on for others to see should the counselor be absent.

ENTRY, ASSESSMENT AND DIAGNOSIS

At the initial stage of counseling with clients, the counselor needs to identify why the clients are extremely trusting, instantly hostile, or react in some specific ways. Your primary task is to understand the client's reaction from the client's perspective and be aware that each interaction is part of the overall clinical process. The counselor's task is also to identify reasons why the client comes into counseling and eventually the presenting problem(s). This information will help the counselor in the planning of goals and treatment plan for the client.

The choice of psychological assessments used and eventually the diagnosis are important because its accuracy will save time, ensure effective techniques used and efficacy. Paul (1967) pointed that one should not simply ask if therapy in general is effective. Instead, one should ask "What treatment, by whom, is most effective for this individual with that specific problems, and under which set of circumstances?". To date about all that can be stated with confidence regarding therapy differences is what Whiston and Sexton (1993) concluded: "On the whole, the research indicates that no one theory is any more effective than any other. Similarly, adherence to any one theory or approach does not guarantee successful outcome". Of greater concern than arguments over theoretical superiority is evidence that between 6 percent (Orlinsky & Howard, 1980) and 11 percent (Shapiro & Shapiro, 1982) may get worse rather than better in therapy. Strupp (1989) identified some of the factors, and he highlighted one, that is, ineffective communications as experienced by clients can

contribute to negative outcomes. This means we must be mindful that we have the potential to do harm as well as good and that the effectiveness of our interventions will not always be in positive directions. Thus counselors have the responsibility to ensure that they are equipped with skills to perform psychological assessment, diagnosis and counseling.

TREATMENT PLAN

When a client walks into a counselors' office or clinic, the counselor must first be aware and acknowledge that that he/she is an individual. A counselor needs to develop his/her own ability to work with differences. To do that, the counselor must think at length about who he/she is and his/her own personal experience, so that he/she is sensitive to differences or similarities with clients. Sue and Sue (1990) states that as mental health professionals, we have a personal and professional responsibility to (a) confront, become aware of, and take actions in dealing with our biases, stereotypes, values and assumptions about human behavior, (b) become aware of the culturally different client's world view, values, biases, and assumptions about human behavior, and (c) develop appropriate help-giving practices, intervention strategies, and structures that take into account the historical, cultural, and environmental experiences of the culturally different client (pp. 6).

Thus counselors need to be aware of the historical background of people and the current social context, relating to perceived racial, gender, cultural, and other differences. Racism, sexism, homophobia, and economic injustice are not things of the past. They are ongoing, daily, and destructive realities in the lives of people. Those who have not experienced that reality for themselves may not understand how it affects clinical interactions. As a result, they may be unaware that clinical interactions occur in a context that is far more complex than simply "two people talking together." Sue and Sue (1990) framed the matter in this terms: Thus, the world view of the culturally different client who comes to counseling boils down to one important questions: "What makes you, a counselor/therapist, any different from all the others out there who have oppressed and discriminated against me?" (pp.6).

A counselor who is unaware that clients may harbor such questions is likely to experience frustration, failure, and hostility without understanding the underlying causes. Furthermore, counselors who are unaware of the cultural context may misinterpret the meaning of a client's actions and may ascribe erroneous diagnoses or causal explanations. In short, counselors need to understand and appreciate the history and daily experience of clients from different cultures as a possible part of the problem.

COUNSELING CASE NOTE MANAGEMENT

Under this section of case note management, the author will propose and describe clinical writing styles, records notes, progress notes, and format of records used in the clinical setting.

Clinical Writing

All counselors need to keep good case notes. It is important that they have proper clinical writing skills. There are four keys to good writing:

1. Simplify Your Writing But Not Your Clients

Strunk and White (1972) instruct counselors to use definite, specific, and concrete language in writing. Zinsser (1980) strongly endorses the principle of simplicity in writing without simplifying the client. It is important to write as simply and directly, and to communicate accurately about your client.

The following are two examples of writing. Please select the one that demonstrates simplicity and directness in writing.

Example A: At various occasions during the session, Mr. Tan exhibited signs of nervousness and distress.

Example B: In response to questions about his family, Mr. Tan began to shift in his chair, stammered slightly, and appeared to avoid eye contact.

2. Leave Out Words That Are Not Needed

Strunk and White (1972) state that " a sentence should contain no unnecessary words, a paragraph no unnecessary sentences...". This requires that the counselor makes all the sentences short, write in detail, and ensure that **every word tell**.

The following are two examples of writing. Please select the statements that omit needless words.

Example A: According to the results of the test, there is evidence of depression in the mild to moderate range, along with anxiety and apparent concerns about issues relating to family.

Example B: Test results suggest the presence of mild to moderate depression, anxiety, and concerns about family matters.

3. Choose Words Carefully

Harvey (1997) recommends that report be “readable”. Harvey uses the measure of language at Form 5 level (18 years old) and below. Harvey explains this approach by pointing out that psychological and other mental health reports are increasingly being reviewed by clients and others who have less formal education than those writing the reports. Thus, making reports more intelligible to these consumers may enhance their usefulness and reduce misunderstandings.

Choose the example below that provides the correct and accurate information.

Example A: Mr. Ong denied any abuse of alcohol or drugs.

Example B: Mr. Ong said he does not abuse alcohol or drugs.

Example C: Mr. Ong does not abuse alcohol or drugs.

4. Clarity

Choosing words carefully is part of the larger issue of achieving clarity in writing and clinical work. This demand includes both clarity of individual words and clarity in sentence structure and organization. To ensure clarity and limit misunderstanding, you can have someone else read your report before it goes to the intended recipient. If this is not possible, it is often helpful to pretend you know nothing of the case yourself, then read the report out loud. Reading aloud brings out aspects of writing that we do not recognize when we read silently to ourselves. If time permits, another extremely valuable technique is to set the report aside for several days and then read it again with an open mind.

Records Notes

The general rule for determining what to put in records is “if something is important, document it and keep a record”. Good records should include all present and previous relevant information about a client’s history and treatment, progress note, correspondence, releases of information, documentation of consultation, billing information, informed consent forms, and any other pertinent information.

Piazza and Baruth (1990) describe six categories of material that should go into records. They are (a) intake information (basic personal data such as

name, address, home and work phones, date of birth, sex, family members' names, next of kin, and employment status, date of initial contact, reasons for referral, and names of other professional who are seeing the client); (b) assessment information (psychological assessment, social and family assessment, vocational/educational assessment, drug and alcohol use assessment, and health assessment), (c) treatment plans, (d) case notes, (e) closure/termination summary, (f) other data (authorization for treatment, releases of information, copies of test results, communications with other professionals etc.).

Progress Notes

Progress notes are the foundation of most clinical records. They provide a record of events, are a means of communication among professionals, encourage us to review the process of treatment in counseling, and are a legal record. When writing progress notes, review the events in order to again assess and better understand what happened. This helps the counselor to process and check treatment. Also ensure that when you read the notes several months or years from now that you can remember what happened, what was done and why it was done.

In clinical settings, there are several kinds of progress note. One type is *event based*. Such notes describe a specific and usually brief event, and what was done about it. Event-based progress notes take two forms. They are the problem-oriented form and the goal-oriented form. A second type of note *describes continued interactions* during the counseling sessions.

In writing progress notes, clarity, precision and shortness are most important criteria. There are various styles of progress notes. The DART note format and SOAP note format are used primarily to record specific events or interaction.

The *DART* note format comprises of D = Description of the client and situation, A= Assessment of the situation, R = Response of the counselor and the client, T = Treatment implication and plan. The *SOAP* note format comprises of subjective, objective, assessment and plan information.

Format of Records

There is no standard format to write case notes. Below are some formats in which a counselor can use in keeping the counseling records.

Sample 1:

**PERSONAL PARTICULARS
(Fill in by Client)**

Name:

Address:.....

IC No:

Telephone: (O)..... (Hse).....(HP).....

Gender: M () F () Age:

Marital status: () Single () Married () Separated

() Divorce () Widow () Living together

Student: ()

If YES, Level of Education:

Name of School/ College:

Working Person: ()

If YES, Occupation:

Place of work:

Referral by:.....

Signature

.....

Please Tick (/) in Related Brackets

Tick(/)	Scope of Problem	Statement
	Academic	
	Career	
	Personality	
	Social	
	Family	
	Marriage	
	Self-Development	
	Motivation/ Discipline	
	Health	
	Mental Health	
	Others:	

CASE NOTE FOR INDIVIDUAL COUNSELING

FAMILY MEMBERS INFORMATION

Name	Relationship	Gender	Age	Level of Education

Mother's Name:.....

Father's Name:

Family Address:

Family Tel No.: (R).....(HP).....

BACKGROUND OF CLIENT

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RELATED INFORMATION

(Problem(s), past reference, further reference and others)

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Ref No:

CASE NOTE

Session: Date: Time:.....until.....

PRESENTING PROBLEM(S)
(Information of problem(s)/ conflict, thought, emotion / attitude and others)
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GOAL(S) OF COUNSELING
(Targeted for the present or the future)
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ASSESSMENT
(Psychological testing and analysis, assessment of client and the significant others)
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INFORMATION ON COUNSELING PROCESS

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ALTERNATIVE AND ACTION PLAN

(Action plan, procedure, homework, practice and others)

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FOLLOW-UP CASE

(Follow-up session, further information needed and others)

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COUNSELOR'S REFLECTION

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Sample 2:

INFORMATION OF INDIVIDUAL COUNSELING SESSION

Date:

BIODATA

Name: Gender:
IC no: Date of birth:
Working Person ()
If YES, Occupation:
Place of work:
Student ()
If YES, Level of education:
Name of School/ College:.....
Address:
.....
Telephone: (O)..... (Hse)..... (HP).....
Name of Father/ Mother/ Caretaker:.....
Address:
.....
Telephone: (O)..... (Hse)..... (HP).....

FAMILY MEMBERS

Name	Relationship	Gender	Age	Level of Education

BACKGROUND OF CLIENT

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.....
.....

RELATED INFORMATION

(Source, referral, and other important information)

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Date:	Notes:

Sample 3:

CASE NOTE: INDIVIDUAL COUNSELING SESSION

Date: Session: Code:
Time:.....

Name			
Gender			
Date of Birth/ Age			
Address			
Tel No.	(O)	(Hse)	(HP)
Name of Mother			
Name of Father			
Family Address			
Tel No.	(Hse)	(HP)	

ASSESSMENT <i>(Psychological test and analysis, history of family, social support, health and others)</i>

PRESENTING PROBLEM(S) <i>(Information of problem(s)/ conflict, thought, emotion / attitude and others)</i>

GOAL OF COUNSELING (*Targeted for the present or the future*)

ALTERNATIVE AND ACTION PLAN
(*Action plan, procedure, homework, practice and others*)

FOLLOW- UP CASE (*Follow-up session, further information needed and others*)

COUNSELOR'S REFLECTION

REFERRAL AND MULTI-DISCIPLINARY COOPERATION

In clinical practice, counselors need to work with other professionals such as psychologists, psychiatrists, medical professional and social workers. The cooperation of the professionals must be with the consent of the clients. Counselors must be aware of their limitation in helping the clients, know who to refer to, and then discuss referral intentions with their clients. The client must agree to get referral.

CASE CLOSURE / TERMINATION

There must be sufficient time to work through closure or termination. It is essential to notify clients well in advance of the actual termination date. Opinions vary about how much advance time is necessary. Some writers suggest that six week is a minimum (Penn, 1990), while others prefer substantially more time (Siebold, 1992). Termination must address the cognitive, affective, and behavioral components of the client's reactions and plans.

Quintana (1993) suggests that termination is a particularly critical opportunity for clients and counselors to update or transform their relationship to incorporate clients' growth. For this transformation to occur, clients need to acknowledge the steps they have taken toward more mature or healthier functioning. Perhaps most important is for counselors to acknowledge and validate their sense of accomplishment. Penn (1990) recommends that counselors reinforce the use of the therapeutic tools that the clients have learnt to use over time and therefore take away with them.

To help in the process of case closure/termination, below are some questions the counselor can use:

What did it feel like to ask for help?

What did you like best about our work together?

What did you like least about our work together?

What will you miss about our work together?

What do you look forward to when we stop working together?

These questions promote discussion between the counselor and clients as a preparation for case closure/termination.

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