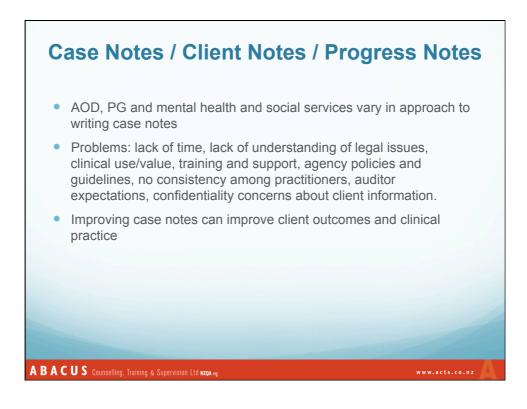
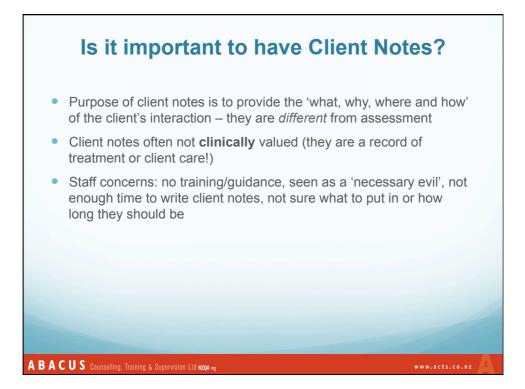
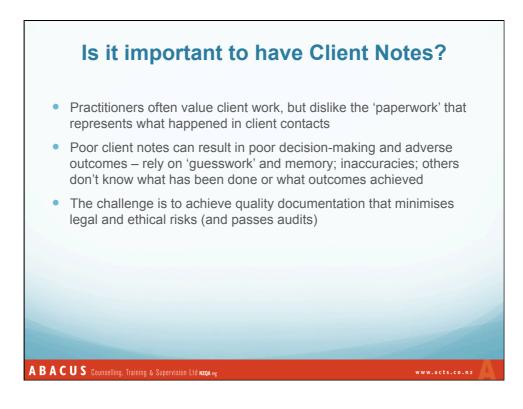


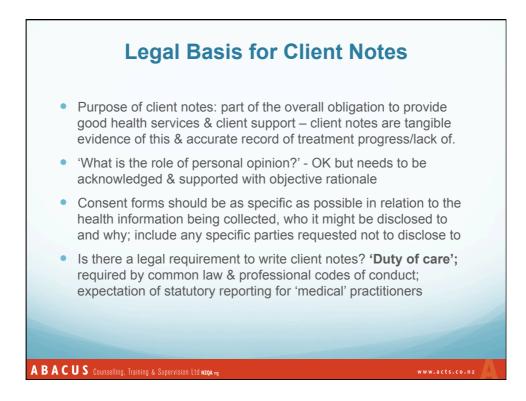


Good example of a Case Note? 6/8 ame Shan ABACUS Counselling, Training & Supervision Ltd NZQA reg

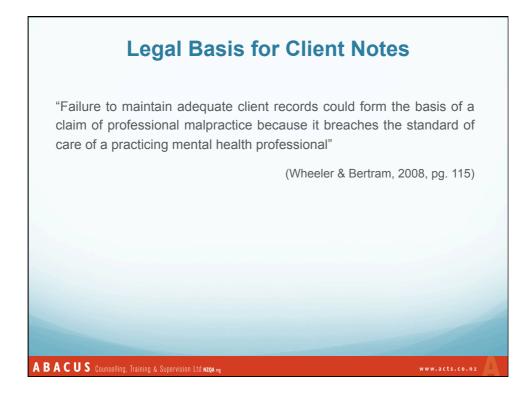


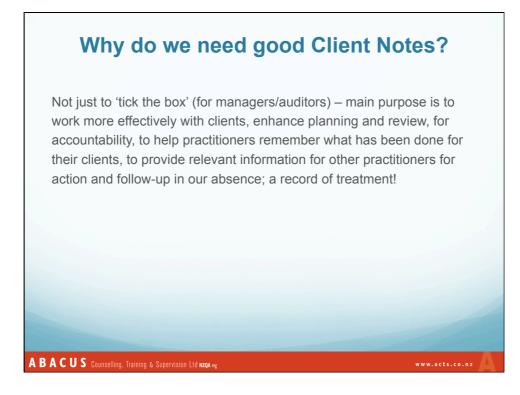


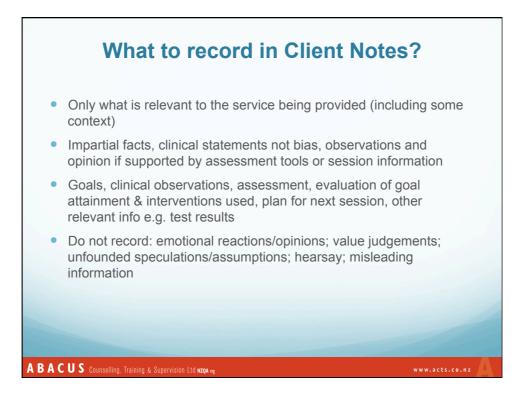


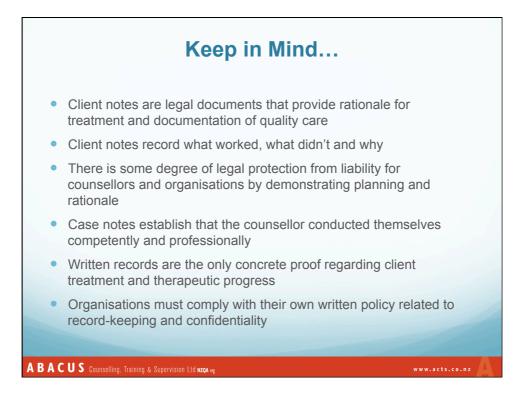












How much detail should be in the Notes for 'Sensitive Issues'?

Discuss this in the whole group:

- What issues are 'sensitive' for your clients?
- How much of this do you put in your notes?
- If so, why and who is it for? (e.g. client, you, or service)
- Is there anything you don't put in notes now that you are wondering if it should be there?

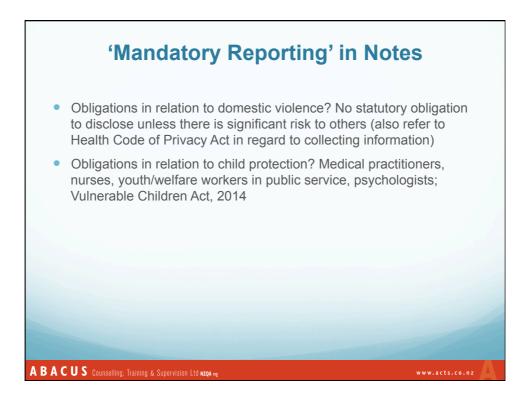
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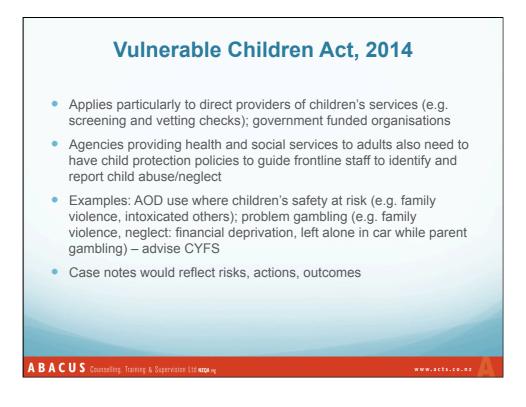
Appropriate level of detail: physical, mental, sexual abuse; HIV, Hep B, C Is the information offered or collected relevant to the service being

provided? If in doubt, seek client's consent to record the information if you believe it is relevant, or if the client requests you record it

Is it intrusive:

- 'Sensitive issues': sexual (orientation, sexual practice, abuse, pregnancy/terminations, births outside marriage, STDs, sexual dysfunctions)
- HIV status (unless safety issues); hepatitis, mental health history; addictions; or diseases/problems with 'social stigma'





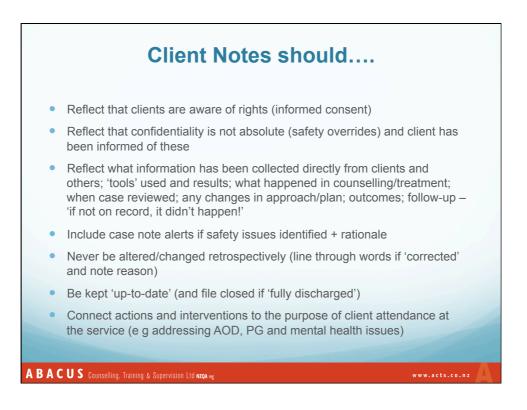
Case Scenario

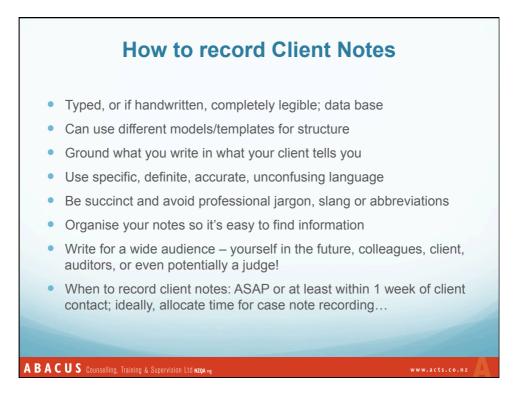
You are a counsellor in an alcohol and drug treatment service and Carmen has come in for help to deal with alcohol and drug use problems. She tells you she is a sex worker and she is a great storyteller and obviously has lots of sexual issues she is willing to discuss (her sex change, sexual practices, client stories, STDs, 'sexual misadventures' etc – all of which are interesting). She makes a lot of money at times and also has gambling problems. She says she has nothing to hide as she is 'well known' so tells you not to worry about consent forms.

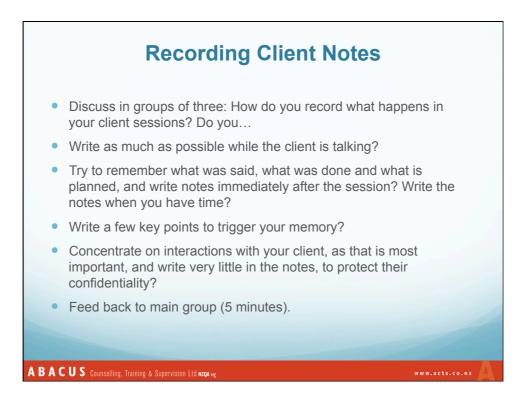
How far do you go in listening to and 'exploring' the sexual issues and behaviours and recording them in notes?

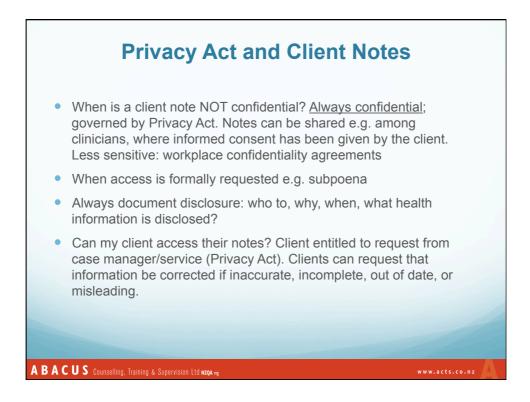
- To what extent do you follow up 'gambling' in the notes?
- Is a consent form necessary, since she doesn't care?
- Discuss with person next to you (10 min) and feed back to group.

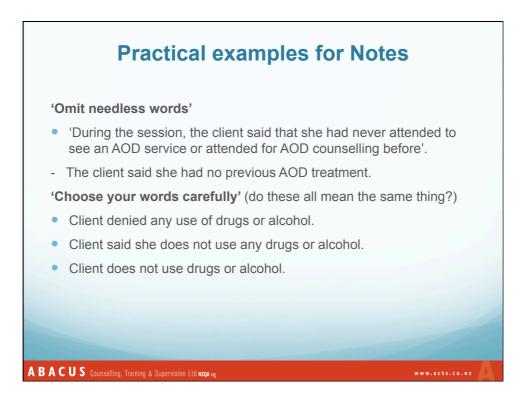
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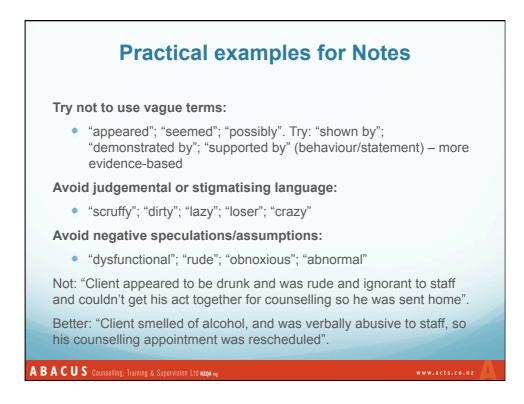


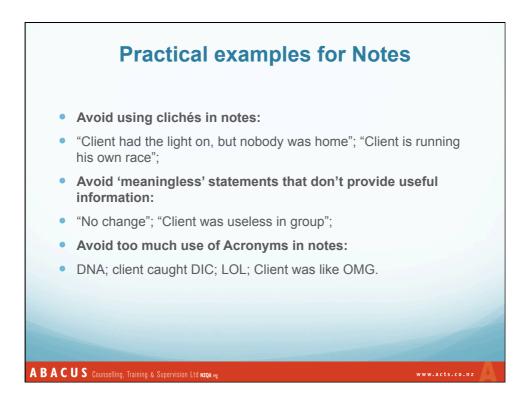












Client Note Models – SOAP & DAP

SOAP

- Subjective what the client tells you/others tell you about client; concerns, problems, attitudes
- Objective what you clinically observe; screen & test results; other documentation; mental state examination
- Assessment info analysis of problem, explanations, hypotheses, diagnoses
- Plan interventions used/ planned to achieve goals, treatment progress, goals for next session; prognosis, follow-up

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DAP

- Data info from session e.g. current issues or problems, signs & symptoms, behavioural concerns, current interventions, etc.
- Assessment assessment of client progress/setbacks, goal attainment etc.
- Plan review of treatment plan, objectives by session, or over cumulative sessions; where to from here

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