CareCertify LLC

Substance Use Disorder Training Series

SUD-09

Documentation & Treatment Planning

Participant Guide

Substance Use Disorder Training Series · Audience: Counselors · Technicians · Support Staff · Recovery Peers · CE Hours: 1.0

Documentation Tells the Story of Treatment

Your documentation is where the work becomes visible. It communicates with the team, shows that services matched the client's needs and treatment plan, meets Chapter 245G standards, supports reimbursement, and is a protected legal record. If it isn't documented, for practical and legal purposes, it didn't happen.

This guide covers the key documents, the timelines, the 'golden thread' that ties everything together, and how to write effective, objective notes. Good documentation isn't busywork — it's part of good care.

Learning Objectives — by the end of this module you will be able to:

- Explain why documentation matters in SUD treatment
- Describe the assessment, treatment plan, and progress notes
- Apply the 'golden thread' linking need, plan, and service
- Write effective, objective progress notes
- Document in a timely manner and correct errors properly

Section 1: Why Documentation Matters

Documentation communicates with the treatment team and supports continuity, demonstrates that services matched the client's needs and treatment plan, meets Chapter 245G standards, supports reimbursement, and is a legal record protected under 42 CFR Part 2 and other laws. For practical and legal purposes, undocumented care didn't happen — which is why doing it well matters.

Section 2: Assessment, Treatment Plan, and Progress Notes

Several documents frame the work. The assessment establishes the client's needs and diagnosis. The individual treatment plan (Minn. Stat. 245G.06) sets person-centered goals and the services to reach them, developed by an alcohol and drug counselor. Progress notes record each service delivered and the client's response. Treatment plan reviews update the plan as the client progresses. Each has required elements and timelines under Chapter 245G.

Section 3: The Golden Thread

The 'golden thread' connects the client's assessed need, the goal in the treatment plan, the service you provide, and the progress note that records it. Each progress note should relate to a treatment-plan goal,

showing the service was needed and on-plan. When the thread is broken — a service that doesn't tie to a goal — it's both a documentation and a reimbursement problem.

> **Tie every note to a goal**
>
> If you can't connect what you did to a treatment-plan goal, pause. The service and the note should always trace back to the plan and the client's needs.

Section 4: Treatment-Plan Timelines and Reviews

Chapter 245G sets timelines for the individual treatment plan — for example, within ten days of service initiation for a residential program, with specific timelines for nonresidential and opioid treatment programs — and requires treatment plan reviews on a schedule (more often when clinical needs warrant). Missed timelines are compliance problems. Know your program's deadlines and keep documentation current.

Section 5: Writing Effective Progress Notes

A good progress note answers: what goal or intervention was addressed, what you did, how the client responded, and what comes next. Be specific and concrete rather than vague. Focus on the service provided and the client's functioning and progress toward goals, and follow your agency's required note format and elements.

Section 6: Objective, Non-Judgmental Language

Write objectively: describe behavior rather than labeling character, and attribute the client's statements ('client reported…'). Avoid stigmatizing terms like 'addict,' 'in denial,' 'noncompliant,' or 'dirty/clean.' Clients have the right to see their records, so write everything as if they will read it. Language in records affects how the team sees the client and reinforces or reduces stigma.

Section 7: Corrections and Documentation Integrity

Records must be honest. Never erase, backdate, or falsify an entry. Correct errors the proper way per agency policy — typically a single line through the error with your initials and the date. Document only services you personally provided, and sign your own notes. Documentation integrity is non-negotiable and protects the client and you.

Section 8: Confidentiality of Records

The records you write are protected under 42 CFR Part 2, HIPAA, and Minnesota law (covered in SUD-05). Protect records, screens, and devices, and share only as the law allows. Good documentation and strong confidentiality go hand in hand — guard the records as carefully as you create them, because they hold some of the most sensitive information a person has.

Key Terms

Term	What it means
Assessment	The document establishing a client's needs and diagnosis.

Individual treatment plan	The person-centered plan of goals and services (245G.06).
Progress note	A record of each service delivered and the client's response.
Golden thread	The link connecting assessed need, plan goal, service, and note.
Treatment plan review	A scheduled update of the plan as the client progresses.
Documentation integrity	Honest, accurate records corrected the proper way.

Check Your Understanding

1. Name three reasons documentation matters.
2. What are the key documents and how do they relate?
3. What is the golden thread?
4. What does Chapter 245G require about treatment-plan timelines?
5. How should documentation errors be corrected?

What's Next

> **Looking ahead**
>
> Next, SUD-10: Maltreatment Reporting & Safety covers your duty to report abuse and keep clients safe.