

# how to use therapy notes

How to Use Therapy Notes: A Practical Guide for Therapists and Counselors

**how to use therapy notes** effectively is a question that many mental health professionals contemplate throughout their careers. Therapy notes are more than just routine documentation; they serve as a vital tool to enhance client care, track progress, and ensure compliance with legal and ethical standards. Whether you are a seasoned therapist or a newcomer to counseling, understanding how to use therapy notes can improve your practice and ultimately benefit your clients.

## Understanding the Purpose of Therapy Notes

Before diving into how to use therapy notes, it's important to grasp why they matter. Therapy notes, often called clinical notes or progress notes, are written records that document the details of each therapy session. They help therapists keep track of the client's mental health journey, therapeutic interventions used, and any changes in symptoms or behavior.

Unlike general medical records, therapy notes typically contain more detailed observations about the client's emotions, thoughts, and interpersonal dynamics. They also serve as a communication tool between healthcare providers when coordinated care is necessary. Additionally, therapy notes can be essential for insurance reimbursement and maintaining compliance with healthcare regulations such as HIPAA in the United States.

## Types of Therapy Notes and Their Uses

Not all therapy notes are created equal. Understanding the different types of notes can help you decide what to document and how detailed your records should be.

### Progress Notes

Progress notes summarize each session's content, including the client's mood, behaviors, and responses to therapeutic interventions. They are usually brief and focus on tracking goals and outcomes.

### SOAP Notes

A popular format among many clinicians, SOAP notes break down information into four categories: Subjective (client's reported feelings), Objective (observable behaviors), Assessment (therapist's clinical impression), and Plan (next steps in therapy). Learning how to use therapy notes in this structured format can improve clarity and consistency.

## **Process Notes**

Also known as psychotherapy notes, process notes are more detailed and subjective records reserved for the therapist's personal use. They explore the therapist's impressions, hypotheses, and reflections that might not be appropriate for inclusion in the official medical record.

## **How to Use Therapy Notes to Enhance Client Care**

Using therapy notes effectively means more than just filling out paperwork. These notes should be an active component of your clinical work.

### **Track Client Progress Over Time**

By regularly reviewing your therapy notes, you can identify patterns or shifts in your client's mental health that may not be immediately obvious during sessions. This insight helps tailor treatment plans to better suit evolving needs.

### **Inform Treatment Planning**

Therapy notes provide a roadmap for future sessions. They allow you to recall which interventions have been effective and which strategies need adjustment. This ongoing evaluation is crucial for personalized care.

### **Facilitate Communication with Other Providers**

When working in multidisciplinary teams, well-maintained therapy notes ensure everyone involved in a client's care is on the same page. This collaboration can lead to more coordinated and comprehensive treatment.

### **Support Legal and Ethical Accountability**

Detailed and accurate therapy notes protect both the client and therapist legally. They document the care provided and can serve as evidence if questions about treatment arise.

## **Best Practices for Writing and Maintaining Therapy Notes**

Knowing how to use therapy notes properly also involves mastering the documentation process itself.

## **Be Clear and Concise**

Avoid vague language and focus on specific observations and interventions. Clear notes reduce misunderstandings and make it easier to track progress.

## **Maintain Confidentiality**

Therapy notes often contain sensitive information. It's essential to store them securely, using encrypted digital systems or locked physical files, and to share them only with authorized individuals.

## **Use Objective Language**

While it's important to capture emotional and subjective content, strive to write in a professional and unbiased tone. Avoid assumptions or judgmental phrasing.

## **Document Consistently**

Make note-taking a routine part of your sessions. Timely documentation ensures information is fresh and accurate, which is invaluable for clinical decision-making.

## **Leveraging Technology to Optimize Therapy Notes**

In today's digital age, therapy notes don't have to be handwritten or stored in bulky binders. Various electronic health record (EHR) systems and specialized therapy note software can streamline the process.

## **Benefits of Electronic Therapy Notes**

- Easy access and retrieval of client information
- Automated reminders for documentation deadlines
- Integration with billing and scheduling tools
- Enhanced security features to protect client privacy

## **Choosing the Right Software**

When selecting a platform, consider factors like user-friendliness, compliance with healthcare laws, customization options, and cost. Many therapists find that the right software not only saves time but also improves the quality of their notes.

# Common Mistakes to Avoid When Using Therapy Notes

Even experienced therapists can fall into pitfalls when it comes to note-taking. Being aware of these helps maintain high standards.

- **Overloading Notes with Irrelevant Details:** Stick to information pertinent to treatment and client progress.
- **Delaying Documentation:** Waiting too long to write notes can lead to inaccuracies.
- **Using Jargon or Abbreviations:** Unless universally understood, these can cause confusion.
- **Neglecting to Update Notes:** Therapy is dynamic; notes should reflect the current state of care.
- **Failing to Secure Notes Properly:** Breaches in confidentiality can have serious consequences.

## Integrating Therapy Notes with Client Feedback

One of the most powerful ways to use therapy notes is to combine them with client input. Inviting clients to reflect on their progress or review notes can deepen therapeutic alliances and empower clients in their healing process.

For example, therapists might summarize key points from a session in the notes and share relevant insights during the next meeting. This transparency fosters trust and helps clients feel more engaged in their treatment.

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Understanding how to use therapy notes is an evolving skill that grows with experience and reflection. When approached thoughtfully, therapy notes become more than bureaucratic necessities—they transform into valuable tools that enhance therapeutic effectiveness, protect both parties, and contribute to better mental health outcomes.

## Frequently Asked Questions

### What are therapy notes and why are they important?

Therapy notes are detailed records that therapists keep about their sessions with clients. They help track client progress, plan future sessions, and provide documentation for insurance or legal purposes.

## **How do I organize therapy notes effectively?**

Organize therapy notes by date and client, using clear headings and consistent formats. Digital tools or specialized software can help keep notes secure, searchable, and easy to update.

## **What should be included in therapy notes?**

Therapy notes typically include the date of the session, client information, session goals, interventions used, client responses, progress towards goals, and plans for future sessions.

## **How can I ensure confidentiality when using therapy notes?**

To ensure confidentiality, store therapy notes securely using encrypted digital platforms or locked physical files. Share notes only with authorized personnel and follow legal regulations such as HIPAA.

## **Can therapy notes be shared with clients?**

While therapy notes are primarily for the therapist's use, some aspects can be shared with clients to enhance collaboration. However, sensitive or clinical observations are usually kept confidential to maintain therapeutic boundaries.

## **How do therapy notes support treatment planning?**

Therapy notes provide a comprehensive record of client progress and responses to interventions, allowing therapists to adjust treatment plans effectively and tailor approaches to meet client needs.

## **Additional Resources**

How to Use Therapy Notes: Unlocking Their Full Potential in Clinical Practice

**how to use therapy notes** effectively is a question that resonates deeply with mental health professionals seeking to optimize patient care while maintaining compliance with legal and ethical standards. Therapy notes, often referred to as progress notes or clinical documentation, play a pivotal role in the therapeutic process. They serve as a detailed record of sessions, capturing insights, treatment plans, client progress, and clinical observations. Yet, the utility of these notes extends beyond simple record-keeping. Understanding how to use therapy notes strategically can enhance therapeutic outcomes, ensure continuity of care, and support clinical decision-making.

This article delves into the nuanced applications of therapy notes, exploring best practices, the balance between thoroughness and confidentiality, and the evolving role of digital tools in managing these essential documents.

# Understanding the Purpose of Therapy Notes

Before exploring how to use therapy notes, it is important to clarify their primary purpose. Therapy notes are the clinician's personal record of each session, distinct from formal medical records. They provide an accurate snapshot of client interactions, therapeutic interventions employed, and the client's response to treatment.

In many jurisdictions, therapy notes are considered private documents and are often kept separate from the client's official health record. This distinction is crucial because therapy notes may include subjective impressions and hypotheses that do not necessarily belong in the formal record. Clinicians use these notes to track progress, plan future sessions, and reflect on therapeutic techniques.

## Key Components of Therapy Notes

Effective therapy notes typically include several elements:

- **Session date and time:** Accurate timing helps in tracking treatment chronology.
- **Client's presenting issues:** Briefly noting concerns discussed during the session.
- **Therapeutic interventions:** Descriptions of techniques or strategies used.
- **Client's response and progress:** Observations of mood, behavior, and feedback.
- **Plans for future sessions:** Goals or homework assignments.
- **Clinician reflections:** Subjective thoughts or hypotheses guiding treatment direction.

## How to Use Therapy Notes to Enhance Client Outcomes

Utilizing therapy notes effectively requires more than just recording session details. They are dynamic tools that assist clinicians in delivering personalized and responsive care.

### 1. Facilitating Continuity of Care

Consistency across sessions is vital in mental health treatment. Therapy notes enable therapists to recall prior discussions, client progress, and challenges encountered. Particularly in cases where multiple clinicians are

involved, well-maintained notes ensure seamless handoffs and reduce the risk of redundant assessments.

For example, in multidisciplinary teams, sharing summarized therapy notes—while respecting confidentiality—can improve coordination between psychologists, psychiatrists, and social workers. This collaborative approach often leads to more comprehensive care plans and better client outcomes.

## 2. Informing Treatment Planning

Therapy notes serve as a foundation for developing and adjusting treatment plans. By analyzing notes over time, clinicians can identify patterns, triggers, or setbacks that might not be evident in a single session. This longitudinal perspective enables data-driven adjustments to therapeutic strategies.

Moreover, therapy notes assist in setting measurable goals. Documenting client progress towards specific objectives helps both therapist and client remain focused and motivated. This structured approach aligns with evidence-based practices and supports accountability.

## 3. Supporting Legal and Ethical Compliance

While therapy notes are generally considered confidential, they may be subject to legal scrutiny in certain cases, such as court proceedings or insurance audits. Therefore, knowing how to use therapy notes with attention to accuracy and professionalism is essential.

Clinicians must strike a balance between candid documentation and protecting client privacy. Avoiding judgmental language and focusing on observable behaviors rather than interpretations minimizes potential risks. Additionally, therapists should be familiar with relevant laws like HIPAA in the United States, which dictate how therapy notes should be stored and shared.

## Digital Tools and Innovations in Therapy Note Management

The digital transformation in healthcare has introduced a variety of electronic health record (EHR) systems and specialized software designed to streamline therapy note documentation. These tools offer benefits such as standardized templates, secure storage, and ease of access.

## Advantages of Electronic Therapy Notes

- **Improved organization:** Digital notes can be easily sorted, searched, and linked to client records.
- **Enhanced security:** Encryption and access controls protect sensitive

information.

- **Time efficiency:** Templates and auto-fill features reduce documentation time.
- **Integration capabilities:** Ability to connect with billing systems and appointment schedulers.

However, some clinicians express concerns about the potential depersonalization of note-taking when relying heavily on digital tools. The risk of over-standardization may lead to overly generic notes, which diminish their clinical usefulness.

## Balancing Technology and Clinical Judgment

To maximize the benefits of digital therapy notes, therapists should customize templates to fit their therapeutic style and client needs. Avoiding rigid adherence to checklists encourages thoughtful reflection and richer documentation.

Furthermore, regular training on software updates and privacy protocols ensures that clinicians remain compliant and adept at leveraging technology. In this way, digital tools become an extension of clinical expertise rather than a replacement.

## Best Practices for Maintaining Effective Therapy Notes

How to use therapy notes responsibly involves adhering to established best practices that enhance their value and safeguard client interests.

1. **Write notes promptly:** Document sessions as soon as possible to preserve accuracy.
2. **Use clear, concise language:** Avoid ambiguity and jargon to ensure clarity.
3. **Maintain objectivity:** Focus on facts and observable behavior rather than assumptions.
4. **Secure storage:** Protect notes with encryption and restrict access.
5. **Regular review:** Periodically revisit notes to monitor client progress and inform treatment changes.

Adopting these practices not only improves clinical effectiveness but also positions therapists favorably during audits or legal reviews.



## Ethical Considerations in Therapy Note Usage

Confidentiality remains paramount when handling therapy notes. Therapists must obtain informed consent detailing how notes are stored and shared, especially if third parties such as insurance providers are involved.

In some cases, clients may request access to their therapy notes. Navigating these requests requires sensitivity and adherence to professional guidelines. Transparency regarding what is documented and why can foster trust and collaboration in the therapeutic relationship.

The sensitive nature of therapy notes also demands vigilance against data breaches. Implementing robust cybersecurity measures minimizes risks of unauthorized disclosure.

## Conclusion: Leveraging Therapy Notes as a Clinical Asset

Professionals who master how to use therapy notes unlock their potential as more than mere documentation. When crafted thoughtfully, these notes become an integral part of the therapeutic alliance—enhancing communication, guiding interventions, and supporting ethical practice. The evolving landscape of digital tools adds layers of convenience and security, but the core value of therapy notes lies in their capacity to reflect the clinician's insights and the client's journey.

Mental health practitioners who prioritize clear, timely, and confidential therapy note management position themselves to deliver higher-quality care and navigate the complexities of modern clinical practice with confidence.

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**how to use therapy notes: Documentation for Physical Therapist Assistants** Wendy D Bircher, 2017-10-01 Build your documentation skills—and your confidence. Step by step, this text/workbook introduces you to the importance of documentation; shows you how to develop and write a proper and defensible note; and prepares you to meet the technological challenges you'll encounter in practice. You'll learn how to provide the proper documentation to assure all forms of reimbursement (including third party) for your services. You'll also explore issues of patient confidentiality, HIPAA requirements, and the ever-increasing demands of legal and ethical practice in a litigious society.

**how to use therapy notes: *The OTA's Guide to Documentation*** Marie Morreale, 2024-06-01 The bestselling, newly updated occupational therapy assistant (OTA) textbook, *The OTA's Guide to Documentation: Writing SOAP Notes, Fifth Edition* explains the critical skill of documentation while offering multiple opportunities for OTA students to practice documentation through learning activities, worksheets, and bonus videos. The Fifth Edition contains step-by-step instruction on occupational therapy documentation and the legal, ethical, and professional documentation standards required for clinical practice and reimbursement of services. Students and professors alike can expect the same easy-to-read format from previous editions to aid OTAs in learning the purpose and standards of documentation throughout all stages of the occupational therapy process and different areas of clinical practice. Essentials of documentation, reimbursement, and best practice are reflected in the many examples presented throughout the text. Worksheets and learning activities provide the reader with multiple opportunities to practice observation skills and clinical reasoning, learn documentation methods, create occupation-based goals, and develop a repertoire of professional language. Templates are provided to assist beginning OTA students in formatting occupation-based SOAP notes, and the task of documentation is broken down into smaller units to make learning easier. Other formats and methods of recording client care are also explained, such as the use of electronic health records and narrative notes. This text also presents an overview of the initial evaluation process delineating the roles of the OT and OTA and guidelines for implementing appropriate interventions. New in the Fifth Edition: Incorporation of the Occupational Therapy Practice Framework: Domain and Process, Fourth Edition and other updated American Occupational Therapy Association documents Updated information to meet Medicare Part B and other third-party payer requirements Revised clinical terminology on par with current trends Added examples from emerging practice areas Expanded tables along with new worksheets and learning activities Included with the text are online supplemental materials for faculty use in the classroom, this includes: access to supplemental website worksheets, learning activities, and scenario-based videos

to practice the documentation process.

**how to use therapy notes: Documentation Basics** Mia Erickson, Mia L. Erickson, 2012 Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively. The new Second Edition of *Documentation Basics: A Guide for the Physical Therapist Assistant* continues the path of teaching the student and clinician documentation from A to Z. Mia Erickson and Rebecca McKnight have updated this Second Edition to reflect changes of the American Physical Therapy Association and the ever-evolving profession. Updated inside *Documentation Basics: A Guide for the Physical Therapist Assistant, Second Edition*: The discussion on integrating disablement into documentation The discussion on how a PTA can show medical necessity and need for skilled care The discussion on using documentation to communicate with other providers Writing the assessment and plan to coincide with the initial documentation Sample notes completed on forms More examples and practice, including physical agents, school-based services, paediatrics, traumatic brain injury, spinal cord injury, and interventions consistent with the Guide to Physical Therapist Practice Medicare reimbursement in different settings The importance of consistent, reliable, and valid measurements How to improve communication and consistency between documentation by the PT & the PTA The discussion on disablement has also been updated, shifting away from the Nagi Model toward the International Classification of Functioning, Disability, and Health (ICF). In addition, the PTA Normative Model has been integrated throughout to include more information on clinical decision making. New inside *Documentation Basics: A Guide for the Physical Therapist Assistant, Second Edition*: Navigating the PT plan of care...A step-by-step model for PTAs to use as they navigate the initial PT documentation and plan of care How the PTA uses the PT goals from the initial examination and evaluation Positive and negative aspects of using electronic documentation and a discussion on integrating SOAP notes and the problem-oriented medical record into electronic documentation Sample notes and discussion of documentation in school-based settings, early intervention, skilled nursing settings, in-patient rehabilitation, and direct access Medicare Parts C and D Cash-based services and pro bono services Instructors in educational settings can visit [www.efacultylounge.com](http://www.efacultylounge.com) for additional material to be used for teaching in the classroom. *Documentation Basics: A Guide for the Physical Therapist Assistant, Second Edition* is the perfect guide for all physical therapist assistant students and clinicians who want to update and refine their knowledge and skills in documentation.

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**how to use therapy notes: Using Research in Practice** Jaqui Hewitt-Taylor, 2011-09-06 Latest research findings can provide an evidence base for health care practice which ultimately improves outcomes for patients. With so much published research out there, how do you find, evaluate and use the most relevant studies to shape your own health care practice? This friendly book walks you

through the key stages of locating, selecting and evaluating research findings in health care. Offering an engaging, practice-based approach to an often daunting task, the book: - Explores how to appraise and apply data drawn from a range of quantitative, qualitative and mixed methods studies - Demonstrates how research findings can influence decision-making and can improve your own practice, as well as that of your team - Uses stimulating practice scenarios and worked examples to provide a transferrable blueprint for evidence based practice Drawing on the author's extensive research and teaching experience within the field of practice development, *Using Research in Practice* is an essential text for any health care student or practitioner seeking to evaluate and develop their own evidence base.

**how to use therapy notes:** Legal Issues Across Counselling & Psychotherapy Settings Barbara Mitchels, Tim Bond, 2011-09-15 This fourth book in the authoritative BACP Legal Resources for Counsellors & Psychotherapists series provides practical examples and applications of the law as it applies to therapists in the many different contexts of their work. Helping practitioners move between different practice settings, the book explores how the legal framework within which they work varies across contexts. It introduces practitioners to the statutory structure and obligations of different types of counselling and psychotherapy services, setting out implications for practice such as liability and accountability. Work settings covered include: o Private practice o Commercial organisations - Employee Assistance Programmes o Voluntary sector o Government Health settings (NHS): primary and secondary o Private Health settings: primary and secondary o Education / Schools / FE/HE o Social services o Police and Home Office For each setting, the book considers the statutory basis, how the legal framework impacts on services to clients, systemic issues such as bullying or prejudicial discrimination, responsibility for decision making, and the restrictions and empowerment of therapists and clients within the context of that setting. This book is an essential reference for counselling practitioners working across a range of practice settings, including those with portfolio careers. It is also important reading for all those studying counselling, psychotherapy or clinical psychology.

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**how to use therapy notes:** Seasonal Activities for Sensorimotor Development Ann Bavosa, 2018-10-24 This book contains easy-to-use activities for therapists, educators and carers to provide fun and engaging sensorimotor groups for students with movement and sensory dysfunction. The

activities span an entire year with a different main activity for each week. Themed by season, the activities can be linked to the school year and incorporated into the classroom. The activities promote socialisation, postural strengthening, improvement of gross and fine motor skills, and self-regulation of the body. Comprehensive instructions on how to run a group are included, as well as benefits and adaptations for severely affected individuals and wheelchair users. There are sensory-regulating warm-up appetizers to increase body awareness and prepare the students for movement; main course activities to strengthen fine and gross motor skills; and cool-down desserts to regulate the body and assimilate benefits gained during group activities. The activities are suitable for use with any school-age students, including those without movement difficulties, but are especially beneficial for students with mild to moderate motor disabilities, who exhibit increased difficulty functioning in a group setting.

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Mia Erickson, Rebecca McKnight, 2024-06-01 Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively. The new Third Edition of Documentation Basics for the Physical Therapist Assistant continues the path of teaching the student and clinician documentation from A to Z. Mia Erickson and Rebecca McKnight have updated this Third Edition to reflect changes in the ever-evolving profession. Newly addressed are the changes in documentation requirements for major payers, changes in the disablement models used, and the increasingly common use of electronic documentation in the physical therapy profession. Features inside the Third Edition: Readers are encouraged to think about disablement and disablement concepts when writing notes How to document impairments in body structure and function but more importantly activity limitations and participation restriction Descriptions of the differences in documentation methods using a computer vs paper chart Evidence tied to benefits and challenges of computerized documentation Documenting the rationale for treatment and the unique skills of the physical therapist assistant in patient management New inside the Third Edition: Incorporation of the International Classification of Functioning, Disability, and Health disablement model Chapter on electronic documentation Screenshot examples of the popular WebPT® electronic medical record platform Updated chapters on reimbursement and legal issues Additional examples for student practice included in each chapter Included with the text are online supplemental materials for faculty use in the classroom. Documentation Basics for the Physical Therapist Assistant, Third Edition is the perfect guide for all physical therapist assistant students and clinicians who want to update and refine their knowledge and skills in documentation.

**how to use therapy notes: The Beginning Psychotherapist's Companion Jan Willer Ph.D.,**

2013-08-09 Filling in the gaps from students' lack of experience and confidence, The Beginning Psychotherapist's Companion, Second Edition is a supportive and empathetic guide, addressing real-world concerns and providing essential insights not taught in textbooks. With a reassuring and clear writing style, Willer offers practical suggestions and clinical examples to address the professional development and emotional concerns of the beginning psychotherapist. She guides readers through structuring the first session, making clinical observations, and establishing a therapeutic alliance. Through the use of culturally diverse clinical vignettes, Willer discusses the foundations of ethical practice, including informed consent, confidentiality, documentation, and setting boundaries. The reader is guided on how and when to refer clients for medication and other health care. Crisis management principles are detailed, including suicide and violence risk assessment, child abuse, elder abuse, intimate partner violence, and rape. Willer also provides professional advice on contemporary concerns such as social networking, online searches of clients, the psychotherapist's internet presence, and other important emerging challenges. Comprehensive, practical, and thoroughly updated, The Beginning Psychotherapist's Companion, Second Edition is the ideal resource for students and early career psychotherapists.

**how to use therapy notes: How to Work with Sex Offenders Rudy Flora, Michael L. Keohane,**

2013-06-19 How to Work with Sex Offenders is a cutting edge, state-of-the-art book that provides mental health professionals best practice techniques on how to clinically evaluate, interview, and

treat this challenging patient population. Successful models of individual, family, and group models of psychotherapy are provided for the reader. In addition, this handbook walks the reader through the investigation, arrest, prosecution and court hearing process, from start to finish. Thoroughly revised, this new edition builds on additional research data and new information, adding advanced chapters on female offenders, Internet offenders, pornography, sexual addiction, rape and child and adolescent sexual misconduct. This is a must-read work for undergraduate and graduate students, law enforcement officers, prosecutors, judges, child protection service workers, therapists, and other professionals who work with sex offenders.

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**how to use therapy notes: Harm Reduction Treatment for Substance Use** Susan E. Collins, Seema L. Clifasefi, 2023-05-22 Harm reduction approaches are effective, patient-driven alternatives to abstinence-based treatment for people who are not ready, willing, or able to stop using substances. This volume outlines the scientific basis and historical development of these approaches, and reviews why abstinence-based approaches often do not work. The authors then share their expertise about harm reduction treatment (HaRT), an empirically based approach co-developed with community members impacted by substance-related harm – a first of its kind. The reader learns in detail about the pragmatic mindset and compassionate heartset of HaRT and the three treatment components: measurement and tracking of patient-preferred substance-related metrics, harm-reduction goal setting and achievement, and discussion of safer-use strategies. This volume walks practitioners through all components, provides example scripts for use in daily practice, and illustrates the work through case studies and input from community members. Handouts are available for use in daily practice. This is essential reading for clinical psychologists, psychotherapists, and researchers who encounter people who have substance-use problems.

**how to use therapy notes: MEDINFO 2017: Precision Healthcare Through Informatics** A.V. Gundlapalli, M.-C. Jaulent, D. Zhao, 2018-01-31 Medical informatics is a field which continues to evolve with developments and improvements in foundational methods, applications, and technology, constantly offering opportunities for supporting the customization of healthcare to individual patients. This book presents the proceedings of the 16th World Congress of Medical and Health Informatics (MedInfo2017), held in Hangzhou, China, in August 2017, which also marked the 50th anniversary of the International Medical Informatics Association (IMIA). The central theme of

MedInfo2017 was Precision Healthcare through Informatics, and the scientific program was divided into five tracks: connected and digital health; human data science; human, organizational, and social aspects; knowledge management and quality; and safety and patient outcomes. The 249 accepted papers and 168 posters included here span the breadth and depth of sub-disciplines in biomedical and health informatics, such as clinical informatics; nursing informatics; consumer health informatics; public health informatics; human factors in healthcare; bioinformatics; translational informatics; quality and safety; research at the intersection of biomedical and health informatics; and precision medicine. The book will be of interest to all those who wish to keep pace with advances in the science, education, and practice of biomedical and health informatics worldwide.

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