Streamlining Clinical Notes: Evaluating AI, Traditional Methods, and Ethical Standards

Balancing Efficiency, Accuracy, and Ethical Compliance in Modern Documentation

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Learning Objectives

Evaluate risks of AI in clinical note-taking (e.g., privacy, bias, reliability).

Critique traditional (SOAP/DAP) and AI-driven documentation strategies.

Design ethically compliant templates using AI-assisted tools or not.

(ACA, 2014)

The Documentation Burden (Interactive Poll)

AUDIENCE ACTIVITY: RAISE YOUR HAND IF YOU SPEND >5 HOURS/WEEK ON NOTES.

2025 DATA: 73% OF COUNSELORS REPORT BURNOUT FROM ADMINISTRATIVE TASKS.

KEY TENSION: EFFICIENCY VS. CLINICAL INTEGRITY.

(ACA, 2014)

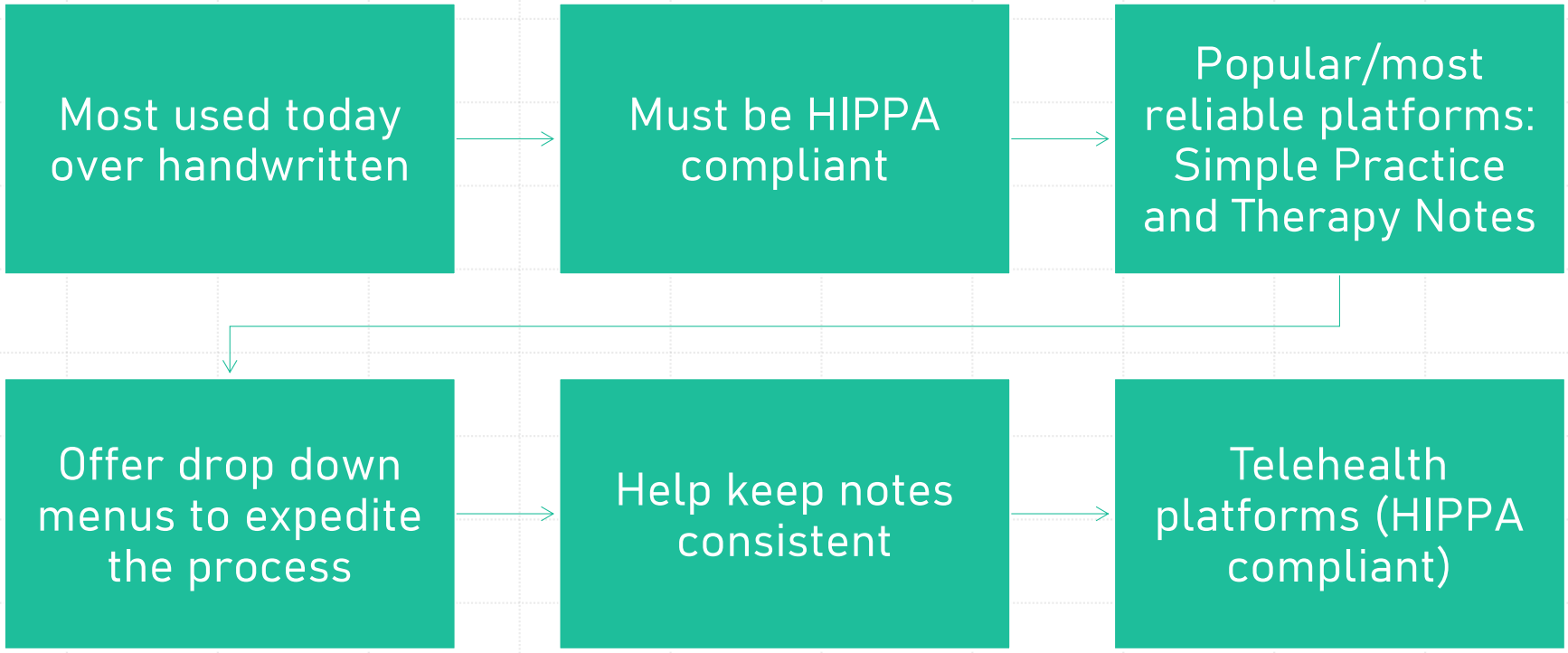
ACA Code of Ethics & Documentation

B.6.a. Creating and Maintaining Records and Documentation
Counselors create and maintain records and documentation necessary for rendering professional services.

B.6.b. Confidentiality of Records and Documentation
Counselors ensure that records and documentation kept in any medium are secure and that only authorized persons have access to them.

(ACA, 2014)

Electronic Health Records (EHR)



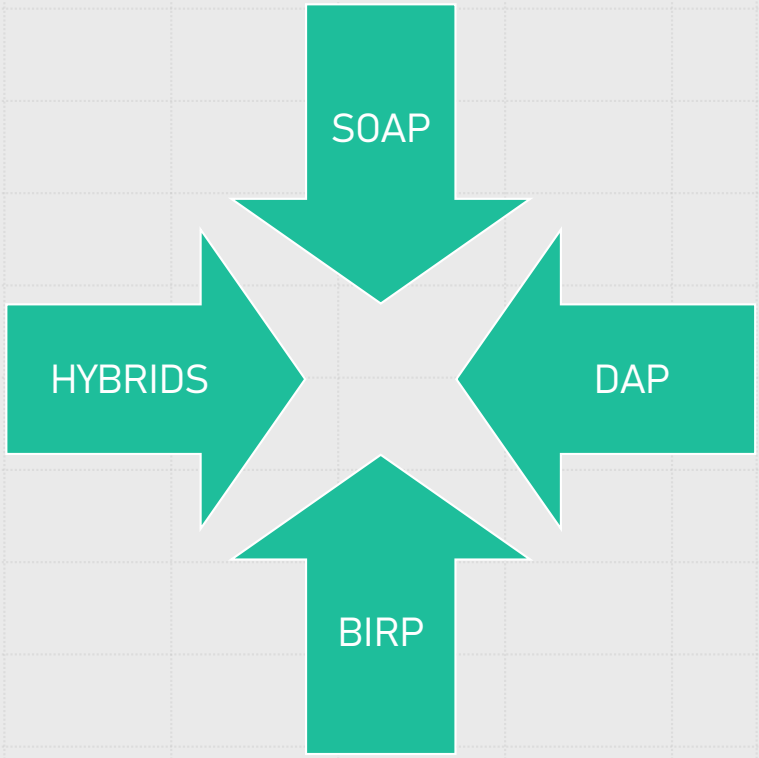
(SimplePractice, 2023)

Progress Notes: What MUST be included?

- **Demographic information**
  - Client's name and date of birth
  - Date of the session, start and end time of the session
  - Clinician's name, and a handwritten or electronic signature
  - For telehealth sessions, the location of the session
- **Description of client's behavior**
  - Presentation (mood, affect, appearance, and behavior) and Symptoms
  - A diagnosis
  - Safety assessment/plan
  - Any changes to medication
- **Treatment Plan**
  - Treatment modalities used & recommended
  - Interventions used (questions asked/explored, coping skills taught, handouts provided, resources recommended)
  - Client's response to interventions (i.e. the client was open to….)
  - The client's progress toward goals
  - The plan for the client between sessions and in the next session

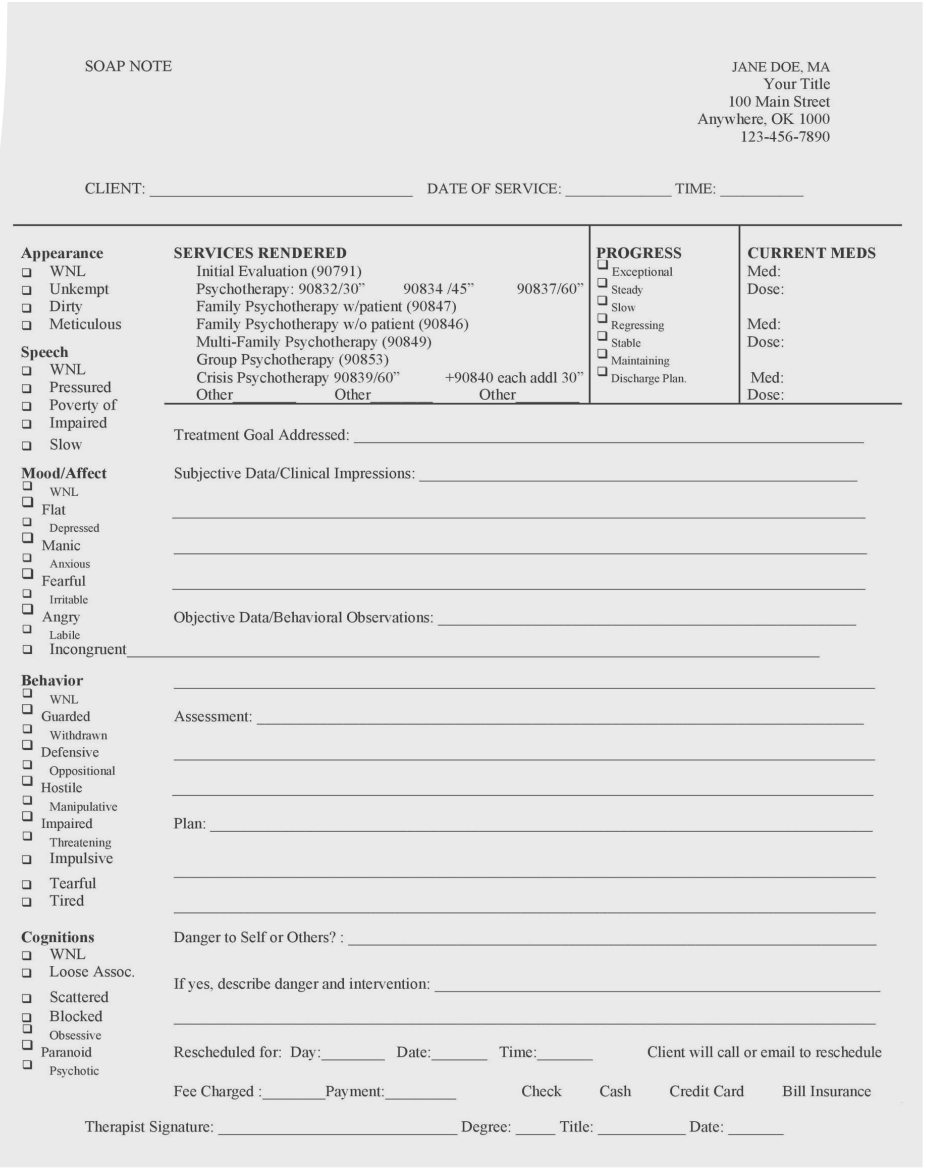
(SimplePractice, 2023)

Types of Progress Notes



SOAP Note Template

(TemplateLab, 2021)



SOAP NOTE

JANE DOE, MA
Your Title
100 Main Street
Anywhere, OK 1000
123-456-7890

CLIENT: _____ DATE OF SERVICE: _____ TIME: _____

Appearance
- ❑ WNL
- ❑ Unkempt
- ❑ Dirty
- ❑ Meticulous

Speech
- ❑ WNL
- ❑ Pressured
- ❑ Poverty of
- ❑ Impaired
- ❑ Slow

Mood/Affect
- ❑ WNL
- ❑ Flat
- ❑ Depressed
- ❑ Manic
- ❑ Anxious
- ❑ Fearful
- ❑ Irritable
- ❑ Angry
- ❑ Labile
- ❑ Incongruent

Behavior
- ❑ WNL
- ❑ Guarded
- ❑ Withdrawn
- ❑ Defensive
- ❑ Oppositional
- ❑ Hostile
- ❑ Manipulative
- ❑ Impaired
- ❑ Threatening
- ❑ Impulsive
- ❑ Tearful
- ❑ Tired

Cognitions
- ❑ WNL
- ❑ Loose Assoc.
- ❑ Scattered
- ❑ Blocked
- ❑ Obsessive
- ❑ Paranoid
- ❑ Psychotic

SERVICES RENDERED
- Initial Evaluation (90791)
- Psychotherapy: 90832/30" 90834 /45" 90837/60"
- Family Psychotherapy w/patient (90847)
- Family Psychotherapy w/o patient (90846)
- Multi-Family Psychotherapy (90849)
- Group Psychotherapy (90853)
- Crisis Psychotherapy 90839/60" +90840 each addl 30"
- Other_____ Other_____ Other_____

PROGRESS
- ❑ Exceptional
- ❑ Steady
- ❑ Slow
- ❑ Regressing
- ❑ Stable
- ❑ Maintaining
- ❑ Discharge Plan.

CURRENT MEDS
Med:
Dose:

Med:
Dose:

Med:
Dose:

Treatment Goal Addressed: _____

Subjective Data/Clinical Impressions: _____

Objective Data/Behavioral Observations: _____

Assessment: _____

Plan: _____

Danger to Self or Others? : _____

If yes, describe danger and intervention: _____

Rescheduled for: Day:_____ Date:_____ Time:_____ Client will call or email to reschedule

Fee Charged :_____Payment:_____ Check Cash Credit Card Bill Insurance

Therapist Signature: _____ Degree: ____ Title: _____ Date: _____

SOAP Note Example

Subjective: *Client reported ongoing worry and anticipatory anxiety. They stated "It is hard for me to get excited to go anywhere because I'm always expecting the worst." They also noted extreme restlessness, muscle tension and an average of 3-4 hours of sleep per night.*

Objective: *Client's speech was rapid and rambling. Their thought processes were tangential. They frequently avoided discussing their anxiety by diverting to unrelated topics of discussion. They were fidgety throughout the session. Their mood was anxious with congruent affect. They denied any SI/HI or psychosis. They were oriented x 4. Writer conducted the GAD-7 assessment with the client and reviewed the severe score result of 18 with them.*

Assessment: *Client continues to experience severe symptoms congruent with their Generalized Anxiety Disorder diagnosis. Their frequent rumination, hypervigilance, physical distress and worry is disruptive to their self care, social life and occupation. Writer will continue to assess for the possibility of Social Anxiety Disorder given client's previous mention of anxiety related relational difficulties.*

Plan: *Client has made minor attempts to implement some of the coping skills discussed with Writer but continues to present with an overall avoidance of deeper intervention for their anxiety. Client has not conducted previously agreed upon homework activities. Writer will continue to build rapport and trust with the client. Writer will provide basic anxiety psychoeducation and teach mindfulness-based relaxation techniques. Writer will introduce the model of CBT to help prepare the client for deeper work on their anxious cognitions, behaviors and emotions.*

(SimplePractice, 2023b)

DAP Note Template

(Ellison, 2022)

Client/ID: **Counselor Initials:**

Session Date:	
Start and Finish Time:	
Data • Focus of session • Descriptions and observations about the client's current state • Interventions used during the session and topics discussed • Client's response to interventions	
Assessment • Client's progress • How the client has responded to treatment • Changes to client's diagnosis (if applicable) • Achievement of treatment goals • Behavior, affect, appearance of client	
Plan • Date, time and location of next session • Goals or homework for client • Referrals • Any changes to current treatment plan	

DAP Note Example

Data: Client expressed deep feelings of grief about the death of her mother. She finds it difficult to “do everyday things like cook and eat”. She is scheduled to return to work next week and she feels “anxious” but is also “excited for normalcy”. Client says she has a good support system and speaks openly to her partner about her grief.

Assessment: Client shows slight improvement. She was attentive during the session and able to discuss her emotions. She is continuing to work on grief coping mechanisms. No suicide risk.

Plan: Client scheduled for a session next week on 4/10/2022. Will reassess suitability of returning to work and discuss reducing her hours.

(Ellison, 2022)

BIRP Note Template

(TheraPlatform, 2023)

THERAPlatform

BIRP Note

Client Name: Lisa Fireplace Medical Record Number: 082E-485

DOB: 09/08/1999

Treating Clinician: Scott Sample ms Provider: Laura Sample

Date of service	Duration	Service Location	Location Code
Wed May 31 2023	1 hour(s) 0 minute(s)	Telehealth Provided in Patient's Home	10

Description	Code
Counseling 30 min	90832

Diagnostic Codes

[F419] Anxiety disorder, unspecified

BEHAVIOR

Client said they were waking up in the middle of the night and having difficulty returning to sleep. Difficulty getting out of bed in the morning. Missed work once because of it. Reported that they felt "sad most of the time" and "alone". Looked tired and lethargic. Therapist noted slumped shoulders and self-defeating comments. Client appears to be gaining weight. Fresh cut marks observed on upper arm.

INTERVENTION

Conducted cognitive restructuring using completed thought record. Scheduled video contact with brother. Assessed for suicidality. Discussed alternatives to cutting behavior and crisis management procedures.

RESPONSE

Seemed embarrassed when confronted with cutting behavior but did discuss it openly. Despite cutting, did not voice any suicidal ideation. Completed homework from last time. Seems engaged with therapy but not with the rest of life.

PLAN

Meet next week. Phone consultation available if necessary. Cutting behavior and thoughts of self-harm will be revisited next week. Client will complete thought record daily. Client is asked to follow-through on contact with brother.

Goal

Status: New

Enhance ability to effectively cope with the full variety of life's worries and anxieties.

Objectives

Objective	Status
Complete a Cost Benefit Analysis of maintaining the anxiety.	New

BIRP Note Example

Behavior: Client reported sleeping only 3-4 hours a night due to worries. Avoiding social interactions because of fear of judgments. Client said, “I would rather stay home than be scorned by other people”. Looked agitated, tired, shaking leg. Appears to be ruminating about lack of friends but afraid to do anything about it.

Intervention: Taught relaxation techniques, including deep abdominal breathing. Went over the concept of “worry time” with client to aid in sleep. Discussed scheduling a prosocial activity for this week. Asked client “what is the worst that can happen?” if they go outside their comfort zone.

Response: Expressed desire to try something new but noted some reluctance. Does not seem motivated to follow through. Didn’t complete homework from last time.

Plan: Meet next week. Client will practice relaxation daily. Will practice “worry time”every night before bedtime. Client will perform scheduled social activity. Next week client will be taught progressive muscle relaxation and review anxious thinking regarding social situations.

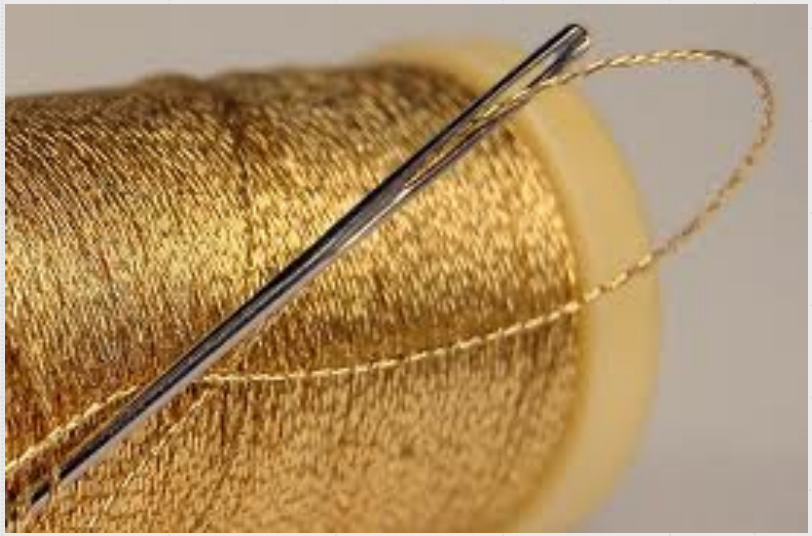
(TheraPlatform, 2023)

The Golden Rule

If it is not documented, it did not happen.

The Golden Thread

The common thread that runs through your documentation. It is the tie that binds together your clinical observation, assessment, intervention, and plan.

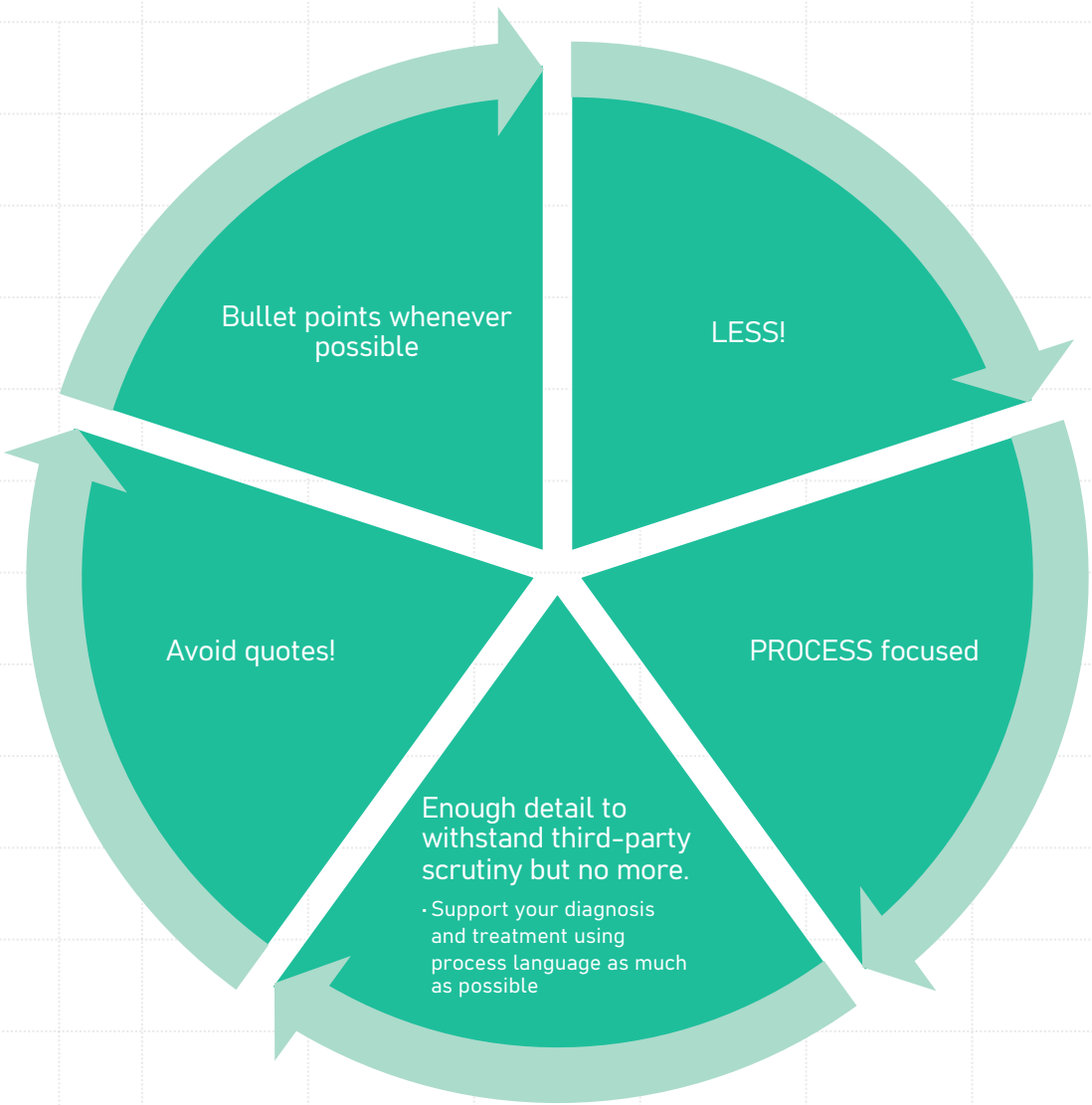


Process > Content

Process focuses on the client's symptoms/problem, the counselor's assessment/interventions, the client's response to interventions, and the plan. Client's are better served/protected when progress notes focus on the process.

Content gets bogged down in the details, may overly use quotes, easy to loose focus of process when lost in content. Content should be vague when possible for progress notes.

(TheraPlatform, 2023)



What makes a thin note?

Examples

(TheraPlatform, 2023)

Client and Session Content	Clinical Note Documentation
Client shares they drank heavily after three months of sobriety. You help them explore what happened in that moment.	Client reports relapse after three months due to recent stressors. Engaged client in identifying triggers and safety planning to support ongoing sobriety.
Client refuses to participate in therapy, stating it's a waste of time. You try to better understand where they are coming from.	Client reports resistance to ongoing therapy. Engaged client in identifying needs for therapy and revised treatment goals to support attendance and progress towards goals.
Client appears depressed in session with observable behaviors of slouching, limited facial expression, and monotone speech. You want to capture how they present in the room.	Client was observed to be depressed in session, as evidenced by slouched speech, flat affect, and restricted animation and speech.
Client and mom are fighting in the session, yelling at one another and reacting defensively. You facilitate processing to regulate their emotions and support connection.	Client and MOC were observed to engage in conflict in response to miscommunication. Engaged client and MOC in healthy communication skills including reflection and active listening to support emotion regulation and to strengthen relationship.
Client discloses they were bothered by something you'd said last session. You ask them to share more to better understand.	Client demonstrated self-advocacy in session by requesting to revisit a former topic of discussion. Highlighted client strengths in communicating needs and explored structure to encourage supportive processing in future sessions.
Client reports struggling with a new relationship due to trauma flashbacks and feeling unsafe. You engage the client in exploring needs for safety and provide psychoeducation of trauma.	Client processed implications of trauma on current relationships including safety needs. Engaged client in exploring characteristics of healthy relationships including psychoeducation on self-sabotage, attachment, and fight/flight/freeze reactions in response to trauma.

Before: Verbose, Content-Heavy Note

Subjective: Client reported ongoing worry and anticipatory anxiety. They stated, “It is hard for me to get excited to go anywhere because I’m always expecting the worst.” They also noted extreme restlessness, muscle tension, and an average of 3-4 hours of sleep per night.

Objective: Client’s speech was rapid and rambling. Their thought processes were tangential. They frequently avoided discussing their anxiety by diverting to unrelated topics. They were fidgety throughout the session. Their mood was anxious with congruent affect. They denied and SI/HI or psychosis. They were oriented x4. Clinician conducted the GAD-7 assessment with the client and reviewed the severe score result of 18 with them.

Assessment: Client continues to experience severe symptoms congruent with their Generalized Anxiety Disorder diagnosis. Their frequent rumination, hypervigilance, physical distress, and worry are disruptive to their self-care, social life, and occupation. Clinician will continue to assess for the possibility of Social Anxiety Disorder given client’s previous mention of anxiety-related difficulties.

Plan: Client has made minor attempts to implement some of the coping skills discussed with Clinician but continues to present with an overall avoidance of deeper intervention for their anxiety. Client has not completed previously agreed upon homework activities. Clinician will continue to build rapport and trust with the client. Clinician will provide basic psychoeducation and teach mindfulness-based relaxation techniques. Clinician will introduce the model of CBT to help prepare the client for deeper work on their anxious cognitions, behaviors, and emotions.

After: Thin, Process-Focused Note

Client presented with anxious mood and reported ongoing worry.

GAD-7 administered; severe score discussed.

Focused session on psychoeducation and basic mindfulness techniques.

Client agreed to practice coping skills; will follow up on progress next session.

Key Features of the Thin Note:

- Uses bullet points
- Focuses on process (what was done, client's response, and next steps)
- Avoids unnecessary details and direct quotes unless clinically relevant
- Includes enough information for clinical and legal scrutiny, but no more

EHRs & Digital Documentation

SimplePractice

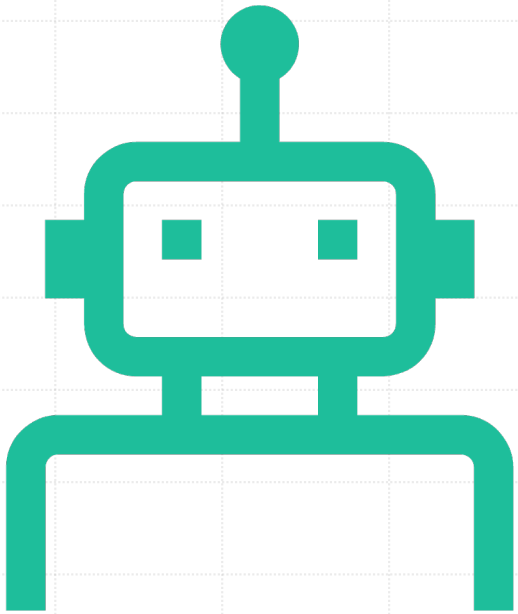
Therapy Notes™ TherapyNotes™

Jane™

Introduction to AI in Clinical Documentation

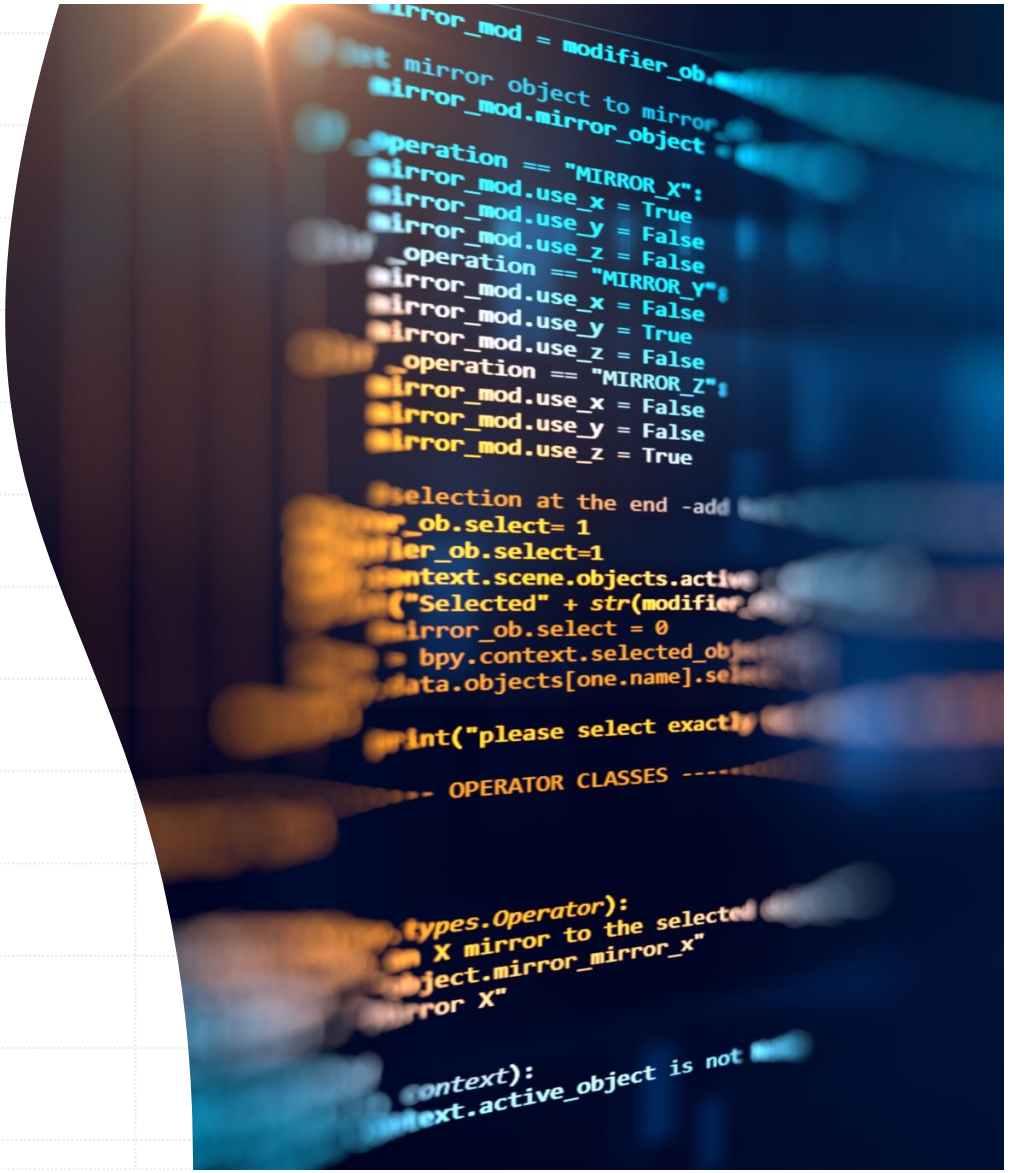
What is AI Documentation Assistance?

- Artificial Intelligence (AI) documentation tools **use speech recognition** and **natural language processing** to **transcribe**, **summarize**, and **structure** clinical session notes for counselors and therapists.
- These tools aim to reduce time spent on paperwork, standardize documentation, and help meet billing and audit requirements, but they are not “plug-and-play” and **require careful oversight** and **clinical review** (TryTwofold, 2025; Supanote, 2025).



What Can AI Documentation Tools Do?

- **Transcribe Sessions:** Convert audio from therapy sessions (in-person, or uploaded recordings) into written text.
- **Draft Progress Notes:** Automatically generate SOAP, DAP, BIRP, or custom-format notes from session transcripts.
- **Suggest Diagnosis and Codes:** Some tools prompt for ICD-10 codes or suggest diagnostic language.
- **Analyze Content:** Use sentiment analysis and keyword tracking to surface clinical themes or risk factors.
- **Integrate with EHRs:** Many tools can export notes directly to electronic health record systems, streamlining workflow.
- **Support Multiple Modalities:** Most platforms support individual couples, family, and group therapy notes (Supanote, 2025; TryTwofold, 2025; JotPsych, 2025).



How AI Works in Counseling

1. Session Input Collection

- The process begins with capturing session content. This can be done via:
  - Live audio recording (in-person or telehealth)
  - Uploading recorded audio
  - Manual text entry or dictation after session
- Most AI tools require clear audio and explicit client consent for recording (HealthOrbit AI, 2025; Blueprint, 2024).

2. Speech Recognition & Transcription

- Advanced speech recognition (ASR) technology transcribes spoken words into text in real-time or from uploaded files.
- Example: Tools like Mem and Supanote transcribe sessions with high accuracy (Mem.ai, 2025; Supanote, 2025).

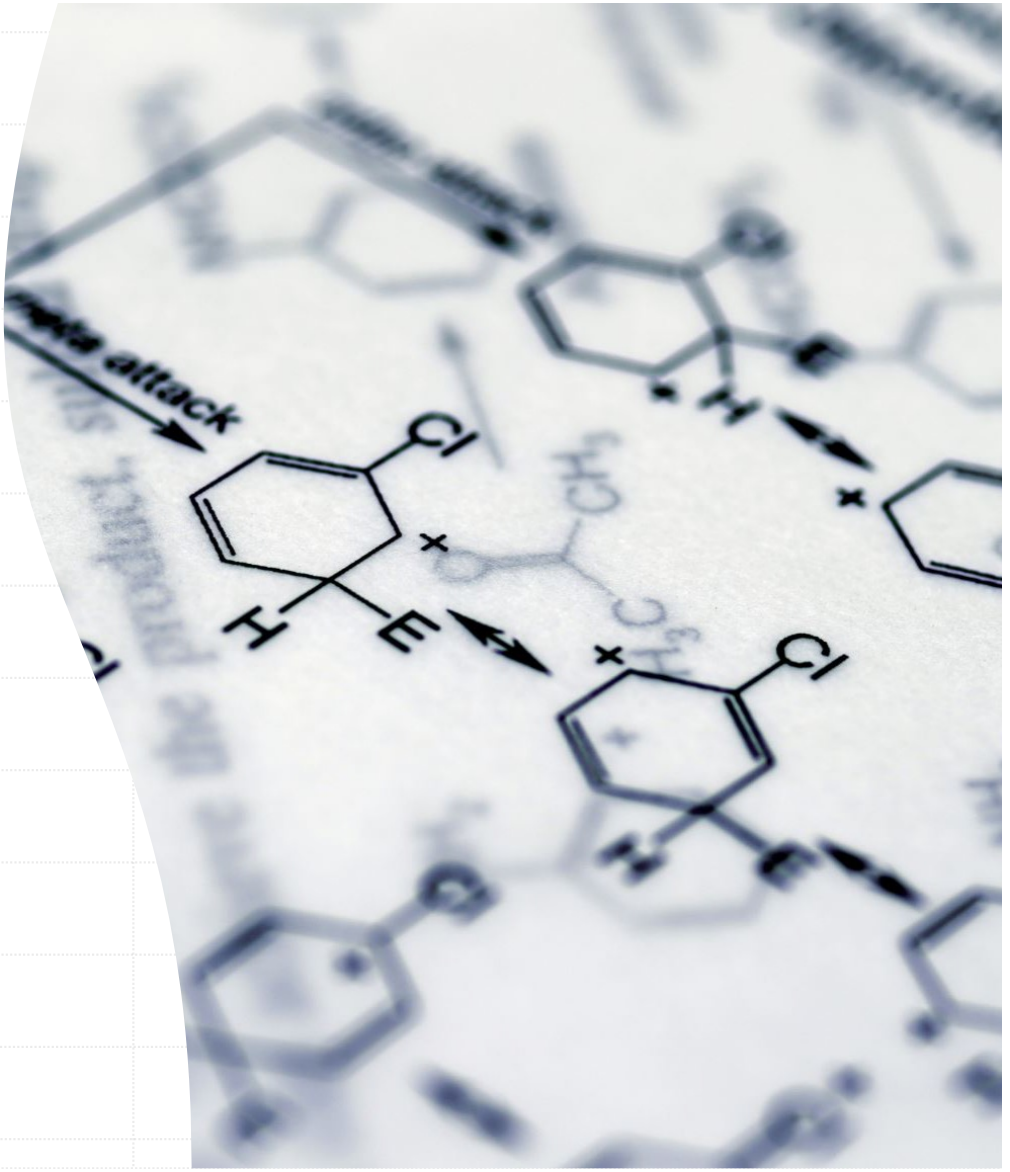
How AI Works in Counseling (continued)

3. Natural Language Processing (NLP) & Summarization

- NLP algorithms analyze the transcript, identify key clinical elements (e.g., symptoms, interventions, progress), and structure them into note formats such as SOAP, DAP, or BIRP.
- AI can summarize lengthy conversations into concise, structured notes, ensuring critical information is not missed (ClinicalNotes.ai, 2024; Blaze, 2025).

4. Contextual Analysis & Error Checking

- Some platforms use machine learning to detect inconsistencies, missing data, or suggest diagnostic codes and risk factors.
- AI can flag incomplete sections or prompt for additional details to support compliance (Mem.ai, 2025; HealthOrbit AI, 2025).



How AI Works in Counseling (continued)

5. Clinician Review & Editing

- The draft note is presented to the clinician for review, editing, and approval.
- **IMPORTANT:** ***The clinician is always responsible for final accuracy, ethical compliance, and ensuring the note reflects individualized care (Fulmer et al., 2021; Lustgarten et al., 2020).***

6. Export & Integration

- Finalized notes can be exported to Electronic Health Record (EHR) systems or downloaded in various formats.
- Many tools offer direct EHR integration, but manual copy-paste is sometimes required if systems are not compatible (Blueprint, 2024; Supanote, 2025).

Key Technologies Behind AI Documentation

AUTOMATIC SPEECH RECOGNITION (ASR):

CONVERTS SPEECH TO TEXT

NATURAL LANGUAGE PROCESSING (NLP):

UNDERSTANDS AND ORGANIZES CLINICAL CONTENT

MACHINE LEARNING (ML):

LEARNS FROM LARGE DATASETS TO IMPROVE ACCURACY AND SUGGEST RELEVANT CLINICAL ELEMENTS

Practical Considerations

Consent: Always obtain **informed consent** for recording or AI use (ACA Code B.6.b; Lustgarten et al., 2020).

Privacy: Ensure all data is encrypted and stored securely; verify **HIPAA** compliance and Business Associate Agreements (**BAA**) (Blueprint, 2024).

Review: Never rely solely on AI—clinician review is essential for accuracy and **ethical standards** (Fulmer et al., 2021).

Examples of AI Products Being Marketed

Product	How Notes Are Acquired	Notable Limitations in Acquisition Method
Supanote	Record live sessions, dictate, or upload audio/text; generate notes in multiple formats (SOAP, DAP, etc)	Requires clear audio for best results; manual upload needed for non-recorded sessions; not all therapy types equally supported
Mentalyc	Record sessions, describe session via voice or text, or manually enter details; supports diverse templates	Manual entry needed if session not recorded; voice-to-text can misinterpret accents or background noise
Upheal	Captures audio from in-person/telehealth sessions, creates transcripts and notes	Requires explicit consent for recording; live transcription accuracy depends on audio quality; may not support all EHRs directly
AutoNotes	Dictate speech-to-text or use customizable templates for manual entry	No live recording; relies on clinician to dictate or type after session; less efficient for real-time documentation
Blueprint	Listens to sessions, transcribes, and generates notes; integrates with EHRs	Requires reliable internet for live transcription; potential lag in real-time environments

AI Features in Leading EHR Documentation Platforms

Platform	AI Feature(s) (2025)	Description/Capabilities
SimplePractice	AI-powered Note Taker (beta), ambient listening, time-stamped notes	Transcribes sessions, drafts SOAP/DAP notes, integrates with EHR, user review required
TherapyNotes	TherapyFuel™ AI, Consent for Use of AI form, coming soon: TherapyFuel Scribe	Generates progress notes from summaries, drafts SOAP fields, ambient listening in beta
Jane App	AI Scribe, Voice-to-Chart, ScribeHealth integration	Transcribes recordings into SOAP/custom notes, browser extension for live scribing

What Does “HIPAA-Compliant” Really Mean?

HIPAA compliance refers to **following the rules** set by the Health Insurance Portability and Accountability Act (HIPAA) for protecting patients’ protected health information (PHI).

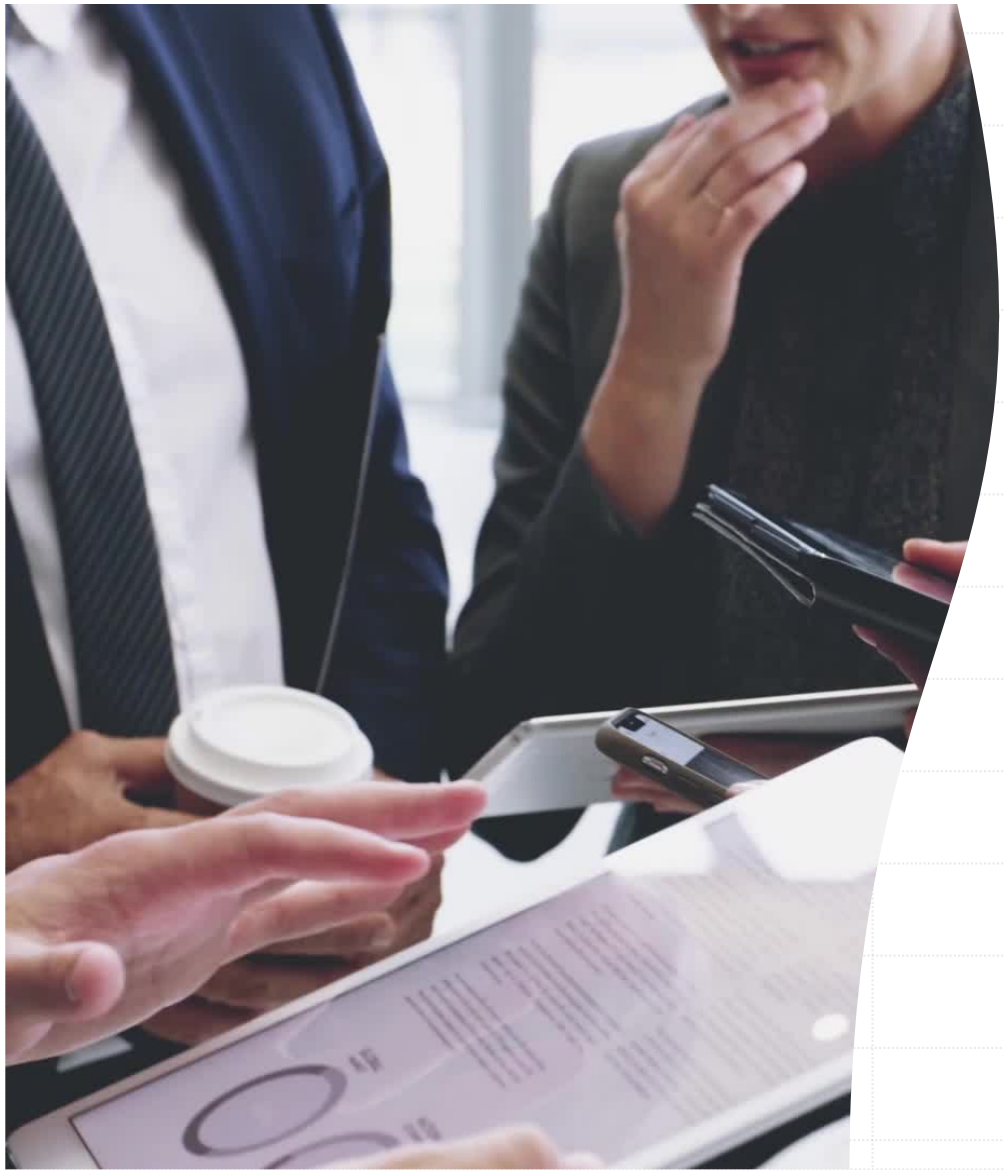
However, there is no official government certification or seal for HIPAA compliance. The U.S. Department of Health and Human Services (HHS) does not recognize or issue any “HIPAA certification” for companies, products, or software. Any company can claim to be “HIPAA-compliant” in its marketing, but this is **not a regulated or verified status**.

Why Are BAAs (Business Associate Agreements) Essential?

- A **Business Associate Agreement (BAA)** is a legally binding contract between a healthcare provider (the "covered entity") and any third-party vendor (the "business associate") that will access, process, or store PHI on the provider's behalf.
- **HIPAA** requires that covered entities *must* have a signed BAA with any vendor that handles PHI. This contract spells out each party's responsibilities for safeguarding PHI, reporting breaches, and complying with HIPAA privacy and security rules.
- Without a BAA, using a vendor—even one that claims to be "HIPAA-compliant"—puts you at **risk of violating** federal law, ethics, and facing significant fines if there is a breach.

Why Is “HIPAA-Compliant” Not Enough?

- Marketing claims alone are not sufficient. Many AI documentation tools and cloud services advertise themselves as “HIPAA-compliant,” but this is **NOT A GUARANTEE** of legal compliance or security.
  - **REMEMBER: No official certification–**There is no government or third-party body that certifies a product or company as HIPAA-compliant. HHS only cares about whether your actual practices and agreements meet the law’s requirements.
- **YOU ARE RESPONSIBLE:** If you use a vendor without a BAA and there’s a data breach, you (the provider) are liable—even if the vendor advertised itself as “HIPAA-compliant”



Would You Approve This AI Note?

Scenario 1

- ***Assessment:*** *Client presents with symptoms consistent with Major Depressive Disorder. Recommending antidepressant therapy.*
- **Background:**
  The client lost her mother three weeks ago, expresses sadness, but shows no suicidal ideation, maintains daily functioning, and reports support from friends.

Poll:

- Approve as written
- Edit before approving
- Reject and rewrite

Would You Approve This AI Note?

Scenario 2

- **AI Note Excerpt:**
  Objective: Client denied suicidal ideation. Plan: No safety plan needed.
- **Background:**
  You recall the client hesitated when asked about safety and you discussed a safety plan, which the AI note omits.

Poll:

- Approve as written
- Edit before approving
- Reject and rewrite

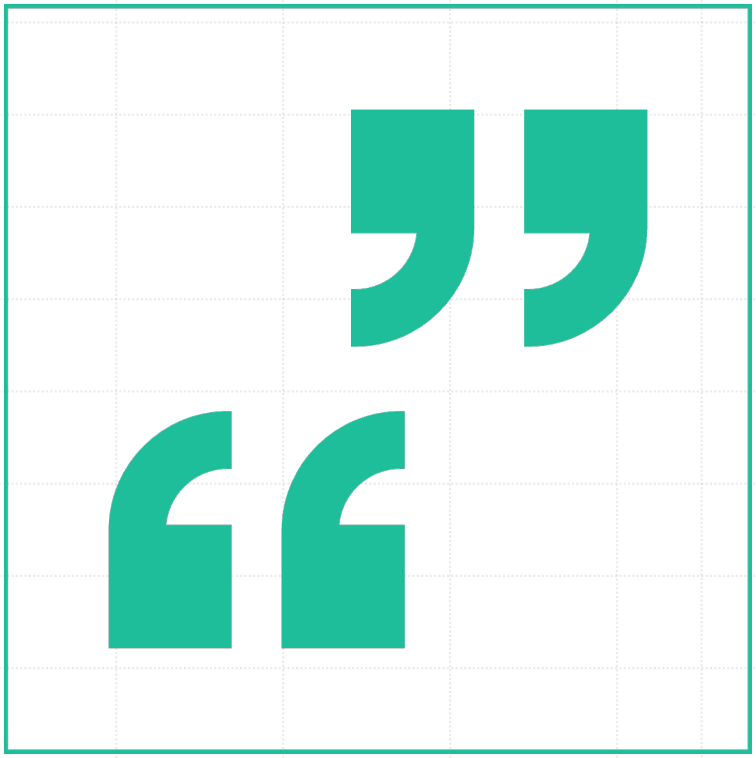
Would You Approve This AI Note?

Scenario 3

AI Note Excerpt:
Subjective: Client disclosed details of a recent affair, including the partner's name and workplace.

Poll:

- Approve as written
- Edit before approving
- Reject and rewrite



Key Takeaways about AI notes

AI-generated notes can contain errors, omissions, or privacy risks—even when they appear polished and authoritative.

Always review, edit, and take responsibility for documentation. Never approve AI-generated notes without careful scrutiny.

Accurate, process-focused, and confidential documentation protects clients, clinicians, and the therapeutic process.

Clinician-Created Templates Are the Safer, Streamlined Choice

1. **Security and Ethical Control**

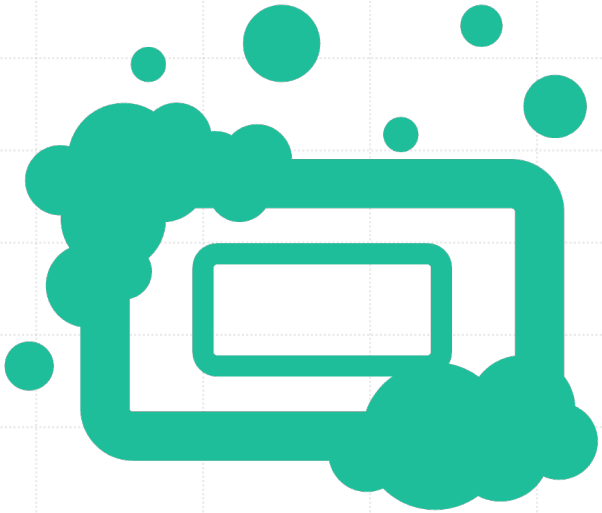
- No digital recordings/third-party AI involvement: Templates you create and use yourself keep all client information within your secure, HIPAA-compliant EHR or paper system, reducing privacy and breach risks.
- You control the content: Only necessary, process-focused information is included, supporting ethical standards (ACA Code B.6.a, B.6.b).
- No risk of AI "hallucinations" or misinterpretations: Your clinical judgment drives the note.

2. **Streamline Documentation Without Sacrificing Quality**

- Templates standardize your workflow: Pre-formatted templates (SOAP, DAP, BIRP) help you quickly capture all required elements, reducing cognitive load and minimizing errors.
- Thin Notes focus on process: Include only what's essential—symptoms, interventions, client response, and plan—using bullet points and minimal details unless clinically necessary.
- Templates can be customized: Tailor them to your specialty, client population, or session type for maximum relevance and efficiency.

How to Create Your Own Thin Note Template

1. **Choose format**
   - SOAP, DAP, EMDR, etc
2. **Identify required elements** (intake-informed consent/cancellation policy, safety assessment, telehealth location, etc.)
   - Emphasize PROCESS over content – avoid unnecessary details or direct quotes unless essential
3. **Draft template**
   - Keep library of 2-4 templates available (intake, progress, crisis, group, etc)
4. **Customize for your practice**
   - Encourage clinicians to add or remove sections as needed



Tips for Success with Thin Note Templates

Start	Edit	Keep	Store
Start with a reference note: Compare your template to a high-quality example you or a colleague have written.	Edit as you go: Don't worry about perfection—refine your template based on what works best in your daily practice.	Keep it consistent: Use your chosen template for every session to build speed and reliability.	Store securely: Use only HIPAA-compliant EHRs or locked paper systems for your templates and notes.

(Powers, 2023)

Process/Psychotherapy notes

- Better handwritten – no digital footprint
- Leave out any identifying info
- Code client names, date record
- Keep these very slim (i.e. words to jog memory, short sentences designed to prompt memory)
- These can help jog your memory for completing progress notes after sessions

References

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