Appendix F: Progress Notes and Psychotherapy Notes

This Appendix covers two kinds of notes written about psychotherapy—progress notes and psychotherapy notes—and highlights the practical value of this important distinction. Progress notes are part of the client record or file, as noted below. Psychotherapy notes are not part of the file. After an overview of the client file or record, the difference between these two kinds of notes is discussed along with guides for writing progress notes.

The Client File or Record

The record or file of a client's treatment at the Clinic consists of:

- Contact information
- Informed consent for treatment (including notification of rights)
- An intake report and/or,
- A written treatment plan or case formulation based on an initial assessment (i.e. interview information, formal assessment if used, and any other information collected from other sources)
- Progress notes documenting treatment, filed in reverse chronological order on the Clinic form *Progress Note*
- A termination note when work is concluded
- Other materials such as releases of information, test protocols, information obtained from other sources and so forth.
- The file or record does not contain *psychotherapy notes* (see below). Another way of saying this is that if it's in the file, it's not a psychotherapy note.

As context for progress notes versus psychotherapy notes, please also refer to the form in Appendix D *Brief Summary of Client Rights to Privacy and Access to Records and Consent to Behavioral Health Treatment* and to the document in that appendix entitled *Protecting the Privacy of Your Behavioral Health Information.*

A general intake outline is contained in Appendix C-4 *Intake Outline and Report* which can serve to organize information and begin treatment planning. Treatment planning will, to some degree vary by supervisor and may be organized around a diagnosis, a problem list, a set of treatment goals or a listing of directions for therapy. Therapy notes (either progress notes or psychotherapy notes) may be easier to write and later to interpret if written toward a good treatment plan.

Progress Notes versus Psychotherapy Notes: A Key Distinction.

Psychotherapy notes. Over the years, clinicians have debated about whether it was permissible to maintain a second set of notes which was not available to anyone except the therapist. One of the few substantive changes brought about by HIPAA is that psychotherapy notes are defined and are protected from normal release to the client, the courts or anyone else. This distinction is sufficiently important that the clinician should be familiar with the language of the federal regulation:

> *Psychotherapy notes* means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. 45 CFR 164.501.

A later section (45 CFR 164.524) gives individuals almost unlimited access to their records, but specifically excludes psychotherapy notes as defined above.

The key elements of this definition and its use are that psychotherapy notes:

- Are produced by a mental health professional
- Are separated from the rest of the medical record
- Don't include the basic treatment and record-keeping that goes in a standard progress note, and
- Are not open to disclosure to the client or anyone else.

Progress notes. Progress notes, then, are notes that are part of the regular file maintained in the Clinic. Because many of the functions of notes for the purposes of the treating clinician can be accomplished through psychotherapy notes, progress notes content can be kept to minimum. The following kinds of information go in a progress note (further guidelines and examples appear below).

- counseling session start and stop times,
- medication prescription and monitoring
- the modalities and frequencies of treatment furnished,
- results of clinical tests, and
- any summary of the following items:
    - Diagnosis,
    - functional status,
    - symptoms,
    - prognosis, and
    - progress to date.

Who Is The Audience?

In any writing project, the first and most important question is "who is the audience?" Throughout the writing process, one must step back occasionally and hear what is written using the ears of the potential audience(s). Often, as with the notes we'll be discussing here, there will be multiple audiences and you must keep each of them in mind while writing. Here is a listing, intended to be in order of likelihood, of those who will see and use progress notes:

- You, the therapist, will look back at the notes as needed in the course of treatment.
- The client or patient may want to look at the notes and the contents of the file and has this right under New Mexico guidelines and HIPAA regulations
- Another therapist who picks up the case at the Clinic or in another setting (with appropriate release of information).
- An evaluator for another agency may review therapy notes, again with the client's permission
- An attorney representing your client or (perhaps more importantly) an opposing attorney in a legal proceeding (this may be by release of information or through a "hidden permission" in a law suit claiming damages for "pain and suffering"—see the Clinic's document *Protecting the Privacy of Your Behavioral Health Information).*

These various potential readers of your notes create different concerns and expectations for the contents of your notes. What will be most useful to you in the future may very well not be what you would want your client to read and a note that works for you and your client may not be something you'd want in the hands of a attorney hostile to your client's interests. You won't know as you write which audience will see your notes, but need to keep in mind that you are writing for these different readers.

This is not, in practice a difficult task. First, keep in mind that your task in a *progress note* is to document that reasonable work occurred toward the goal of helping the client with her or his issues. Your note can be brief; to the extent that you can relate that day's work to treatment issues and methods you've defined previously in a treatment plan, the easier your documentation will be. Keep track of significant events—changes in medications, life events, names of important people that come up—that you will want to be able to easily reference in the future. As noted in the formats described below, include brief assessments of the client's status and progress as appropriate and remind yourself of plans you have for future sessions (homework assignments, topics to follow up on).

Leave longer thoughts, queries and reflections for your psychotherapy notes. The advantage that psychotherapy notes give us is that you can record any hypotheses, personal reactions, doubts, possible interpretations, supervisory recommendations, etc. in a form that will be maximally useful for you.

Where Are The Two Kinds Of Notes Kept?

In general, progress notes will be written immediately following a session and will be kept in reverse chronological order in the client's file locked in the appropriate drawer in the Clinic. The client's file may be removed only for purposes of writing and reviewing notes and replaced when you are finished. Supervisors will

come to the Clinic to review files periodically (at least each semester). If an occasion arises in which you want to remove the file from the Clinic, you need permission of the Clinic Director and need to put a check-out card where the file was so that staff know it is out. If you are in possession of a file, you are responsible for maintaining its confidentiality—keep it in your possession or keep it in a secure place.

Psychotherapy notes *must be kept separate* from the main file. That could be in a different locked drawer at the Clinic (but never in the top drawer where active files are kept). It is likely that these are the notes you'll want with you for supervision and preparation for sessions, so you may keep them in your possession. If so, you must assure that confidential information is protected by securing these files in your home or office. Each clinician should develop habits and methods of protecting confidential information, for instance, psychotherapy notes and testing files that you may want in your possession and care outside the Clinic building.

A note regarding assessment files is in order at this point. You may be keeping assessment materials with you for scoring and writing outside the Clinic. The safest way to preserve confidentiality and secure the file is to keep name identification out of the file until you finalize it in a report. Then secure the original file and all materials at the Clinic.

Styles Of Progress Notes

The following are some suggestions for the content of progress notes:

1. Use the Clinic's standard Progress Note form (Appendix F-2) to provide the basic information about who was seen when by whom, for how long and for what purpose. Payment is recorded on this form as well in addition to the receipts filled out for the client and the Clinic.
2. The note may be brief but should include a description of the major events or topics discussed, specific interventions used, your observations and assessment of the client's status, and any plans you may have for the future.
3. It is not necessary that these notes be extensive. In fact, in future practice when time is of the essence, brevity and capturing the essence of the treatment in a session will be necessary. Two examples of structured systems for progress note writing are listed briefly below with references to more complete descriptions.

Compared to psychotherapy notes. By their nature, psychotherapy notes can be in any form that is useful to you and need not be readable by others (e.g. use of your own personal shorthand is acceptable). Think of psychotherapy notes as a form of self-consultation and preparation for supervision. It is here that you may feel free to detail what happened in a session in order, put your thoughts and feelings about what was going on, list hunches and hypotheses to explore further, and write questions to bring up with your supervisor. You may also want to jot notes from your supervisory session that you want to include in your thinking for future sessions.

D(R)AP format for progress notes. In hospital settings, the most common guideline for notes is the SOAP format (Subjective, Objective, Assessment, Plan) described briefly below. Many practitioners have found the SOAP format awkward or forced for recording progress in psychotherapy. The preferred format for notes at the Clinic uses the acronym DAP (Description, Assessment and Plan). Baird (2002) suggests a similar format and his thoughts on clinical documentation are useful. In a typical therapy session, a client may bring up two or three therapy-significant events or issues or describe the activity of carrying out a homework assignement. Each may be briefly documented in the DAP format.

Description, as Baird elaborates, provides information as to who was involved, where, and when a significant event occurred. It could also be a description of an issue of personal importance discussed by the client and how they experienced the event. A description could also be the way a client carried out an assignment and the difficulties or success they experienced. Baird includes a separate section (R for Response) for what the clinician does in response to the client's issue. We recommend that clinician behavior be woven into description.

Response (per Baird) is what you did after listening and observing and reflecting on what the client brought to the session. This may be an interpretation offered, a clarification, information given, a homework assignment, a challenge to narrow thinking about an issue, formal problem solving around the event, empathetic/supportive behavior on your part, functional analysis of a situation, a normalizing comment, or whatever is appropriate from the therapeutic conceptualization you are using. If the situation is a serious one involving detailed

assessment of danger or legal issues, you would document what you did in whatever detail is necessary to show that you attended to the issues involved.

Assessment is your understanding of what the event means if you know. Baird recommends thinking about how the event or behavior relates to precipitating factors, to previous behavior, to other events in the client's life, to the treatment plan. The important part of this aspect of your thinking and writing is your reflection on the events in the client's life in terms of treatment. Assessment may also record your observations about the client's physical or emotional state and such factors as severity of symptoms, riskiness of behavior, dangerousness, suicidality and so forth
.

Treatment Plan is your plan for future treatment. Baird notes that this may be as brief as "Scheduled for next Wed". If you give homework assignments or want to note topics to follow up on or actions to take before the next session, they can be entered here as reminders.

Examples of DAP notes are given on the Clinic website.

SOAP format notes. SOAP is an acronym for Subjective-Objective-Assessment-Plan and is a part of Problem Oriented medical records developed by L. L. Weed (see Cameron and Turtle-song, 2002 on the Clinic webpage for a fuller description). This method was developed in the medical setting to standardize entries in the patient file (e.g. S(ubjective): "Patient complained of …"; O(bjective): Blood pressure, lab results, results of physical examination; A(ssessment): clinical diagnosis of symptoms; P(lan): prescriptions, treatments recommended, etc.). In psychology practice, Assessment and [Treatment] Plan are similar to what Baird describes.

The SOAP format is widely used especially in hospital settings and is required in some agencies for psychological and psychiatric progress notes as well as medical notes. But some have noted (e.g. Baird, 2004) that the format it may become arbitrary or rigid, for instance, what material goes in which section. It is especially difficult in psychotherapy to sort out what is objective and what is subjective and the meaning of events may be lost. Student-clinicians may find this format useful, however, and examples are given on the Clinic website.

Unformatted notes. Clinicians may write notes in a less or differently structured fashion, such as integrating Baird's sections in a narrative form, providing a chronological sequence of events in a session (process notes) or referring notes to specific issues in the treatment plan. The above discussion, and additional reflection on one's own treatment approach, may stimulate the student to develop their own format for notes that better suit their method and style. Students are encouraged to discuss with their supervisor approaches to progress notes.

Psychotherapy Notes: Reprise

The greater protection provided to psychotherapy notes by HIPAA regulations may allow student-clinicians greater latitude to abbreviate their progress notes and expand on the reflection, reactions, thoughts and feelings that may safely be recorded in psychotherapy notes. To return to an earlier theme, the primary audience for psychotherapy notes is yourself: your client acknowledges in the Clinic's consent for treatment that such notes may be kept and are not available for client inspections. This allows you greater freedom to reflect on difficulties, hunches and questions and make these written reflections a greater learning experience in the context of your supervision.

Suggested Readings

Baird, B. N. (2004) *The Internship, Practicum, and Field Placement Handbook: A Guide for the Helping Professions* (4th ed.). Prentice Hall

Cameron, S. & turtle-song, i. (2002) Learning to write case notes using the SOAP format. *Journal of Counseling & Development, 80*, 286-292.

Wiger, Donald E. (1999) *The Clinical Documentation Sourcebook: A Comprehensive Collection of Mental Health Practice Forms, Handouts, and Records* (2nd ed.). Wiley.

Zuckerman, E. L. (2005) *Clinician's Thesaurus: The Guide to Conducting Interviews and Writing Psychological Reports* (6th ed.). Guilford Press.