Willer, J. (2009) The beginning psychotherapist's

Chapter Thirteen

Progress Notes and the Chart

Writing a good progress note is an essential professional skill. If you ever are accused of malpractice or need to make a deposition or your notes are subpoenaed for any reason, good progress notes will save you from professional embarrassment and worse.

PROGRESS NOTES AND THE STANDARD OF CARE

Julie Chen is a mental health trainee who is working for a group practice that treats high-functioning clients. She sees a marital case that ends in divorce. After the case is closed, the husband leaves her a number of threatening messages demanding that she return the fees he has paid the practice. In consultation with her supervisor and the practice's lawyer who specializes in mental health issues, she does not return the calls or the fees. The husband files suit against the group practice for malpractice, and the case goes to trial. It turns out that Julie has not maintained any progress notes after the initial session, nor did she document the threatening phone calls. She is not certain of the dates of the sessions, either, as the practice collected some payments in cash and the records are muddled. Julie's supervisor did not review Julie's (lack of) written documentation for the case contemporaneously. In court, Julie's verbal report of her treatment of the couple is found to be up to professional standards, but her supervisor and the practice are found negligent because of Julie's lack of appropriate professional record keeping, and the husband was given a substantial monetary award.

Zachary James is a mental health trainee working in a pain clinic. He runs many treatment groups together with his supervisor and does evaluations of

pain patients. He is very busy and procrastinates writing the progress notes that his supervisor has assigned to him. An internal review of documentation found that Zachary was behind on group therapy notes by 6 weeks. Both Zachary and his supervisor were written up by the review committee for providing an inadequate standard of care. When his supervisor insists that he complete the documentation, Zachary is able to deduce what psychoeducational information he presented from his files but is embarrassed to admit that he no longer remembers any personal issues that the group members brought up in the sessions 3 to 6 weeks ago.

Progress notes should always be written on the day of interaction or the following day. Your memory will fade if you postpone the note more than 1 day after the session. Even better, organize your schedule to write your progress notes immediately after each session so that you don't forget important details (Cameron & turtle-song, 2002). Remember, from a legal perspective, "if it isn't written, it didn't happen" (Gutheil, 1980).

Follow the record-keeping standards and guidelines advocated by your professional association. As indicated in the previous vignettes, no matter what you did in the session, if you don't chart the session, you are providing an inadequate standard of care.

THE USES OF PROGRESS NOTES

Keep in mind that there are many potential audiences for the progress notes you write: (a) you, who may need to look back on what you've done; (b) other members of the treatment team; (c) emergency coverage clinicians; (d) reviewers, such as insurers and utilization and quality assurance reviewers; (e) the legal system; and (f) the client (Gutheil & Hilliard, 2001). If the care of your client is ever transferred to another clinician, the notes will be an invaluable source of information about the client's progress.

ELECTRONIC CHARTS

In many facilities, there is now an electronic medical record (EMR) available. If your site uses an EMR, your supervisor can educate you in how to use the EMR software and to sign the note electronically. An EMR allows for improved documentation since notes are always legible. However, with an EMR system in a medical center, psychotherapy notes may become part of the general medical record, so you should determine whether other clinicians throughout the facility will have ready access to them.

With an EMR, you can contribute to improved continuity of care. It is wise to skim all the recent progress notes, including your own, before seeing the client. If there are any emergent psychological issues, even if brought up by a different clinician, the EMR can inform you and you can address them as needed with the client. With an EMR, be aware that other clinicians will be reading your notes and be especially mindful of the level of detail. Since other clinicians can easily see your notes in your setting, you might add more detail that could be helpful to them:

> Instead of this: "Ms. R stated that she was having problems with her medication; I suggested that she call her psychiatrist."
>
> You might write this: "Ms. R stated that she was having dizziness, nausea, and headaches. She believes that this is due to her medication. I suggested that she call her psychiatrist."

The second note would be much more helpful to your psychiatrist colleague.

Occasionally, everyone will make errors when charting. If you have an EMR at your facility, it is unlikely that you will be able to change notes after they are signed. If you mistakenly put a note in the wrong chart, talk to the computer experts to see if the note can somehow be made unreadable. If you have made an error in a note, you can probably put an addendum onto your previous note with the new date and the corrected information.

PAPER CHARTS

Make an effort to write legibly in a paper chart. On each new blank page, write or stamp the client's full name, date of birth, and any numerical identifier. When you are signing a paper note, sign with your first initial or first name, your last name, and your degrees (if any). Add your title underneath your name. If your signature is not legible, I recommend that you print your name underneath the signature. As a trainee, your supervisor should be reviewing and cosigning all your notes, so leave space for the supervisor's signature below yours. Do not include any blank lines inside the body of the note or between the end of the note and your signature.

Write with black pen only in a paper chart. Black pen makes better photocopies than other colors. Do not use felt pen, as it can smear if something is spilled on the chart, or pencil, which is legally problematic because of its ease of erasure (Cameron & turtle-song, 2002).

If you make an error in a paper chart, ensure that your corrections are not done in a way that would arouse suspicion of inappropriate alteration of the

chart should the chart ever be reviewed in a court of law. Cameron and turtle-song (2002) suggest the following: "Never erase, obliterate, use correction fluid or in any way attempt to obscure the mistake. Instead, the error should be noted by enclosing it in brackets, drawing a single line through the incorrect word(s), and writing the word 'error' above or to the side of the mistake. The counselor should follow this correction with his or her initials, the full date, and time of the correction. The mistake should still be readable, indicating the counselor is only attempting to clarify the mistake not cover it up" (p. 291).

CONTENTS OF THE CHART

There is no definitive list of information that should be included in a client's chart (Moline, Williams, & Austin, 1998). However, here is a helpful list of chart items compiled from various sources (Moline et al., 1998; Rivas-Vazquez, Blais, Rey, & Rivas-Vasquez, 2001). This first list is comprised of documents that the psychotherapist would generate or gather from the client:

- Intake forms filled out by client (if required)
- Informed consent form, including legal limits to confidentiality (if there is no written form, the first progress note should document discussion of these issues)
- HIPAA (Health Insurance Portability and Accountability Act) form
- Mental health insurance company, policy number, and phone number
- Initial note that includes the following:
  - Referral source and reason for referral
  - Identifying data, including name, phone number (work and home), date of birth and age, gender, ethnicity, physical description, marital status, occupation, school or education, children living with client (ages and names), and other persons living with client (ages, relationship to client, and names)
  - Background/historical data
  - Functioning level, adequacy of coping, social support, and strengths
  - Diagnosis and prognosis
- Release of information forms that you and the client generate (make a copy to send out and keep the original in the chart)
- Treatment plans
- Progress notes, cosigned by a supervisor if you are being supervised
- Termination summary

If these items come to you from the client or other sources, they should also be included in the chart:

- Release of information forms sent from other health care professionals
- Any legal documents pertaining to the client, such as subpoenas
- Any correspondence, writings, or drawings given or sent to you by the client
- Printouts or electronic copies of any e-mails sent between you and the client containing any clinically pertinent information
- Communications sent to you by other professionals regarding the client
- Chart information that other sites sent you in response to a release of information
- Any questionnaires administered to the client
- Any other documents pertaining to the client

A separate chart should be opened for each client being treated, even if they are being treated jointly in marital or family therapy. This preserves the confidentiality of each family member. Many clinicians use abbreviations in the chart, and many common mental health abbreviations are listed in appendix 17. However, note that some experts recommend that no abbreviations be used because of the possibility of confusion or misinterpretation (Simon, 2004).

FORMAT

Arun Singh is a mental health trainee practicing at an outpatient clinic. He treated a client, Kenneth Lewis, for 2 years for adjustment disorder and relationship problems. About a year after therapy is terminated, Kenneth is arrested for murdering his girlfriend, which he had done during the period of treatment with Arun. Arun's progress notes are subpoenaed, and he is required to testify at the murder trial. The defense is claiming that Kenneth is not guilty by reason of insanity. Arun was not aware of the murder at the time. He is anxious about testifying but knows that he had thoroughly documented the client's stability at each session. The fact that Kenneth was emotionally stable throughout the treatment turns out to be a crucial piece of evidence.

This vignette illustrates the importance of documenting an assessment of the client at every psychotherapy session. For that reason, I always write progress notes in the SOAP (Cameron & turtle-song, 2002) or DAP format. The sections for this type of note are as follows:

- S/O is an abbreviation for "subjective and objective," which are generally combined into one section, or you can use D for "data" instead:
  - Subjective is what the client says.
  - Objective is what you observe about the client; include any significant behavior.

  - This section should include any interventions that you have made and how the client responded.
  - You should also include any advice that you gave to the client and the client's response. ("I advised the client not to drive after he had consumed more than two drinks, and the client stated that he understood the risks and agreed that he would call a cab on those occasions.")
  - These two are generally combined into one section by most clinicians but can be written separately.
- A is an abbreviation for "assessment," which includes the following:
  - Whether the client is stable today
  - If the client has been struggling with emotional stability, a statement about whether the client is worse or better than the previous session
  - Any important emotional tone to the session
  - Any risk management evaluations you had to make in this session
- P is an abbreviation for "plan," which includes the following:
  - Any homework you have given the client (e.g., "Mr. F agreed to keep a sleep diary over the next week.")
  - Any important steps the client states he or she will accomplish by next week (e.g., "Ms. G agreed to go to an Alcoholics Anonymous meeting tomorrow.")
  - Any referrals that you have made and how they will be accomplished (e.g., "Mr. R agrees to contact his internist to be evaluated for his chronic headaches.")
  - Anything you will be doing to manage the case between now and then (e.g., "I will fax release of information to Dr. Q.")
  - Issues or interventions to consider for the next session (e.g., "Ms. K brought up her frustration with her best friend at the end of the session. We agreed to discuss this next week.")
  - When the client will next be seen.

This progress note format forces the clinician to remember to include the assessment and the plan after each session. These crucial bits of information are often forgotten by clinicians who do not use this format. As you can see from the vignette, this information can be crucial if the notes are ever involved in litigation or in any internal review.

Progress notes should be well organized and easy for other clinicians to skim. Put different topics (e.g., depressive symptoms, anxiety symptoms, and family history) in separate paragraphs. Use simple, clear topic sentences, even if it seems a bit repetitive: "Ms. K. displayed numerous symptoms of depression."

TONE

Progress notes should be neutral and professional in tone. Avoid any implied criticism of the client or of any other clinician. It is most respectful to refer to adult clients in the notes by their title and last name, such as "Ms. Rodriguez," or you can abbreviate this as "Ms. R."

Never make negative comments about the client or observations about the client in the chart that could be seen as value laden or overly opinionated (Cameron & turtle-song, 2002; Gutheil, 1980). Here is an example:

> Wrong: "Ms. S. was very manipulative again today. She was making her typical suicide threats in order to get more attention from the staff on the inpatient unit."
>
> Right: "Ms. S. made suicidal statements on the unit today. However, on questioning, she denied any active suicidal intent. We discussed how she might verbalize her requests for help in a more prosocial manner."

I appreciate Gutheil's (1980) suggestion that, while writing progress notes, you always imagine that there is a hostile lawyer looking over your right shoulder and imagine how the lawyer might belittle you in court. I would add to this advice that you should also imagine that the client is looking over your left shoulder, ready to take offense at any tactless or careless remark you make in the chart that would lead to therapeutic disruption.

CONTENT

Chaniya Wilson is a psychotherapy trainee working in an outpatient clinic. The clinic is part of a large academic medical center that requires all clinicians to post progress notes in the EMR (electronic medical record). She is seeing a client, Teresa Baker, who has borderline personality traits. One week, Teresa comes into the office in a rage, brandishing a printout of her progress notes. She has marked what she deems to be inaccuracies in red ink throughout the notes.

Progress notes document whether the psychotherapy is appropriate and effective, and they are a tool to help keep psychotherapy on track. Document the client's emotional status and symptoms. Document the issues that were addressed. Use the progress notes to remind yourself of the homework assigned to the client the past week. If you make treatment recommendations, note whether the client agreed to comply. Note any plans that you have for

the next session. It is wise to establish the habit of reviewing the recent chart notes before each session, as this will help you keep track of your client's progress, any homework you gave, and the goals for the client's treatment.

Progress notes should include an appropriate amount of detail. Major topics that were discussed during the session should be noted, but the details of the discussion are generally unnecessary, unless there is a crisis. Keep in mind that malpractice attorneys say, "If it isn't written, it didn't happen" (Gutheil, 1980), so anything of clinical importance must be documented. Here are some examples:

> Too much detail: "Ms. B came in upset and said that she had another fight with her brother. He said something that she thought was insulting, then she yelled at him, then they had a shoving match again, and he called her a 'bitch on wheels.' She said that she hates him. After some discussion, she calmed down and was able to hear some input about how to talk to her brother more effectively."

> Right level of detail: "Ms. B discussed interpersonal conflict with brother. We worked on effective communication skills."

Many psychotherapists have extensive training in how to interpret the meanings of the interactions between the therapist and the client. We call this "process." The actual topics discussed are referred to as "content." Progress notes should stick to documenting content and behavior and should avoid process (Gutheil, 1980). Do not document hypotheses, dynamic issues, suppositions, or interpretations. The vignette at the beginning of this section indicates one of the benefits of keeping your notes focused on content. Another example might clarify:

> Instead of writing: "Ms. N took her shoes off and put her feet up on the couch during the session. This unusual behavior symbolizes a crucial attachment change regarding her relationship with the therapist."

> You might write this: "Ms. N took her shoes off and put her feet up on the couch during the session. She had not engaged in this behavior during a session before."

As is implied by this example, it can be helpful to note any unusual behavior in the chart, even if its meaning is not totally clear. However, even if you think you know the meaning of the behavior, the meaning is usually not appropriate to write in the chart. Again, don't include speculations, psychodynamics, or clinical insights in the progress notes.

SAMPLE PROGRESS NOTE FOR INTAKE SESSION

7-5-20xx
90801

S/O. Ms. Ava Reid is a 26-year-old single White female who works as a waitress at Diner Z and attends community college classes. She lives by herself in an apartment; she has no children. She is tall and thin with straight medium brown hair and has a ring through her right eyebrow.

Ms. R reports a history of chronic depression with poor self-esteem, feelings of guilt, and chronic sadness. She reported that this has worsened within the past month. Now she has difficulty falling asleep because she is ruminating about a failed relationship. She feels tired "all of the time" and has had little appetite. She has lost about 10 pounds without trying and is now markedly thin.

Although she states that she "can't take it anymore," Ms. R has been continuing to go to work and class and has apparently been coping adequately with these responsibilities. She denied any suicidal ideation and also denied ever being suicidal in the past or ever engaging in any suicidal behavior. She denied feelings of hopelessness and has no relatives who committed suicide.

Ms. R has a history of childhood sexual abuse by an older cousin and has had nightmares off and on over the years but in the past year has had only about one per month. She reported that she rarely thinks about the traumatic incidents and has discussed them in therapy before as needed.

Ms. R denies any symptoms of psychosis or mania now or in the past. She denies significant symptoms of anxiety. She denies any past or present violent ideation or behavior.

Ms. R said that she attends Unitarian church on a weekly basis. She has a number of friends from her church group as well as two good friends whom she has relied on for support since she was in high school. She stated that in the past week, she has been talking about her difficulties with her friends and that this has been very helpful to her.

Ms. R stated that she drinks about two times per week when with friends. She consumes between one and three drinks each time.

Ms. R comes from an intact family. Her parents live in a nearby suburb, and she has one younger brother. She characterizes her family relationships as supportive but distant.

Ms. R has been in treatment once in the past and stopped after about 6 months. She stated that she had addressed her history of childhood sexual abuse in those sessions and had stopped because she had been feeling much better.

A. Ms. R is suffering from symptoms of increased depression. She is not at risk for suicidal behavior, as she has no suicidal ideation or intent. She has social supports that she is using well, she states that her involvement with her friends and her church sustains her, and she has no previous history of suicidal behavior or ideation.

P. I talked with Ms. R about the importance of ongoing treatment for chronic depression. She stated that she understood. She accepted appointments next week with a psychiatrist for medication evaluation and a social worker for supportive counseling. Staff will further assess PTSD symptoms as tolerated.

/signed/ Fatimah Abdul, B.S.W.
/cosigned/ Nathaniel Wood, L.C.S.W.

In the heading, the progress note is dated and given a CPT code of 90801, indicative of an initial mental health evaluation session. CPT stands for "current procedural terminology" and indicates what type of health care appointment the client had.

In the first paragraph of the S/O section, the clinician gives basic information about the client's demographics, appearance, and life situation so that future readers of the progress note are oriented to Ms. R. The clinician uses indentations for each paragraph and uses topic sentences that introduce the reader to the content that will be detailed in each paragraph. You can see that the clinician screened for PTSD, depression, mania, substance abuse, and psychosis. The client may need further evaluation to determine whether PTSD is also a current diagnosis since sometimes it is difficult to determine whether a client has sufficient PTSD symptoms for a diagnosis during an intake session. The clinician also briefly described the client's functioning level, which is adequate despite the severity of her depression, and assessed the client's social supports. She briefly described the client's family of origin and will probably need to gather more data on that later.

In the A section, the clinician makes whatever conclusions she can about the client's diagnosis. She clearly documents that the client is not at risk for suicidal behavior at this time.

In the P section, the clinician documents the follow-up plan of ongoing psychotherapy and medication management and the client's agreement with that plan. The clinician clarifies that staff will need to further assess PTSD symptoms in the future as tolerated by the client. As this is an electronic progress note, it is signed electronically.

SAMPLE PROGRESS NOTE FOR PSYCHOTHERAPY

7-1-20xx
90806
S/O. Ms. Njembe came in today feeling very upset. A close friend was concerned that he might have cancer.

Discussion of this issue led to the conclusion that Ms. Njembe can be more concerned about others and not have concern about her own health problems, which include poorly controlled asthma and arthritis pain. She stated that she avoids talking about her problems with others, thinking that they cannot tolerate them and will think negatively of her.

A. Stable but somewhat tearful today. Indicating that she often feels very depressed and anxious under stress, tends to ignore these feelings otherwise.

P. Return for appointment as scheduled next week. Will continue to address self-esteem and mood issues. Ms. Njembe agreed to homework of talking to a different friend about some of her concerns. She agreed to contact the physician referrals I gave her.

/signed/ Fatimah Abdul, B.S.W.
/cosigned/ Nathaniel Wood, L.C.S.W.

This note is similarly formatted to the intake note, although the CPT code of 90806 is for a 45- to 50-minute individual psychotherapy session. Note that the session summary includes significant topics discussed but is brief. The A section consists of an assessment of current emotional functioning today. The P section documents all plans agreed to in the session. Note that the clinician did not include the names of either of Ms. Njembe's friends in the progress note.

WHAT TO DOCUMENT: FULL STORY OF ATTENDANCE AND TREATMENT

Ahmad Hakim is a mental health trainee. He is managing a very suicidal client, Rachel Nghiem. Lately, Rachel has been missing her sessions. Ahmad diligently calls her after each missed appointment and leaves her a message indicating his concern and when she could come in next. Rachel's attendance continues to be irregular. Then, after two missed sessions, Rachel commits suicide. The institution that Ahmad works for has a formal review of the case. Ahmad had thoroughly documented his outreach efforts with Rachel before her death. Here are the notes that Ahmad wrote:

8-5-20xx
90806
S/O. Ms. N talked at length about her troubled relationship with her son. She stated that her antidepressant medications appeared to be helping her this time. She said that she had no suicidal thoughts over the past week.

A. Less depressed. Her suicidal thoughts have always been passive, and today Ms. N reports that she hasn't had any in the past week.

P. Attend scheduled session next week.

/signed/ Ahmad Hakim, M.S.
Psychology Practicum Student
/cosigned/ Lydia Strong, Ph.D.
Licensed Clinical Psychologist

8-12-20xx
No-show

Ms. N did not show up for her scheduled appointment. I called her home number and left a message asking her to call me. I reminded her to come in for her next session scheduled for 8-19-xx at 2:00 P.M.

/signed/ Ahmad Hakim, M.S.
Psychology Practicum Student
/cosigned/ Lydia Strong, Ph.D.
Licensed Clinical Psychologist

8-19-20xx
No-show

Ms N. again did not attend her scheduled appointment. I called her home number and her cell phone number and left messages expressing my concern and asking her to call me as soon as possible. I reminded her to attend her next session scheduled for 8-25-xx at 2:00 P.M.

/signed/ Ahmad Hakim, M.S.
Psychology Practicum Student
/cosigned/ Lydia Strong, Ph.D.
Licensed Clinical Psychologist

The management of the case was found to be appropriate by Ahmad's supervisors and peer reviewers. Later, this documentation in the chart deterred Rachel's relatives from filing a lawsuit for wrongful death against the institution.

Your notes should tell the full story of the client's treatment and attendance, as Ahmad's did in the previous examples (Cameron & turtle-song, 2002). You can see from the notes that Ahmad was aware of Rachel's difficulties with suicidal thoughts and had been monitoring them regularly. He appropriately documented his outreach efforts to this client, whom he knew had some suicide risk.

Beginning therapists are often uncertain what interactions and clinical activities should be documented with progress notes. I have provided a partial list here:

- Psychotherapy sessions
- Cancellations by client (briefly note why, if known)
- Cancellations by therapist
- No-shows
- Outreach phone calls following missed sessions
- Any phone call with significant clinical content
- Some treatment team meetings
- Some consultations between professionals
- Any clinically significant e-mails from the client (print out the e-mail and put it in a paper chart or copy and paste it into an electronic chart)

An example of a phone call or e-mail that need not be documented would be a client asking a routine question such as the time of the next appointment. An example of a phone call or e-mail that *should* be documented is a contact from a client who missed two sessions, states that she has been depressed, and agrees to come in later in the week. Check with your supervisor if you are unsure. It is possible that your supervisor will want you to document every e-mail, whatever the content.

Clinically relevant phone calls are difficult to remember to document since only a tiny percentage of them turn out to have any important clinical significance in the long run. However, we cannot predict in advance which phone call might be the one that it is crucial to document.

Occasionally, there may be other interactions of significance that should be documented that I have not included here. For example, under certain circumstances, a therapist at a Veterans Affairs medical center might attend a benefits hearing for one of her clients. The therapist would then document that this meeting had been attended and why.

WHAT TO DOCUMENT: CLINICAL MANAGEMENT OF TREATMENT-INTERFERING BEHAVIORS

4-23-20xx
90806

S/O. Mr. U attended his appointment for the first time in a month. We reviewed our initial goals for him to attend weekly psychotherapy sessions. Mr. U. stated that he was having financial and child care problems that were interfering with his ability to attend. We brainstormed about getting some help from his mother. After some discussion, he agreed to ask his mother to babysit every week during his scheduled appointment time. He also said that he knew she would contribute to his transportation costs if he asked her to do so. He verbalized his intent to attend on a weekly basis from now on.

A. Mr. U was open to discussing his attendance problems. Stable.
P. Attend scheduled appointment next week. Mr. U agreed to discuss child care and transportation with his mother before then.

/signed/ Ahmad Hakim, M.S.
Psychology Practicum Student
/cosigned/ Lydia Strong, Ph.D.
Licensed Clinical Psychologist

6-19-20xx
90806
S/O. Ms. Q and I discussed her difficulties taking her psychotropic medications regularly. I educated her again about how regularly taking her medication will help prevent future manic and depressive episodes and will help keep her out of the hospital. We reviewed several strategies for medication adherence. After a discussion, she agreed to keep them with her toothbrush and take them every morning before she brushed her teeth.
A. Stable.
P. Ms. Q's next appointment is scheduled in 2 weeks. We agreed to check in on her progress with taking her medications regularly then.

/signed/ Arun Singh, M.A.
Psychology Intern
/cosigned/ Lydia Strong, Ph.D.
Licensed Clinical Psychologist

Be sure to address treatment-interfering behaviors during the psychotherapy session and in the chart. These behaviors could include lack of attendance and lack of adherence to treatment recommendations. You can't effectively treat a client who doesn't attend appointments or who doesn't take needed medications and is therefore at significant risk of rehospitalization. In these situations, it is incumbent on you to demonstrate in the progress notes that you are making an effort to address these issues so that you can provide an effective treatment. In the previous progress notes, the trainees have helped the clients with problem solving and have documented their efforts.

WHAT TO DOCUMENT: SAFETY AND RISK ISSUES

Christina Jones is a mental health trainee in a community mental health center. Her new client has intense suicidal ideation and is on many psychotropic medications. Some of the medications have a risk of overdose. The treatment team discusses the case and agrees to give medications out on a weekly basis until the client is more stable. Christina documents this discussion in a separate note in the client's chart:

6-25-20xx
Treatment Team Meeting
Present at today's treatment team meeting were Dr. Gilford, Dr. Victor, Ms. Thomas, and myself. We discussed the client's risk of overdose as well as her need for medications. The team agreed that medications are warranted because of the likelihood that they will help her depression and reduce the risk of suicide in the long term. To reduce short-term risk, Dr. Gilford agreed to prescribe a less toxic medication whenever possible and give medications out on a weekly basis. I will reinforce the suicide prevention plan with the client again at our next meeting.

/signed/ Christina Jones, M.D.
Psychiatry Resident
/cosigned/ Laura Gilford, M.D.
Psychiatrist

Most settings have ways of documenting routine treatment team meetings that mental health trainees do not need to worry about. However, if a therapist's client is exhibiting risky behavior and the team discusses the case and comes to an agreement about it, then the team's assessment and treatment plans should be documented, as in the case of Christina's client.

Progress notes concerning a crisis situation should be written as soon as possible and definitely should be completed before the clinician leaves to go home for the day. Stay late if you have to. See chapters 18 to 21 for further information on documenting crises.

WHAT TO DOCUMENT: CLIENT'S HOSTILE OR THREATENING BEHAVIOR

Fatimah Abdul, a mental health trainee, is treating a client who has schizophrenia. The client expresses anger and violent ideation toward Muslims. Fatimah is Muslim herself and wears a head scarf. While the client never makes any negative comments about her and is always pleasant toward her personally, she feels threatened by his remarks. She wisely discusses her concerns with her supervisor. After this consultation, she carefully documents all the inappropriate comments that the client made in the last session. She also goes

back and makes an addendum to several previous notes on occasions where she remembers his angry remarks but had not documented them. Fatimah and her supervisor do a careful risk assessment of the client. After determining that he has no known history of violent behavior and consulting with the psychiatrist about adjusting his medication to reduce paranoid ideation (which had been increasing in other settings as well), Fatimah decided to continue to see the client for now. However, she and her supervisor decide that, when he is more stable, they are determined to give the client feedback about his inappropriate remarks.

Fatimah is interviewing a different client in the emergency room. The client stands up and begins to yell at her. Fatimah gently asks the client to calm down and asks him to lie back down on the gurney. The client complies with these requests. She carefully documents the behavior in his chart.

If you feel threatened by a client or if the client's behavior or statements are hostile, you should document carefully and thoroughly, as Fatimah has done. This behavior is highly clinically relevant and may be crucial information in evaluating risk factors and stability of the client in the future.

WHAT TO DOCUMENT: CLIENT'S SEXUAL STATEMENTS OR BEHAVIOR

Jared Russell is a mental health trainee treating a female client with borderline personality disorder. At one point in a session, the client stands up and asks, "Should I take off my blouse?" Of course, Jared tells her not to do so. At the end of the session, he carefully documents in her chart exactly what she had said and his response to her. He discusses this issue very carefully with a supervisor and documents the discussion in the chart. During the next session, he carefully explores the client's inappropriate behavior from last time. He emphasizes to her the professional nature and professional boundaries of their relationship. Again, he carefully documents this discussion in the chart.

There is one important exception to the rule to avoid documenting process: document any statements or behavior that suggests that the client has sexual feelings toward you. On rare occasions, clients may make blatant or subtle inappropriate sexual remarks toward you. This behavior should always be documented as well as what you say in response to the client. This documentation must be contemporaneous in case there is ever any question about

whether your response was appropriate in the future. Jared also documents the steps he takes to address the client's behavior in supervision and in the next session.

WHAT TO DOCUMENT: YOUR INTERVENTIONS AND RECOMMENDATIONS

1-6-20xx
90806

S/O. Ms. G. admitted to cutting herself with a razor, leaving superficial scratches on her arm, when she was home alone with her 2-month-old baby. I asked her to show me the scratches, which were indeed superficial. She was able to identify a feeling of loneliness and emptiness that triggered the behavior. I suggested that we review some alternative behaviors. However, she refused, stating that this has worked well for her for years and that she had no intentions of changing. After some discussion, she was willing to acknowledge that this behavior could be scary to her baby when the baby was older.

A. There is no evidence that the baby is in any danger; in fact, she verbalizes her desire to take good care of the baby frequently. Ms. G denied any suicidal intent during today's session. She continues to appear depressed, however.

P. We agreed to further discuss the issue next week. Will discuss the issue with the treatment team.

/signed/ Christina Jones, M.D.
Psychiatry Resident
/cosigned/ Laura Gilford, M.D.
Psychiatrist

1-13-20xx
90806

S/O. I asked Ms. G about cutting again. She admitted to cutting herself with a razor and again showed me superficial scratches on her arm. She was able to identify that feelings of loneliness and emptiness triggered the behavior. She verbalized her desire to stop engaging in cutting, stating, "It's such a bad influence on my daughter." We discussed some alternative behaviors that she could engage in when feeling lonely and empty. These included calling a friend, praying, writing in her journal, and refocusing her attention on her baby. She agreed to attempt these changes and follow up on her progress next week.

A. While Ms. G's cutting is of concern, at this point, the scratches she has made on her arm are superficial, and she denies making any other scratches in other areas of her body. She verbalizes her intent to address the behavior.

P. Attend scheduled appointment next week. Ms. G agreed to try some alternative behaviors and discuss how that went. She agreed that if she does cut, she

will pay attention to her thoughts and feelings at that time so that we can discuss them further.

/signed/ Christina Jones, M.D.
Psychiatry Resident
/cosigned/ Laura Gilford, M.D.
Psychiatrist

While writing a progress note, many therapists do not document any of the remarks or suggestions that they have made to the client during the session. This is a mistake. You will often make important interventions and therapeutic recommendations, and these should be documented. In the two previous notes, Christina documented the attempts that she made to help the client substitute more effective coping strategies for cutting. As Christina does, document when the client agrees with your recommendations and when the client doesn't. If the client refuses, document how you plan to deal with the refusal (e.g., in the first session, Christina gets the client to agree to discuss the issue again next week). Note that Christina also carefully assessed the safety of Ms. G and her baby as needed.

WHAT *NOT* TO DOCUMENT

Some things should not be documented in the chart. You should avoid including the names of the client's friends or significant others in the chart. If a client is criticizing another clinician at the facility where you work, this information should not be included in the chart (Cameron & turtle-song, 2002). Here is an example:

Wrong: "Mr. R. talked about how he feels that his psychiatrist is 'a mean bitch who's out to get me.'"
Right: "Mr. R. and I discussed how he can communicate more effectively with his psychiatrist."

If the client uses curse words, it is unprofessional to use them in the chart. If you feel it would be illustrative to quote a phrase of the client's when she uses a curse word, "bleep" it out:

Right: When I asked Ms K. whether she had taken the medication prescribed by her psychiatrist, she stated, "F— — that s— —!"

Finally, do not include information that could be seen as slander toward others in the chart; this could expose you to legal liability (Simon, 2004):

Wrong: "Mr. J. talked about how he suspects that his coworker Joe S. is the one stealing from the till at work. He thinks it may be blamed on him instead."
Right: "Mr. J. talked about his worries regarding allegations that someone had been stealing on the job."

WHEN THERE IS PRIOR MENTAL HEALTH DOCUMENTATION

A client who is new to you may not be new to your training site. My recommendation is that you review the entire chart of the client at your current facility before seeing the client for the first time. If there is significant information in the chart, you will want to indicate in a progress note that you are aware of this. For example, a new client might have a history of inpatient hospitalization following a suicide attempt at the facility. You will want to indicate your own awareness of this important historical information in your first note. For example, "The client indicated that he had been previously hospitalized at this facility for acute depression. His report of this incident was consistent with the chart documentation."

Alternatively, this client may be new to both you and the site but may have a prior mental health history at other facilities or with other practitioners. In these circumstances, it is incumbent on you to be aware of the content of the previous mental health treatment notes. Get a release from the client during the first session and send a copy of this release to the previous practitioner or facility. Document in the chart that you sent the release. Ignorance of their content is no excuse if you are sued for risk issues (Baerger, 2001).

Unfortunately, some facilities are negligent about responding to requests for information. Give the facility 2 to 3 weeks to respond. Then if you haven't gotten anything, document that in the chart, send another copy of the release, and document that you have done so. Again, if you don't get anything, document that the facility has not responded. Talk to your supervisor and possibly also the site's legal counsel for further advice at this point.

WHEN YOUR CLIENT WANTS TO READ THE PROGRESS NOTES

Your client may want to read the progress notes you have been writing. Generally, state law and professional association guidelines indicate that the client has a right to read the progress notes (Moline et al., 1998), so agree to let the client read the notes. Before you show the notes to the client, it would be wise to explore in therapy why the client wants to look at the notes. Then suggest

that the client read the notes *during* the next scheduled session. Indicate that you recommend this so that you are immediately available to answer any questions as they come up.

Often, clients have unrealistic expectations about their progress notes. After agreeing to let the client look at the notes and providing a structure to do so, this is a good time to explore what the client's worries, ideas, and fantasies are regarding the content of the progress notes. The client may expect that you have written sparkling and brilliant insights. However, if you limit yourself to content rather than process, this will not be the case. Most clients will actually find the progress notes quite boring. Consider warning them ahead of time, "I'm happy to show you the notes, but I have to tell you it will probably be a bunch of facts that you already know." Document that the client has reviewed the notes in the chart, along with any significant statements or affect.

Sometimes the client requests changes in the chart after reading it. You must gently refuse to make changes to the chart (Gutheil & Hilliard, 2001). The chart is a contemporaneous record of what happened in therapy. However, if you think that the client has a valid point about inaccuracies in the chart, you may agree to make an addendum, dated today, to a previous note.

HOW TO DOCUMENT: SENSITIVE ISSUES

Jared Russell, a mental health trainee, is meeting with a long-term client who has PTSD. The client has not been talking to anyone on the treatment team about his traumatic experiences. During this session, the client tells Jared about being sexually abused by his uncle. Then the client asks Jared not to document anything that he has just said in the chart. Jared explains to the client that other clinicians need to know that the client has a history of trauma because they will want to provide a treatment that meets the client's needs. Jared also explains that it is unnecessary to include all the details. He tells the client what he is likely to write: "Mr. R reported that his uncle would fondle him on occasions when his parents were not at home. He cannot remember the frequency of these abusive episodes but stated that they were too frequent to count between the ages of 6 and 10." The client says that this is okay.

Christina Jones, a mental health trainee, is meeting with a new client. The client reveals that her husband drinks to excess and hits her when he is very drunk. She also stated that she is afraid that the husband might some day hit her children, although she states that he hasn't yet. The client then asks Christina not to document any of this information in the chart. Christina says, "I know that you are bringing this up because you are concerned about it. I am concerned as well. Since this issue concerns safety, I am ethically bound to document it. The other people who are working with you need to know about this so that they can help you, too. However, I will be happy to make it clear in the note that I know you are bringing it up because you are concerned about the issue and you are seeking help to work on it. How does that sound?"

Sometimes clients will ask that you not document certain things they tell you in their charts. In some situations, the client may be aware that there is just one chart at the facility that is shared by all the health care practitioners.

Before responding, think about the client's situation carefully. Ask yourself these questions: Is this information a critical piece of historical information that other clinicians should know? Is this information related to suicidality or other potentially risky situations? Is there any other strong reason for this information to be documented? In the first vignette, Jared feels that the information must be documented, but he is sensitive to the client's concerns and reassures the client that his note will be brief. In the other vignette, the client told Christina information that is related to important risk and safety issues. Do not skip charting a safety issue, even if the client requests that you do so.

Often clients will tell us about upsetting experiences from the past, such as childhood abuse, rape, other traumas, or atrocities committed in the military. When they are ready to address these difficult issues, they may tell us considerable detail about the episodes of trauma. Unless there is a pressing reason to do so, it is wise not to include details. Nonetheless, it is often clinically relevant to document that the client did experience this particular trauma. In addition, certain aspects of the trauma might be of clinical relevance, such as the age at which it occurred, how long, and so on. An example might clarify this:

> Instead of writing: "Mr. O stated that when the Vietnamese women did not cry enough while being raped, [additional explicit details about Vietnam wartime atrocities]."
> You might write: "Mr. O talked about his experiences seeing Vietnam War atrocities."

At other times, the issue at hand is embarrassing to the client but has no major bearing on any risk issues or other aspects of the treatment. In those cases, it is fine to either record the issue in vague generalizations (Gutheil & Hilliard, 2001) or, if it is more embarrassing than clinically relevant, to even skip documenting the issue.

HOW TO RELEASE RECORDS

In most circumstances, you must have a valid signed release of information to release chart materials. Then check with your supervisor before you release

any records. Do not release more than is asked for. If you have some concerns about how the release of these records might impact the client, discuss this with the client before records are released. The client has the right to revoke the release at any time.

In general, you should not release information that you have obtained from other facilities or practitioners; they should be contacted directly for their chart material on the client. In certain instances, you can refuse to provide records if you consider this detrimental to the client (Moline et al., 1998); however, if you have followed the guidelines for writing progress notes provided in this chapter, you are unlikely to be faced with this possibility.

On rare occasions, information can be released without a written release from the client. These situations were discussed in the "Confidentiality" section of chapter 7.

ENSURE SECURITY OF CLIENT INFORMATION

> **DoD [Department of Defense] Personnel Info Part of VA [Veterans Affairs] Data Theft.** As the investigation into the stolen Department of Veterans Affairs (VA) data continues, the full extent and ramification of the theft has grown. It was learned last month that, aside from the information of approximately 26 million veterans contained on the laptop and external hard drive stolen from a VA employee's home, the personal information of 2.2 million military personnel was included, as well. And, while law enforcement agencies have stated that the theft was a simple burglary and that the computer equipment was likely erased and resold before its contents were ever made public, government overseers say that such a theft could easily happen again. (Spotswood, 2006)

The security of client information must be guarded at all times. Do not take written or electronic records home. They must remain on-site at all times. The true incident in the previous quote regarding VA and DoD records illustrates why. You cannot vouch for the security of records off-site.

ENSURE APPROPRIATE DISPOSAL OF CLIENT INFORMATION

> **Hundreds of Patient Records Found in Pharmacy Dumpster.** Drugstores are not supposed to put your personal health information into open dumpsters. But 13 Investigates [Indianapolis television station WTHR] has shown it happening at pharmacy after pharmacy as drug stores all across Indianapolis failed our recent test. Store workers admit if even one patient record gets into the trash, that's one too many. But what we discovered in just one trash bag this week surprised even us. It didn't contain just one patient record—it had 732 of them. That's right—732 patient records on labels, receipts, prescriptions, order forms and pill bottles, all in one garbage bag behind one pharmacy. (Segall, 2006)

Occasionally, we have client information that needs to be disposed of. Here are some examples:

- Fax cover sheet with name of patient, accompanying release, or other document
- Extra copies of chart notes (perhaps printed out from electronic chart to fax in response to a release of information)
- Written phone message to call client
- Brief jotted notes as a reminder of what to document, which are now unnecessary since you completed the progress note

This information must be shredded. Do not ever throw it in a trash bin unshredded. You might put the privacy and safety of your clients at risk. The investigation into pharmacy privacy that was cited previously began when the station found out that thieves had masqueraded as pharmacy employees to get an elderly woman's Oxycontin (Tucker, 2006). The thieves had found her prescription information in the pharmacy trash bin.

HIPAA AND PROGRESS NOTES

Throughout this chapter, I have been discussing how mental heath charting is traditionally done. However, there is another option described by the HIPAA Privacy Rule. It is possible to keep very sketchy notes in the clinical record and also keep more extensive progress notes (called "psychotherapy notes" by HIPAA) that contain more detailed and personal information in a separate location.

The HIPAA Privacy Rule allows these "psychotherapy notes" to have special privacy protections when they are kept separate from the rest of the clinical record. "Psychotherapy notes" are defined as follows: "notes recorded (in any medium) by a health-care practitioner, 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 exclude "medication prescription and monitoring, counseling sessions 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," so this would be the information that would be in the general medical record (American Psychological Association Practice Organization, 2007, p. 8).

As Brendel and Bryan (2004) indicate, what HIPAA refers to as "psychotherapy notes" are essentially what most therapists would call "process notes." As I'm sure you've noticed, I have been advising you throughout this chapter not to document process issues in the chart anyway. When you reread the progress note before a session, the content will remind you of the process issues sufficiently so that you do not need process notes. I recommend that you try to do without them, unless your supervisor wants you to keep process notes as a teaching tool.

Apparently, the main point of this aspect of the HIPAA Privacy Rule was to bar insurance companies from having access to process notes on clients *if* we keep them separate from the rest of the chart. Ask your supervisor whether these kinds of notes are kept separate from the rest of the clinical record at your facility.

There are many valid clinical reasons why you would *not* want to separate your progress notes into these two categories (as allowed by HIPAA) and instead keep just content notes in the one and only clinical record, as I have advised in this chapter. First, the "psychotherapy notes" or process notes can be subpoenaed (Brendel & Bryan, 2004), and most clinicians would not like to have their notes on the therapeutic process scrutinized in court; if these notes do not exist, they cannot be subpoenaed. Given the collaborative nature of much mental health treatment, it is often clinically useful to have important psychotherapy information available to other mental health practitioners at the same facility; critical information could be lost by keeping separate process notes. In addition, the facility may have an EMR system that does not allow two separate sets of notes. As trainees come and go and certain clients come and go as well, it can be helpful for later treatment practitioners to have a more complete record of the client's past psychotherapy. Finally, important issues such as risk management must be thoroughly documented in the clinical record anyway.

TREATMENT PLANS

Mental health professionals in medical centers and clinics and those working with certain managed care organizations are required to produce written treatment plans. Interestingly, physicians in other health specialty areas rarely have to produce any treatment plans (V. Nee, personal communication, February 23, 2007).

The format of treatment plans varies according to requirements of the site and the managed care organization (Zuckerman, 2003). However, in general, treatment plans typically include the following:

- *Diagnostic and Statistical Manual of Mental Disorders* diagnosis, usually all five axes

- Behavioral description of symptoms and/or behaviors that are targets of treatment
- "Objectives," meaning shorter-term goals, again as behaviorally described as possible
- "Goals," meaning longer-term goals
- Target dates or number of sessions for accomplishment of objectives and goals
- Interventions and treatments that will be employed
- Who is responsible for implementing each intervention/treatment
- Referrals made and adjunctive treatments employed

Your supervisor can show you some examples of treatment plans made according to the format and requirements of your site.

RECOMMENDED READING

Cameron, S., & turtle-song, i. (2002). Learning to write case notes using the SOAP format. *Journal of Counseling and Development, 80*, 286–292.
A short and helpful article about how to write appropriate progress notes.

Gutheil, T. G. (1980). Paranoia and progress notes: A guide to forensically informed psychiatric record-keeping. *Hospital and Community Psychiatry, 31*, 479–482.
Despite its age, this classic article provides timeless, wise, and succinct advice about writing progress notes.

Moline, M. E., Williams, G. T., & Austin, K. M. (1998). *Documenting psychotherapy: Essentials for mental health practitioners.* Thousand Oaks, CA: Sage.
The authors provide a thorough discussion of documentation issues, including why good documentation is essential, what belongs in a clinical record, documenting crises, and other topics.

EXERCISES AND DISCUSSION QUESTIONS

1. Your client reveals that she has been taking money and drugs for sex, then asks you not to document this in her chart. Would you document it? Why or why not? What would you tell the client?
2. Your client states about his wife, "I could just kill her sometimes, I'm so angry." The client then asks you not to document this in the chart: "My psychiatrist will think I'm crazy if you write that in there." Your client has denied any history of violent behavior, and you think he wasn't literally that angry—he was just being dramatic. Would you document it? Why or why not? What would you tell the client?
3. Write progress notes for the clients in the two vignettes in chapter 12.