Documenting Services Delivered in Behavioral Health Programs:
Writing progress notes

Writing progress notes is perhaps the most common documentation activity performed by direct service providers. There are two primary functions of a progress note. The first function or purpose of a progress note is to record services provided by a staff member. Progress notes are the primary source of data indicating that a service was delivered. The second function of a progress note is to document the course of treatment; i.e., progress or lack thereof related to a treatment intervention. Both functions of the progress note are essential elements of evidence-based practices. Both functions are described below.

Documenting Service Delivery

Documenting services delivered is an important and interrelated component of any treatment intervention. The documentation process is based on and rooted in the original treatment plan and goals of the intervention. All contacts with consumers/clients are logically connected to a proactive intervention (including crisis-based contacts). The documentation process is an easy task to complete if the direct service provider is recording an activity that was planned in advance and linked to an appropriate treatment program or intervention. Therefore, effective documentation of services begins long before the service is delivered. Good progress notes begin with effective treatment planning. If more work is given to the proactive development of an effective treatment intervention, less work will be needed in documenting those services. In essence, thorough and comprehensive treatment planning leads to easy documentation in progress notes, whereas poorly developed treatment planning leads to extensive documentation in progress notes (or worse, incomplete or unclear documentation of services).

There are several principles of evidence-based practices that influence the structure of progress notes. These principles include:

A. Collaborative relationship. All evidence-based interventions in mental health and addiction treatment are based on a collaborative relationship between an individual with an identified need (e.g., help overcoming a substance use disorder, depression, or related issues, such as assistance finding a job) and a direct service provider (e.g., addiction counselor, recovery coach, case manager, or job coach) or team of providers. This principle implies that the two individuals work together to solve problems, achieve goals, and overcome barriers to goals.

B. Person centered planning. A related principle to the collaborative relationship is a focus on person-centered planning. Person-centered planning implies that the consumer/client is given control over his or her treatment and that all treatment interventions are selected to help this individual achieve self-defined goals. This principle also implies that direct service providers are consultants working with individuals, rather than experts with the authority to select interventions without partnering with clients/consumers.

C. Goal directed services. All evidence-based interventions are designed to achieve specific outcomes or treatment goals. Evidence-based interventions are usually manualized, highly structured, and based on a set of guidelines. Even if an intervention is not designated as an evidence-based intervention, such as case management or peer-driven services, it is still being used to accomplish a goal. This implies that a goal needs to be identified in order to provide services. Stated another way, services are not provided when a goal has not been identified.
D. Measurable and reasonable goals. This principle indicates that the goals-outcomes (short- & long-term) selected by consumers and direct service providers need to be observable, measurable, within the individual’s capacity (i.e., reasonable), & logically connected to the intervention being implied. This principle also implies that direct service providers and consumers need to avoid selecting goals/outcomes that are difficult to observe, measure, or beyond the capacity of the individual.

These four principles are used as guides for writing progress notes. In addition, there are four types of service contacts that can occur between a direct service provider and consumer/client. The four types of contacts include:

(1) Engagement & treatment planning. This is usually the first activity that occurs between a direct service provider and consumer/client (crisis contacts occasionally occur before this activity). This activity occurs before any treatment intervention has been established or delivered and can reoccur over time (at least the treatment plan development part). Treatment plan development can include monitoring behaviors to establish a baseline rate for a particular target behavior. Engagement is an individualized process, but it is not an unlimited activity. If direct service providers are unable to engage individuals within a reasonable amount of time (e.g., 4 to 8 weeks in a community-based model), change the plan or service provider.

(2) Service delivery. After a working relationship has been developed and a treatment plan has been established, the next logical series of service contacts are activities associated with a particular treatment intervention. Frequency, intensity, and duration of contacts are based on consumer preference and the particular intervention that is being used.

(3) Closure or transition. All effective or evidence-based interventions have a beginning and an end-point. Closure activities are used to praise individuals for completing a particularly treatment intervention as well as achieving a planned goal, and helping them to either move on to the next goal or close services. If the intervention does not have an end-point, it cannot be evaluated. If an intervention cannot be evaluated, it’s probably ineffective or, worse, detrimental to the client/consumer. Transitioning activities can also be used to end an intervention that has shown to be ineffective and modify the treatment plan to try another technique.

(4) Crisis-based interactions. Crisis-based contacts are, by default, unplanned or unpredicted contacts outside the established treatment plan. In addition, to meet the criteria of “crisis”, the individual will require assistance that cannot be delayed or diverted. Many direct service providers erroneously label predicted or expected behaviors as a crisis. Most crisis events are actually predictable events that were not addressed in the treatment planning process. For example, a relapse of alcohol or other drugs for an individual who recently completed addiction treatment is not unexpected. In addition, if a behavior occurs frequently (more than two or three times), it is, by default, not a crisis, but rather a predictable behavior that requires an intervention. Most of these mislabeled events will probably fall under the first activity of treatment plan development (e.g., need to revise plan to address ongoing behavior) or service delivery (e.g., relapse prevention or planned assertive outreach due to a relapse).

The four principles of evidence-based practices combined with the four types of service activities provide the structure for writing a progress note documenting that a service was delivered. One additional element is the application of the 3 Ws (who, where, & when). All
progress notes begin with a list of individuals involved in the activity, where the activity occurred, and when (include the total amount of time involved in the activity).

Table 1 displays a grid for organizing progress notes. Each row represents an activity and each column represents elements of the progress note. Each activity requires a note regarding each element.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Who, Where, &amp; When</th>
<th>Purpose of activity</th>
<th>Expected goal of activity</th>
<th>Evaluation of activity</th>
<th>Follow-up appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement and treatment planning</td>
<td>Name of client, name of staff person, &amp; name of other individuals involved, Clearly state location Note the beginning time and ending time and total time</td>
<td>Clearly state how engagement or treatment planning occurred. Also, list any tools or surveys used in the engagement or treatment planning process.</td>
<td>State the goal up front, even if the client does not have a goal, the direct service provider should have a goal for meeting with the client</td>
<td>Follow-up appointment achieved, treatment plan has been written (or a part of it), behavior has been observed, data collection of behavior will continue</td>
<td>Provide a date for follow-up and who will be involved in the next meeting, briefly summarize treatment plan and where the plan can be found</td>
</tr>
<tr>
<td>Service delivery</td>
<td></td>
<td>Note specific treatment plan goal or step. All interventions need to be linked to a treatment plan intervention or step (numbers can be used)</td>
<td>Goal needs to be measurable and will change at every contact. State the goal up front, even if the client does not achieve the goal</td>
<td>Achieved, partially achieved, did not achieve. If not achieved, please explain what happened and what will change</td>
<td>Provide a date for follow-up and who will be involved in the next meeting</td>
</tr>
<tr>
<td>Closer/transition</td>
<td></td>
<td>Summarize why the treatment intervention has been completed or terminated</td>
<td>The goal is to summarize the treatment ending or why another treatment intervention will be provided</td>
<td>Closer is understood or transition is understood</td>
<td>List referral plan and that referring agency has been contacted</td>
</tr>
<tr>
<td>Crisis-management</td>
<td></td>
<td>Only used if behavior has not been observed in the past. Describe the crisis in clear terms and avoid vague or ambiguous language (e.g., client was acting crazy)</td>
<td>Clearly state how crisis was addressed and provide, if possible, a functional analysis of how the crisis was initiated</td>
<td>Has the crisis state been resolved?</td>
<td>Follow-up should be clear, responsibility assigned, and soon after the event. Behavior associated with the event should be addressed in a new treatment intervention</td>
</tr>
</tbody>
</table>
**Documenting Progress of Treatment**

The second function of a progress note is to document progress associated with a treatment intervention. Progress is noted in Table 1 under the evaluation of the activity. Evaluating the outcome of the activity requires minimal effort and writing when delivering a well developed treatment intervention. On the other hand, a poorly developed treatment intervention will lead to an increase in effort, time, and writing in order to evaluate an activity. It is difficult to evaluate an activity if it is unclear why the activity was delivered. In other words, if you are lost in the woods, it is difficult to know if you are making progress toward finding a way out.

Evaluating an activity requires only a few, clear statements about the expected goal. These statements include:

- A brief note about the expected goal (e.g., the goal today was to improve the skill of saying no to alcohol by role playing and modeling assertiveness skills for saying no to family members)
- A brief note about the outcome (e.g., After several role plays [we both switched the roles], Carol was able to comfortably say no to multiple requests for drinking without stuttering or becoming passive)
- A brief note about the next step (e.g., Carol is going home this weekend and has agreed to write down any situations where she will be asked to have a drink and what she does about the request. Carol also has a backup plan of calling her sponsor if she struggles to say no to a family member)
- A brief note about the next appointment (e.g., we decided to meet next Monday to review how Carol used the skill of saying no and if it helped her avoid drinking over the weekend).

Another example:

- A brief note about the expected goal (e.g., John selected the goal of submitting two job applications by today without my help)
- A brief note about the outcome (e.g., John submitted one job application, but his car broke down before he could drop off the second one at the department store)
- A brief note about the next step (e.g., John wants to complete the step, so he is going to have his brother help him fix his car by next week. If he can’t fix the car by Friday, he will call me and I will give him a ride to the department store to drop off the job application)
- A brief note about the next appointment (e.g., we decided to meet next Tuesday, if John doesn’t call me this Friday, to practice interviewing for when he gets a chance to talk to an employer).

A good progress note is clear, brief, and linked to the treatment plan. In essence, the progress note tells a simple and easy to follow story about a treatment intervention and an individual’s response to the intervention over time. Progress notes are used to report only on the outcome of
the intervention and are not used as a diary of conversations or a verbatim recording of each session. Common errors associated with progress notes include:

- Recording dialogue between clinician and client (e.g., the client said …… and then I said…….. and the client responded by saying………). Dialogue is rarely necessary to record and will lead to wasted time writing an extended note. Conversations are expected to occur with the intervention, but the details of the conversation are usually not necessary to record. It is okay and often useful to summarize important information noted by clients/consumers in the session, but only when the information is relevant (and new) to the established treatment plan (e.g., the client noted that her ex-boyfriend is getting out of prison next week and that he is a “big” trigger for her using cocaine).

- Recording detailed reports of what occurred in the session (e.g., on the first role play, Carol was unable to ……… so I tried it again, this time I said …………. , after that try Carol then tried to………….). Details are not needed, particularly if the outcome was achieved, as planned. If the intervention or activity did not produce the desired result, simply report that it didn’t work and try something else. The progress note is not used to record that the clinician understands how to implement the activity; that is the job of a supervisor.

- Recording excessive or extraneous details associated with the planned activity or reasons for why the activity did not occur or was not completed (e.g., John explained to me that he thinks the fuel pump in his car needs to be repaired or that ………., he told me that he called his brother about the problem and his brother said……….). Excessive or extraneous details of behaviors are not necessary when they are not directly related to the intervention or planned activity. Simply note that John’s car is broken and that he has a plan to get it fixed (or not). Summary statements are easier to follow and comprehend and should be used to organize detailed information in the progress note.

- Recording details about repetitive behaviors (e.g., Julie called me again this week telling me about the argument she had with her father, Julie explained that her father ………., which led to Julie wanting to hurt herself, again, by ………………………). Even if the behavior is the target of an intervention, such as learning how to be assertive, reducing the need to self-mutilate, reducing drinking, learning how to manage anger or avoid negative people, it is not necessary to provide extensive detail about the behavior, particularly if the behavior has been explained at least once in the form of a functional analysis.

- Writing an extensive note that correlates with the amount of time spent with clients. Some direct service providers feel compelled to write long notes if they spend an extensive amount of time with clients during an activity. Teaching someone how to shop for healthy and affordable food, accompanying a client to an AA meeting, looking for an affordable apartment, or learning how to ride a bus while managing panic attacks can take hours to complete (and multiple opportunities to practice the skills), but the progress note needs only to state that these skills-training services were delivered and the consumer’s response to the training/intervention (e.g., apartment or job acquired, increase time in the store while having a panic attack and not running out of the store,
client understands bus schedule will try it on his own tomorrow, needs more training, or not effective at behavior change). A four-hour, evidence-based activity and a 15-minute conversation will require about the same amount of words and space on a sheet of paper (or field in a computer).

- Writing the same note repeatedly. Direct service providers can easily fall into the trap of coping/replicating notes over time, particularly when the activity is repeated over an extended period of time, such as delivering medications to clients who need assistance following a medication regimen. Neither the activity nor the note should be repeated over time without a proactive plan for modifying the activity over time. Delivering medications to clients, taking clients shopping for food, managing disability benefits for clients, providing transportation to a medical appointment, providing group or individual therapy, helping a daily drinker or pot smoker reduce their drug use, or any other activity that may require repeated administrations, needs to include a plan for augmenting or changing the activity over time (e.g., shaping behavior) and this plan needs to be reflected in the progress note. For example, delivering medications needs to be augmented with a plan for helping clients learn how to acquire the medications on their own (e.g., exploring transportation options) or improve memory skills for taking the medications (e.g., having family or friends provide assistance, writing down medications on a calendar, or practicing & memorizing the regimen). Medications can be delivered on multiple occasions, but the progress note needs to include a discussion of how the transfer of medication management is being achieved. If the repeated activity is not leading to an observable change within three or four attempts, the note needs to include a discussion of how the course of treatment will be modified, augmented, or changed to another intervention. Furthermore, attending group or attending individual therapy does not qualify as an indicator of progress. It is necessary to report that a service was rendered/received and attendance is an indication that the service was received. Nonetheless, group or individual therapies are tools used to help people achieve a goal. The goal of any group or individual counseling activity is to acquire a specific skill or knowledge. Once the skill or knowledge has been acquired, something else should occur and written in the progress note.

- Using vague or ambiguous terms to describe target behaviors, goals, or interventions. Commonly used and abused words in progress notes include:
  i. **Motivation**: avoid the term, except when referring to Motivational Interviewing. Instead of using the word motivation, which often implies that the person is choosing not to be motivated (i.e., lazy), describe the destination that a person will reach (e.g., entering treatment) or the activity that they will perform (e.g., walk around the block twice this week).
  ii. **Quality of life**: be specific instead of using this term. What aspect of quality of life (e.g., housing, safety, relationships, health, or leisure activities) will the person address?
  iii. **Self-esteem**: this is a ambiguous term that cannot be observed and is rarely related to anything but self-esteem scales. Again, what aspect of self-esteem is being addressed; e.g., body image, depression, self-destructive thoughts, the impact of stigma, or relationship issues? There are multiple effective cognitive-
behavioral and behavioral techniques that can be used to address negative thoughts and behaviors, but only if the specific thought or behavior is identified. Self-esteem is colloquial and over-used term within Western culture.

iv. **Happy or happiness**: Happiness cannot be measured and, even if this emotional/psychological state could be reliably measured, it is a fairly unstable emotion or thought. Instead, focus on what will make the individual happy and in their words? You cannot reliably measure increased or decreased happiness, but you can reliably measure activities, such as time with children (or significant others), access to social events, participation in leisure activities, or learning a new hobby that will impact happiness (if the consumer selects these activities).

v. **Compliant (e.g., Medication compliant)**: this is an outdated medical-model term that should not be used when developing a person-centered plan. Compliance does not exist in a collaborative relationship. Do you ask your husband/boyfriend or wife/girlfriend to be more compliant with your demands in the relationship? Even physicians understand that they can’t order their patients to be more compliant, but they can work with them to improve adherence to the medication regimen.

vi. **Satisfaction**: another commonly abused term that is usually used to describe a consumers’ evaluation of the clinician’s activity. Surprisingly, most consumers are satisfied with most activities, even if the treatment is not helpful or needed. The purpose of working with clients/consumers is to help them achieve treatment goals, not to be satisfied with the clinician. If clients are achieving their self-defined goals, they will likely be satisfied; nonetheless, satisfaction should not be used as a proxy measure for treatment effectiveness or for the appropriateness of treatment.

vii. **Independence (or empowerment)**: There are multiple effective interventions designed to improve individuals’ independence in the community, such as supported employment, education, and housing. Nonetheless, all these interventions lead to specific outcomes, such as obtaining a competitive job, completing a degree, or living in an apartment for a specific amount of time (and reducing rates of institutionalization). Instead of using the words independence or empowerment, select the specific activity that will promote these two broad terms.

viii. **Addiction or addictive behaviors (or substance use/abuse behaviors)**: These terms can be used in a treatment plan, but even within the treatment plan, the objectives will need to specify the behavior being addressed as well as the target drug (i.e., the drug of choice). Avoid using broad terms, such as substance use behaviors or addictions (or mental illness), and describe the specific behavior that was addressed in the activity, such as saying no to a drug dealer, discussing the pros & cons of entering treatment, finding leisure activities that don’t require alcohol, identifying triggers, listing negative thoughts that lead to drug use, or engaging supportive family members in the treatment process.
Evaluating the Quality of a Progress Note

Direct service providers and their supervisors can evaluate the quality of progress notes. Table 2 provides a list of questions that can be used to score progress notes. The scoring grid is used for quality improvement purposes. The goal is not to achieve perfection in scoring, but to learn how to improve the quality of notes overtime with a standardized scoring system. The scoring grid can be used by a supervisor or as a group exercise in supervision. All staff members within a team can practice scoring each other’s notes as part of a case review process. The scores are discussed with ideas on how to improve them over time.

Table 2: Score Progress Notes

<table>
<thead>
<tr>
<th>Item #</th>
<th>Structural item of the progress note</th>
<th>Score of 2</th>
<th>Score of 1</th>
<th>Score of 0</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Are all individuals involved in the session clearly identified in the note?</td>
<td>All individuals are identified with full names and a description of who they are</td>
<td>Some or all the individuals are identified, but it isn’t clear who they are</td>
<td>Individuals are not clearly identified in the note</td>
</tr>
<tr>
<td>2</td>
<td>Does note begin with a clear statement of the purpose for the meeting/activity and is this purpose linked to an established treatment or vocational plan?</td>
<td>The note begins with a clear sentence on why the meeting occurred and the activity was clearly linked to a treatment plan goal (the TP goal was noted)</td>
<td>Either the purpose for the meeting was unclear or the activity was not linked to a treatment plan goal</td>
<td>There is no indication of a purpose for the meeting or linkage to a treatment plan</td>
</tr>
<tr>
<td>3</td>
<td>Was a consumer goal listed for the meeting and was it linked to the intervention or treatment plan?</td>
<td>A goal was noted in the meeting and it was clearly linked to the ongoing intervention or treatment plan</td>
<td>A goal was listed, but it was difficult to determine why the goal was selected or how it was going to be achieved</td>
<td>A goal was not listed</td>
</tr>
<tr>
<td>4</td>
<td>Does the note contain an evaluation of the session/meeting</td>
<td>The note included an evaluative statement that was clear, indicated if the goal was accomplished (or not), and was related to the goal of the session</td>
<td>The note contains an evaluation of the session, but the statement is vague or general statement (e.g., client was satisfied with the session)</td>
<td>The note does not contain an evaluation of the session. There was not indication the goal was achieved or the goal was not noted</td>
</tr>
<tr>
<td>5</td>
<td>Does the note contain a statement about following up with the client/consumer and does include a response to the evaluation of the session (if needed)?</td>
<td>The note contains a specific date for the next meeting and it also includes a brief statement about what will occur in the next session</td>
<td>The note contains a follow up date or a brief discussion of what will occur in the next meeting, but not both</td>
<td>There is no indication of a follow-up session or it is unclear when the two individuals will meet again and for what reason</td>
</tr>
</tbody>
</table>