DAP Notes, SOAP Notes and Therapist Confidential Notes

Introduction to Session Notes

It has been estimated that approximately 25% of a therapist's job is administrative. That includes recording accurate and effective session notes. Sadly, this part of the counseling experience is probably the first duty that is neglected, put off for some other time, and even more inappropriately, cheated on.

I was in a classroom setting once, and the professor started the lecture with some long, drawn out personal story that involved a number of characters, intricate information, and names that were too involved to even remember. Then, after his ten-minute introduction, he lectured for an hour. When he was done, he made an announcement. He said: "This class will change the way you function and perceive in the counseling setting. Everyone is about to fail this class today. The assignment that I am about to give you is worth 5% of your overall semester grade."

It was at that point that he asked us to recount, in writing, the whole diatribe of nonsense that he started the class with. He wanted all of the details: names, locations, narratives, and everything associated with his opening story. I didn't even turn in the assignment. I had nothing. I "zoned out" during his diatribe.

Near the end of the class, he made a simple remark that has stuck with me ever since. And it should stick with you. He said: "Is the document that you just wrote worthy of presenting to a court of law? If not, don't turn it in and take the hit."

What was the point of that exercise? His point was simple and very profound.

Legal and Ethical Issues

If you are not taking notes during a client session, there is no way that you will even remember the content of the session at the end of the session – much less remembering it tomorrow. Tomorrow is a fantasy. You will remember nothing of significant substance. What if the client sues? Commits suicide and the family sues? Do you think that is only remotely possible? Think again. You are wrong and you may be exposing yourself to legal liability unnecessarily.

It doesn't matter who you are. You may say, "I'm just a pastor in a church and I counsel 'free of charge'". Do you think you can't be sued? Yes you can. Are you a sole proprietor? Someone who has their own counseling practice that is not connected with another agency? Does that give you a free pass regarding counseling notes? You can and will be sued in instances that you cannot even believe. Do you have accurate and viable notes on every session to back you up when that day comes?

The bad habit of not taking accurate session notes is not beneficial to either the client or to the therapist. And, in the case wherein the therapist is working for an organization that will end up bearing potential legal liability, the effects can be overwhelming where viable and accurate documentation is needed.

In short, it is unethical for any therapist – whether working alone (even pastors) or for an organization – not to take effective session notes during the same day that the session transpires. Everyone with any type of counseling education knows this. How many times have you heard it in a classroom setting: "If there is no note, the session didn't happen."

It is imperative – ethically – that you record a session note after every session, even if that session was "casual." These notes may be vital to you and to others working with you, in the future.

Equal to the legal purpose of session notes is the ethical reason for them. It is unreasonable in this busy world to assume that you will remember key points of any counseling session with a client when it comes around to the next session. This is not fair to the client: it simply isn't fair.

Structured counseling notes – whether *SOAP* or *DAP Notes* – always end with the *Plan* for the next session. As you, the therapist, work through the note in a structured manner, that process of recording facts will usually lead to what needs to happen next. Based on what was just discussed in session, what needs to happen next to meet clear, objective goals?

Before every session with a client, the previous two or three notes should be opened and read. This will give you a clear understanding of where you need to go in the current session. Without this type of counseling methodology every counseling session is just a random discussion of the client's current events. The sessions don't really go anywhere productive at all.

The counseling process should build one session on another to solve a client's problem and to meet a specific treatment goal that has been defined in writing and agreed upon by both parties. If that is not happening a disservice is being done to the client.

MARETweb Project Session Note Choices

There are three types of notes available to you in the *MARETweb Project*. One of these three options should be used every single time that you counsel a client.

When you record a client note of any kind, it appears in the *Client Summary*. That reference includes the date that the note was recorded. After you create the session note, you will have ten days to edit the note prior to the note becoming "permanent." This document permanency is a requirement of *HIPPA* so that notes cannot be arbitrarily altered "at will" some time in the future.

You can also electronically "sign" a note.¹ That indicates that you have chosen to "seal" the document intentionally. You will need to use your password to "sign" the document. Documents that are not "signed" within ten days are recorded as "sealed without signature." This should not be your choice way of closing documents since it indicates that you ignored the ten-day warning for the voluntary signing of documents.

Functions Common to All Note Formats

There are a number of functions and fields associated with session notes that are common to all three session note formats. We will cover those first so that they do not need to be repeated. All three session note formats are available for use when a client record has been loaded. Users will find the three formats by scrolling down under the *Client Summary* heading.

New Notes

Under each of the three session note formats the user will find a "new note" link. Once the link is clicked a blank session note will appear. There are four items that are common to all three session note formats.

Title: Every session note should have some type of title. It doesn't matter what the title is but you should title the session note uniquely enough so that the content of the session will be somewhat familiar from the title. Something like "session" is appropriate, but if you are looking for a specific note, you may be looking for a while if every note is titled "session." Something more appropriate might be "fight with husband." That gives you a clue what the note is about.

Therapist ID: This is an optional field. It is useful if more than one therapist is recording information on a specific client. Always make sure to use the same unique name or other identifier for each individual.

Session Date: The system automatically records the date that the note is recorded on. In a perfect world, that date should be the same date as the session date. That is not always the case. While the system itself records the date of the note, you should record the date of the session here.

Others Present: Anyone else who was present during at least part of a counseling session should be recorded here. It doesn't matter who they are or why they were part of the session. Record all other people present here.

¹ This feature will be available November 2015.

Edit Notes

When you choose to edit an existing session note of any kind, you will see a box that contains all documents that are available for editing.² To edit a specific note, do the following:

- Click on the note you wish to edit (this must be done even if there is only one note in the box).
- Click on the edit button under the document list box.
- Edit the session note.
- Click on the save button when you are finished.

Print/Preview Notes

The print/preview functionality is very similar to the edit functionality with an addition to your options.

Option #1: This option allows you to select a single session note from a listing of all session notes in the system (of a specific kind). You are not limited by the ten-day rule since you are not editing the documents. With *Option #1*, you can select one specific note to view. After you select the single note that you wish to view, click on the Preview button.

Option #2: This option allows you to select a number of session notes to view all at the same time. You may only choose from the most recent downward. So, if you choose to view three documents, you will see the most recent document and the two documents prior to that document. This functionality is designed to allow you to look backward from the most recent session in order to get "up to speed" for an upcoming session. When you choose this option, the most recent session will appear first and the oldest session note will appear last.

Other Common Functions: There are other common functions between all three types of session notes and the *Preview* feature. 1) When you choose to *Preview* your session notes, they will be formatted in a manner that lends itself to formal printing.³ 2) At the bottom of the session note selection form you will notice that there are three options for signature lines. These three lines are all independently optional. They allow you to include signature lines for the counselor, the program manager and for a clinical supervisor. By ensuring that there is a check mark in a desired box, the appropriate signature lines will appear on the *Preview*.

² Starting November 2015, only documents that have been in existence for less than ten days can be edited. All other documents will be automatically sealed.

³ Each Internet browser lends itself to printing in a slightly different way. Usually, the user will click on the *FILE* option at the top of the page that needs to be printed. From there, the user will probably be given options to format the document. Those options include the ability to remove header and footer information (including the web address of the document and other extraneous information that is not desired). If you do not know how to print from your browser you will need to explore that issue with help from the browser itself.

SOAP Notes

SOAP Notes are the *de facto* format for counseling session notes. The reason for such broadbased acceptance is not clear except that SOAP Notes are the standard in medical healthcare. Since there is some integration between the medical world and the counseling/psychological world, it stands to reason that counselors and therapists would naturally adopt the medical model for case note formatting. It may be essential for therapists to use the SOAP Note format if session notes are being shared in the medical community.

In my opinion, however, *SOAP Notes* are not the best method of recording counseling-based information. Why? Because of the "*subjective*" field used as the "*S*" in *SOAP*. This is largely a medical field and it does not lend itself well to the psychological crossover.

Let's face it. The *Subjective* field should only contain the *subjective* "feelings" of a client. While there may be some intrinsic value to that information, it does not lend itself well toward a cohesive documentation of the whole session. How many times have you been at a complete loss for information to put in the *Subjective* field? How many times have your *Subjective* and your *Objective* fields blurred information and been confusing and redundant? How many times have you put in goofy statements like: "Client says he feels good today"? That's filler and really doesn't matter too much.⁴

These four fields are much more appropriate in a medical setting. For example:

Subjective – Patient expressed that he feels like he is "burning up."

Objective – The patient had an oral temperature of 102 degrees.

Assessment – It appears that the patient is exhibiting signs of a viral infection including xyz symptoms.

P*lan* – Patient was administered oral medication for fever. Reassessment will be made in one hour.

If you choose to use *SOAP Notes* (or you are mandated to do so), the four fields should contain the following information as segregated as possible.

S*ubjective* – Client-based *subjective* feelings only. There should be no indication of objectivity as observed by the therapist. The *Subjective* portion of a *SOAP Note* often starts like: "Client says she feels..."

Objective – The Objective portion of the session note contains observable and identifiable characteristics and behaviors that the therapist sees (in spite of what the client says). It is common to use the phrase "It appears...." or "It is apparent...."

Assessment – Assessment should include clinical findings. It may be more philosophical than the *Objective* portion. This should tie everything (the *Subjective* and the *Objective*) together.

⁴ That's not to say that that information is holistically useless. No. Some of it can be useful, but could also be included just as easily (and probably more cohesively) under the *Data* section of a *DAP Note*.

Plan – What do you plan to do with the information that has been gathered? More than just planning based on what has been observed in this single session, what is the broader *Plan* based on previous information gathered from previous sessions? How has the overall *Plan* been modified or adjusted by this new information? What needs to be done during the next session? What type of short-term goal can be achieved in the next three sessions? What homework has been given at the conclusion of this session to attempt to fulfill the *Plan*?

It should be evident that the purpose of the session note is more than a recording of information and facts about a session. The session note should cause the therapist to reflect on the session and to fine tune the direction that the whole counseling effort is going. This note is a setup for the next session. Without it, there is something fundamentally missing from the whole counseling process.

DAP Notes

DAP Notes, in my opinion, are the most appropriate form of note taking for counselors and therapists. They are simpler. Essentially, the "*A*" and the "*P*" will contain the same information. Your *Assessment* and your *Plan* will be the same.

The difference is that the "*D*" simply contains all *Data* regarding the session and that data is not separated into *subjective* and *objective* compartments. Really, there is no need to do so. As mentioned above under the *Subjective* heading, this heading was actually designed for use in a medical situation.

Unless the therapist is functioning in a medical setting wherein the sharing of case notes is important, the *DAP Note* format may be more appealing and much easier to use.

Data – The Data portion of the session note contains observable and identifiable characteristics and behaviors that the therapist sees. It is intermingled with the *subjective* statements of the client, where those *subjective* observations may be appropriate and relational to the overall direction of the session. This is what a therapist sees and observes during the session that has a bearing on the next two session note areas. This section responds to the phrase "**What did I see?**"

Assessment – See Assessment above. This field should contain similar information. This section responds to the statement: "**What does it mean to me?**"

P*lan* – See *Plan* above. This field should contain similar information. This section answers the question: "*What am I going to do about it*?"

It should be readily apparent to everyone that accurate and timely session notes are an integral part of counseling. Without effective notes, the is an injustice being done to the welfare of a client. Notes are not a luxury. They are not an option. They are an imperative.

Therapist Confidential Notes

Therapist Confidential Notes are the most basic of all notes that you can record. They are not recommended as a primary method of session recording especially since they do not include a "*Plan*" section, which is essential to continuity of the therapeutic relationship.

Therapist Confidential Notes, however, can serve a very useful purpose in the counseling process. *Therapist Confidential Notes* are useful whenever an "event" or non-traditional session occurs wherein there were no clear objectives or "plans" involved in that session. This is most often seen in non-scheduled sessions or in crisis situations.

Another good use for *Therapist Confidential Notes* would be for phone calls that where not part of a regularly scheduled session.

Since *Therapist Confidential Notes* do not contain a specific field for the *Plan* aspect of a session, there are best not used as a usual method of session note recording.