Sample Progress Note for Violence Risk

Annotations have been included in italics to help you understand the structure of the note. This note is for a client who has moderate violence risk and will be treated as an outpatient. Moderate risk clients need very careful documentation because risk is significantly elevated, yet the psychotherapist must justify why outpatient treatment is appropriate.

S/O. Ms Priscilla DeBarge is a 32 year old single white female. She has a long-standing history of schizoaffective disorder, bipolar type. She lives in a group home with other women who have serious mental illness. She is on Social Security disability for mental illness. She came in today for a crisis session.

Ms D was brought to the clinic today by a group home staff member and her older brother, Reggie (42 years old), because she relapsed on alcohol, and she has been having paranoid thoughts about another resident.

According to old chart notes and the group home staffer, Mrs Johnson, Ms D has a long history of alcohol abuse, but with the assistance of AA and dual diagnosis groups, she has been abstinent for the last 11 months. Four months ago, she was placed in the group home and had been doing well. After a recent break-up with a boyfriend, she started to drink again. Over the last week, she has become more paranoid and has been accusing the other resident of stealing her possessions, eating her personal food and plotting against her.

[These three paragraphs are a general orientation to Ms D's life situation and her recent and historical mental health issues.]

Ms D said, "I can't stand that b—! She stole my food and my iPod. I know it's wrong, but I want to hit her, truly I do." I asked Ms D about prior violent behavior. Ms D admitted that she has gotten into many physical fights in the past when she was drinking, but said that when she is sober, she does not fight. She remained convinced that the other resident stole her possessions, but states that she values living in the group home and knows that if she is violent, she will be evicted, so she does not intend to be violent. She denied any violent thoughts toward anyone else. She said that she is sorry about her recent relapse and that she hasn't had any alcohol for the last 2 days. She said that she went to an AA meeting last night and talked to her sponsor on the phone, and felt better afterwards. I asked her if she would call 911 or go to the ER if she felt that she was unable to control these violent ideas and was at risk of acting on them. She agreed to do so.

[The above paragraph communicates that the psychotherapist evaluated Ms D's violent ideation in detail, including her level of intent, and obtained her agreement to a violence prevention plan. The agreement to a plan to call 911 or go to ER as needed should be carefully documented in every crisis note for someone who will be treated as an outpatient.]

Ms D said that her symptoms have worsened lately. She said that she has been hearing voices. She denied hallucinations in other sensory modalities. She said that it was difficult to ride on the bus because she felt that others were thinking negatively of her and were trying to implant ideas in her mind. She spoke in a pressured manner and appeared agitated during the interview. She had some cognitive disorganization and was tangential in her speech, so it was somewhat difficult to interview her. She admitted to having difficulty sleeping and feeling agitated.

[The above paragraph describes the recent symptom picture in more detail.]

I spoke to her brother Reggie about her history. He said that in her early 20s, Ms D used to be picked up by the police regularly for fighting, but that the police would often end up taking her to the state hospital rather than imprisoning her or charging her with a crime. The last violent episode that he knows about occurred 5 years ago, when she hit another brother during an exacerbation of mania, accompanied by alcohol and cocaine use. He said that she hasn't had any cocaine since then and she has spoken many times about deeply regretting that episode.

[Here the psychotherapist documents collateral information about violence history that was gathered from the brother.]

I asked Ms Johnson about the situation at the group home. She said that Ms D's iPod did disappear, but it is unclear whether it was stolen or lost. She has no reason to think that the other resident had stolen it and said that previously Ms D and the other resident had a good relationship. She is concerned that Ms D's paranoia must improve before Ms D returns to the home, so that the situation can cool off.

[Here the psychotherapist documents collateral information about violence history that was gathered from the group home staff member.]

I asked Ms D about suicidal thoughts. She denied having any. She said that her life had been on track, for once, and that she wanted to get sober again and continue the work she's been doing in psychotherapy and with Mrs Johnson at the group home. She said that she interviewed for supported employment last week and hopes that she will be accepted to that program.

[The psychotherapist documents that she screened Ms D for suicide risk.]

I discussed Ms D's situation with Ms D, Mrs Johnson and her brother Reggie. Because the situation needs to cool off at the group home, Reggie volunteered to let Ms D stay at his home for a week. Ms D readily agreed to do so. Reggie said that since she has restarted with her AA group already, he is not worried about her being violent towards anyone in his home.

[The psychotherapist documents agreement about a plan to cool off the potentially volatile situation at the group home so there is time to re-establish Ms D's mental stability and abstinence.]

A. Diagnostic impression: Schizoaffective disorder, bipolar type; relapse of alcohol abuse.
Violence warning signs: exacerbation of psychotic disorder with paranoid ideation, recent relapse on alcohol, recent violent ideation

Violence risk factors: history of multiple episodes of violent behavior when drunk

Violence protective factors: denies intent to be violent, has re-engaged with AA and sponsor, has support of family members, is motivated to not be violent to remain in group home and to get supported employment, understands what needs to happen to stabilize herself mentally.

[Above is a recap of warning signs, risk factors and protective factors from the Subjective/Objective portion of the note.]

Violence risk level: Moderate risk. Although Ms D has a long history of violent behavior, she has been much more stable in the last year and it is likely that she can regain her previous level of stability and functioning soon with sufficient support and intensity of treatment. This exacerbation of symptoms is probably due to her relapse on alcohol, and will probably remit soon as she continues to be abstinent. She verbalizes an understanding of her mental illness and her alcoholism and she verbalizes an intent to follow through with treatment and regain her abstinence. Her family will support and monitor her in this.

[Note the thorough discussion of the psychotherapist's assessment of violence risk above.]

P. Ms D agrees to wait to see her psychiatrist today to evaluate her medications and see if she needs any adjustments for exacerbations of symptoms. Ms D agrees to go to at least one AA meeting per day and call her sponsor daily over the next week. She agrees to come to a twice weekly dual diagnosis group here at the clinic starting tomorrow. I have given her an appointment to come back and see me in 2 days. Reggie agreed to bring her in to the clinic or to an ER if there are any further exacerbations of symptoms.

[The psychotherapist clearly describes the exact details of the initial plan for treatment and follow-up in the Plan portion of the note, above. Emphasis is placed on timely and intensive treatment of her acute distress. Note that re-engagement with substance abuse treatment is emphasized to minimize violence risk as soon as possible.]

/signed/	/cosigned/
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