Pre-Trial Therapy Note Keeping Guide

Case notes should be factual, simple and succinct

(written to safeguard clients and reflect their voice, with the possibility of disclosure in mind)

Case notes — what to record

- How the service user presented
- Who was at the session
- Date, time and location
- Theme of session
- Resources used
- Advice given
- Formulation
- Next steps and onward referrals
- Additional information that may form part of Third Party Material Request (TPM)
- Assessment tools *e.g RCADs, PDQ, GAD*
- Letters to professional network

Do not record:

- Statements suggesting misplaced guilt and shame
- Jargon or generalisations
- Therapists hypotheses or interpretations

Records to keep separately

(unlikely to be, although permitted, within scope of most TPM requests)

- Process notes
- Drawings & personal notes
- Supervision notes
- Case management notes

New disclosures

Was anything shared for the first time that has never been reported to anyone?

If yes, complete a verbatim account of the session on a separate disclosure template.
For children: follow safeguarding procedures and report to social care.
For adults: support the service user to report to the police directly if they wish.