Better psychiatric documentation: From SOAP to PROMISE

Because documentation is an important part of medical practice,[1] numerous tools have been developed to help physicians across all specialties, including the best-known acronym **SOAP**, which stands for Subjective, Objective, Assessment, and Plan.

The **SOAP** note has been used in mental health settings,[2] although this format may fall short for psychiatrists because objective tests are not diagnostic. Also, there's no clear guidance to document specific information, such as behavioral risk assessment.

The acronym **PROMISE**—Problems, Resolved, Outcomes, Medications, Instructions, Safety, and Education—may be better suited for psychiatric documentation.

*The **PROMISE** note* provides an easy-to-remember method to document specific information that might be overlooked in a less detailed format, such as normal findings, adherence and tolerability to medications, outcome ratings, and risk assessment.

The PROMISE note

provides an easy-to-remember method to document specific information that might be overlooked

Problems

are described as ongoing symptoms, signs, and stressors.

Resolved

indicates improvement and normal findings.

Outcome

measures include patient or clinician rating scales.

Medications

documents the effectiveness and tolerability of current and past medications.

Instructions

are directives given; the rationale—cost-benefit analysis—can be documented in this section as well.

Safety

describes a behavioral risk assessment, including demographic, historical, clinical, and environmental risk and protective factors regarding suicidal or homicidal behavior.

Education

describes the verbal or written material shared with the patient.

Psychotherapists can use the same template. For them the **M** would stand for ***Methods of psychotherapy*** practiced in the session.

For an example of the PROMISE note used in practice, see the Table.

Example of a patient's PROMISE note

Problems	Ongoing depressive symptoms: low mood, negative thinking, low interest level; patient has no insurance, pays out of pocket
Resolved	Mild improvement in motivation noted; sleeping and concentration both OK; continues to work full-time; spends time with parents
Outcomes	Clinical Global Impression-Severity Scale score: 4; PHQ-9 depression rating scale score: 12/27, indicating moderate depression (score 1 month ago was 15/27; 20% reduction)
Medications	Current treatment: citalopram, 20 mg/d, nortriptyline, 50 mg/d Prior medications: bupropion, citalopram, clomipramine, fluoxetine, MAOIs, sertraline, and venlafaxine. Patient's adherence to medication is good Tolerability issues: sweating, constipation, dry mouth
Instructions	Increase both medications (20% improvement noted; recommend increase in nortriptyline; patient requests increase in citalopram). Ongoing moderate depression; initial side effects may subside
Safety	Identified risk or protective factors for suicidal, aggressive, or homicidal behavior: chronic depression without remission No current SI, HI, SIB, hopelessness, anxiety, agitation, insomnia, substance use, psychosis, or interpersonal aggression. No access to weapons. No history of suicide attempts. Good supports. Risk assessment: low
Education	1. What is the main problem? Chronic unremitting depression, some mild side effects—eg, dry mouth, constipation 2. What can the patient do about it? Optimize meds; exercise (30 minutes of fast walking per day); increase fiber in diet 3. Why is it important to do this? Achieve remission (PHQ-9 score: <4); improve tolerability
HI: homicidal ideation; MAOIs: monoamine oxidase inhibitors; PHQ-9: 9-Question Patient Health Questionnaire; SI: suicidal ideation; SIB: self-injurious behavior	

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