Psychotherapy and Counselling Federation of Australia

Maintaining client records

"Record keeping, however, is more than just a memory aid. Case notes and other records in therapy can help us track ongoing conceptualisations, make better decisions, keep our clients safe, and enable accurate information sharing with other practitioners. Keeping good records is a requirement of all employing agencies. In private practice, conscientious and accurate record keeping can shield us from legal risks"

– Rao, 2023

Introduction

This resource is prepared by PACFA to enable members to engage with PACFA's ethical framework with regard to record keeping. The Code of Ethics commits members to put the client's interests first, be accountable to high professional standards, keep accurate client records and comply with the relevant privacy laws. (2019b, pp. 9–10).

Effective record keeping is a core competency for PACFA counsellors, psychotherapists and Indigenous Healing Practitioners. It is an aspect of our professional and legal responsibilities, and it is thus appropriate for us to regularly review our record-keeping processes.

If a conflict arises between an organisation's requirements regarding client records and the Code of Ethics or the law, PACFA members are mindful of our obligations to comply with the applicable law. If necessary, we seek legal advice, or advice from our supervisor or from PACFA's ethics support team to reach a solution that complies with the law and ethical principles.

These guidelines provide ***good practice guidance*** for keeping client records and cover practitioners providing supervision services, the supervisee being the "client" in these situations.

What do we mean by client records?

Client records refer to all data and information, whether paper-based or electronic, that is documented, collected and stored during the course of our therapeutic work with clients (Mitchels & Bond, 2021, p. 32). Client records typically comprise the following set of documents:

- the informed consent form signed by the client
- the intake form comprising demographic information, e.g., name, date of birth, address, contact details, emergency contact details
- referral from a GP or other professionals inc. Mental Health Care or NDIS Plans
- session notes (see *Good Practice Guideline: Writing session notes*)
- assessment tools or rating scales used with the client and the results
- audio and video recordings
- risk management plans, actions taken
- emails and text communications
- art or creative work
- release of information forms signed by the client giving permission to communicate with others about their health information
- referrals or letters to other health care providers.

Purpose of client records

Conscientious recording of client information, goals, support and interventions is part of our duty of care to the client. An accurate and current client record allows us to:

- review the counselling, psychotherapy or Indigenous Healing services being provided
- provide accurate referrals sought by the client, and
- protect ourselves from professional liability in the event of legal or ethical proceedings.

Choosing our record-keeping system

There are a number of options for record-keeping, and it is for each of us to decide upon a suitable system while taking into account the policies and procedures of any organisation where we practice. Organising client documentation so that information is easy to access and is durable, also needs to be considered.

Examples of record-keeping systems most observed in practice include:

- Single file system: All records relating to an individual client are stored together in one file
- Two file system: The Intake Forms and contact details may be kept in one file; session notes and correspondences may be kept separately
- Multiple file system: Intake Forms and contact details in one file, financial transactions for accounting/tax purposes kept in one file; correspondence and session notes kept separately to maximise client privacy. Additional files may be created for other records such as audio recordings, supervision notes or items created by the therapist or client during a session. (Mitchels & Bond, 2021).

Record keeping and informed consent

As part of the Informed Consent process, we inform our clients about our record-keeping procedures, including:

- the nature and purpose of the records to be kept
- the safekeeping of the records
- their right to access their records, and
- to whom the information may be disclosed, and under what circumstances.

Keeping our client records secure

The safeguarding of our Client Records (paper or electronic) according to the Privacy Act (1998) and ensuring that client confidentiality is protected, is an ethical requirement of our profession.

Paper-based records

When deciding where to store client records we need to consider the longevity of our client records, as some will need to be stored for a very long time. This requires that safeguards are in place so that others cannot access or alter them.

Best practice:

- Physical storage of notes/files should be locked and the key securely stored at all times.
- If transporting records from one place to another, use of a lockable case or bag labelled 'Confidential' with a 'Return to Sender' address label is recommended.
- If faxing information, the receiver should have advance notice.

Electronic records

As stated by the British Association for Counselling and Psychotherapy (BACP); *Absolute security in the digital world does not exist* (Mitchels & Bond, 2021, p. 81).

What are reasonable security precautions?

- **System, data and online security:** if using electronic, web-based systems for storing and transferring client files, practitioners are responsible for ensuring there is appropriate encryption and security in place.
- **Device security:** Password or other security protection is a basic necessity for PCs, laptops, smartphones and portable electronic devices on which a client's personal data is stored. Should our devices become lost or stolen, data stored on them should be inaccessible to a thief and protected further by using a system that automatically deletes the stolen data or the device. (Mitchels & Bond, 2021).
- Virus protections should be in place to protect records from hacking. (Mitchels & Bond, 2021).

If forwarding information to others (with client consent) we ensure security at the recipient end by checking email addresses and if using password protection, sending the password separately.

If our client records are compromised and a client's privacy is breached, we need to consider the likely consequences and take appropriate action to limit the impact on the client's welfare. It is necessary that we be in compliance with the Notifiable Data Breach Scheme.

Limits to confidentiality of our client records

We need to keep in mind that our client records may be obtained by others through privacy legislation, subpoena, or freedom of information, and that they may be accessed by the client.

Lawful disclosure of client information by a practitioner occurs only when:

- the client has consented to or requests disclosure
- disclosure is required by the law, or
- the law permits or authorises disclosure (such as where there is a direct and imminent threat to the safety or health of the client or of another person. (Mitchels & Bond, 2021).

It may be necessary for us to disclose part of a client record to a supervisor to ensure effective oversight of our work, in which case the client record should be de-identified.

Ownership of our client records

The ownership of client records will depend on the basis upon which we are providing the service to the clients. The guidelines below should be read in conjunction with relevant legislation of our State or Territory and are not intended to override legislation applicable in any jurisdiction:

- if I am self-employed in private practice, client records belong to me
- if I am employed, the records belong to the employer
- if I am a contractor, the records belong to the party specified as the owner of the records in the contract
- if I provide services on a voluntary basis in any of the above settings, these guidelines still apply.

Access to client records within an organisation

Access to client records within an organisation should be in keeping with the principles of privacy and confidentiality.

We are mindful to discuss arrangements relating to the restriction of access to client records when negotiating employment or other contracts. Alternatively, we may need to advocate for the implementation of the principles in these Guidelines to ensure that client privacy and confidentiality rights are upheld.

We bear in mind the following:

- access to client records is generally restricted to the practitioner who created them, even if the practitioner does not legally own them
- the terms of employment or other contractual arrangements need to be taken into account, and applicable employment laws need to be considered, however, legal ownership of client records by virtue of an employment or contractual relationship with the practitioner does not give an organisation or an individual the automatic right to access confidential client records created by the practitioner.

With client consent, their records may be accessed by other professionals in a multi-disciplinary setting to support the delivery of the service, or where their care is being transferred to another practitioner.

Client access to their records

When writing client records, we keep in mind that clients or former clients may ask for access to them. Depending on the situation, allowing access to records is considered good practice and in many contexts is a legal right.

If a client is wanting to view their client record or a section of it, it is appropriate to ask for the request to be in writing, and to schedule a session to sit with the client as they read it. If the client wants a copy of the file, it is appropriate to charge a reasonable fee.

There are some circumstances where it may be appropriate or necessary to refuse access or restrict access to part of the records where providing access would, for example:

- pose a serious and imminent threat to the mental health or life of an individual
- have an unreasonable impact on the privacy of others (for example where services are provided to couples, families, or groups)
- be frivolous or vexatious
- be prejudicial to an investigation or prosecution of alleged unlawful activity (refer to the Privacy and Health Records Acts for a comprehensive list of exceptions).

Where the client records are held by government agencies and departments, a Freedom of Information (FOI) Application or a Government Information Access Application (in NSW) may be required.

Client records and legal proceedings

We keep current with the legal implications of our work with clients relating to record-keeping and the potential for a subpoena of our client records by a court, or access to our client records by a police warrant, and our obligation to comply.

In these circumstances, we create a duplicate copy for ourselves and require a dated and signed confirmation of receipt.

We are aware that it is an offence to alter, add or remove notes forming part of a client's record once a subpoena has been received, with all notes needing to be provided to the Court.

In certain circumstances, we can request the Court to keep sections of the notes private. A request to exclude sections of the notes from being admitted into evidence is made in writing to the Court. The Magistrate or Judge will determine whether notes are to be withheld (Commonwealth Evidence Act 1995).

We are attentive to situations in which information in client records has become outdated, and may therefore be invalid, particularly in circumstances where disclosure might have adverse effects.

We use professional judgment and comply with applicable laws when disclosing outdated information and ensure that the outdated nature of the information and its limited utility are noted.

Access to records by other third parties including lawyers and insurance providers is not obligatory and a copy must only be provided with the written consent of the client. In such circumstances we clarify the precise nature of what is being referred to and whether these are confined to the client's session notes. (Mitchels & Bond, 2021).

When a copy of client documentation is provided to a third party, we require dated and signed confirmation of receipt.

We seek professional support and guidance in relation to legal issues when necessary and seek to establish channels for discussing legal issues with appropriately qualified people, in advance of the specific need.

For how long do we keep our client records?

Client Records are retained in case they are required for future reference, either in relation to future client services or in relation to legal or administrative matters. How long records are kept depends on whether there is a risk of legal action arising from them.

Some states have specific legislation regarding the storage period of client records, and some organisations have specific requirements, and it is necessary that we understand these. In a private practice setting, we comply with Health Records Acts in retaining client records for the minimum period as follows:

Client	Retention Period
Adult over 18 years of age	7 years since the last contact with the client
Young person under 18 years of age	until the client is 25 years of age

There are, however, exceptions to the minimum retention period:

- when a client discloses being a victim of crime, we are required to keep records until the statutory limitation period is reached. Practitioners are required to check the legislation for their state or territory as practices may vary depending on the nature of the crime committed.
- when a client has a current claim for damages or is under guardianship or other court/tribunal order, the records should be kept indefinitely.
- some states and territories have specific legislation regarding retention requirements for indigenous clients. For example, in the Northern Territory and NSW, there is a requirement to keep the records of Aboriginal and Torres Strait Islander peoples indefinitely. (Australian Psychological Society, 2020, p. p.166).

As legislation is often changed, it is necessary that we remain current regarding client record retention requirements.

Disposing of our client records

It is beneficial to have a procedure in place to assist in identifying those client records where retention periods have lapsed and the file is no longer required.

The disposing of client records must be done in a manner that preserves our clients' confidentiality.

The Office of the Australian Information Commission (OAIC) considers personal information is destroyed when it can no longer be retrieved (Australian Privacy Principles Guidelines: 11:3) such as physical destruction (shredding) or removing any electronic storage and 'sanitising' or destroying the hardware. (Australian Psychological Society, 2022).

It is good practice when destroying client records to document the process as per the following example:

Client name	Date of initial entry in client record	Date of last entry in client record	Date of disposal

Planning for the unexpected

For those of us in private practice, there is an ethical responsibility to plan for the possibility of our sudden incapacity or death. These arrangements need to ensure continuity of care for our current clients, directives regarding client records (their transfer, continuing storage, or disposal) and attending to unfinished business of the practice.

This will involve the appointment of a person(s) who needs to be bound by the confidentiality agreed between us and our clients, for example, a trusted colleague or a specially appointed trustee. These arrangements are best served with the writing of a Professional/Clinical Will or similar written document.

Relevant codes and relevant legislation

We are informed by PACFA's Code of Ethics and the Government Codes of Conduct and are aware that there are state, territory and Commonwealth laws that apply to our record keeping including confidentiality, access and refusal of access, and their emphasis on obtaining informed consent before client records are released to a third party.

We seek to keep current with legislation relevant to our work setting, and are particularly aware of the following legislation:

- *Privacy Act 1988* (Cth) including the Australian Privacy Principles and the Notifiable Data Breach Scheme
- *Freedom of Information Act 1982*
- In Victoria: *The Health Records Act 2001*
- In NSW: *The Health Records and Information Privacy Act 2002*
- In ACT: *The Health Records (Privacy and Access) Act 1997*
- In the NT: *The Information ACT 2002*
- In Queensland: *The Information Privacy Act 2009*
- *Health Legislation Amendment Act (eHealth Act) 2015*
- *My Health Records Act 2012.*

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This document has been reviewed and updated by Dr Gill McCulloch, PACFA Professional Standards Committee. May 2023