



15

Record-keeping

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Chapter Overview

Record-keeping is widely accepted as an ethical requirement for good practice. This chapter examines the ethical basis for keeping or not keeping **records**, and the significance of records being kept securely. Ethical **issues** around clients' access to their records and their use in courts are considered. The chapter concludes with how records ought to be written.

Keywords: record-keeping, records, **notes**, **security**, access, courts, writing, storage

There are a number of **issues** around record-keeping which continue to grow in importance. The most fundamental of these concerns is whether there is an obligation to keep **records**. There is no consensus among counsellors in Britain on this issue, but the expectation that counsellors should keep records has grown. It is now rare to find a counsellor who does not routinely keep **notes** – however brief – of their work with clients. I will start by considering the ethical reasons for keeping records, before exploring subsidiary issues about the **security** of records, access to records by clients, colleagues and the authorities, their content, and the question of how long records should be retained after the completion of **counselling**.

Is It Desirable to Keep Records?

The arguments in favour of record-keeping include the following:

- The process of writing records involves counsellors in organizing their thoughts and feelings. This is in itself helpful to the counselling because it enables counsellors to reflect systematically on what has occurred and plan for future sessions. In other words, the process of making records enhances the quality of the counselling.
- Records provide counsellors with an *aide-mémoire* for incidental details, such as the names of people mentioned by a client, and this then frees the counsellor to concentrate on issues raised by the client rather than recalling details from one session to another.
- Systematic record-keeping makes any changes in the client's material over a series of sessions more apparent. The process of recall by memory inevitably involves a degree of 'rewriting' the past in terms of a perspective rooted in the present. Written records produced contemporaneously with the counselling make any changes that have occurred during the counselling more visible. This provides valuable information to the counsellor, who may choose to share this knowledge with the client when it is appropriate.
- Systematic record-keeping provides evidence of the degree of care taken by counsellors in their work, which may be useful if a client makes a complaint against a counsellor to a professional body or begins legal action against a counsellor. It also protects against differences in memory between client and counsellor.
- As counsellors seek to be professional and credible with other professional services, they need to develop record-keeping practices that support them in performing their role and meet the public expectations of any professional for quality of service and **accountability**. This is regarded as an increasingly significant reason, which probably explains why most of the counsellors that I meet at workshops around the country have chosen to keep records.

The balance of practice has shifted towards an assumption that counsellors do keep records of their work unless there are good reasons for not doing so. Nonetheless there are ethical reasons not to keep records at all or only keep records for some clients for whom records are unproblematic. The arguments most frequently offered against record-keeping are as follows:

- The **problems** of ensuring records are both secure and really confidential. For example, some counsellors may work in settings where burglaries are so frequent that it is difficult to maintain secure records. Community-based services operating out of converted buses or other forms of mobile premises have to consider the possibility of the theft of the entire counselling premises, including the records.
- Record-keeping may complicate **trust**-building with some clients. For example, counsellors working with clients who are vulnerable to legal prosecution (e.g. prostitutes, illicit drug users and others) may have to take account of their clients' fear that the police or other authorities could seize any records.
- Record-keeping is time-consuming.
- Some counsellors are opposed to the possibility of clients acquiring a legal right to see records kept about them. Some counsellors, therefore, prefer not to keep records in order to prevent this eventuality.
- Some counsellors have reservations about creating records which may be demanded by clients for use outside the counselling relationship in legal actions against others. They hope that an absence of records will enable them to concentrate on the therapeutic relationship without having to consider how that work would be viewed in a court of **law**. If they hope that the absence of records will prevent them from being required to provide evidence in court cases involving a client, they will be disappointed. An absence of records means that the counsellor is more likely to be called in person as a witness because there is no other way of obtaining evidence. Where records exist, the counsellor may be permitted to provide a report of the relevant information based on the records or they may be required to submit all the records as an alternative to appearing in person.

It is clear from this summary of the case for and against the keeping of records that the arguments are, on balance, in favour of record-keeping by counsellors as a general standard of good practice. However, the argument in favour of keeping records can be countermanded by circumstances in which records cannot be kept securely or circumstances where the existence of records would deter clients and work against the public benefit of ensuring the availability of counselling on terms acceptable to clients. A client's attitude to record-keeping would also be relevant in individual cases.

Both the law and professional **ethics** require that clients have consented to records being kept. Ethically, this forms part of the client's full and informed consent. Legally, it is about citizens' **rights** to know about and exercise control over

personally sensitive information that is being kept about them and to know the purpose for which it is being kept. When a client refuses to permit a counsellor to keep records, the counsellor is faced with a choice between continuing to see the client on this basis or refusing to see them unless some form of record can be kept. In my experience, most counsellors will attempt to establish why a client is so concerned about whether records are kept or not and attempt to adapt their practice to meet that client's needs. Some agencies will not see clients who totally refuse to permit any records at all.

Security of Records

Once it has been decided to keep records, knowledge of their existence and the level of security with which they are kept become an aspect of the client's informed consent. There is a strong ethical argument that clients need to know these facts in order to be in control of the information that they decide to disclose to the counsellor. This represents an optimal standard. The minimum standard suggests that if clients are not informed about the security of records, they should be entitled to assume that records are kept with sufficient security to prevent them becoming known to people other than those authorized by the client. Counsellors who have taken this into account have adopted different kinds of procedures according to their circumstances.

The first line of defence against unauthorized **disclosure** is the physical security of the records. This would normally match the anticipated risks to the records. Locking records in a desk or filing cabinet will prevent casual inspection by anyone with access to the room in which they are kept, but this is inadequate against someone willing to force an entry as most desks and filing cabinets are easily broken into. Where forced entry is reasonably foreseeable, it may be more appropriate to keep the records in a safe. Keeping records in a physically secure container for hard copies and as electronically secure files on computers is a basic ethical requirement.

In addition to the physical security of the records, or sometimes as an alternative to it, some counsellors have adopted systems that ensure the anonymity of records. Four methods are frequently used:

1. The counsellor uses **codes** to identify records known exclusively by themselves. The code might be in the form of numbers or initials. No information is included within the records that could identify clients. This may be practical with small numbers of records but is usually impractical with larger quantities.
2. An alternative method is a split system of record-keeping. For example, personally identifiable information (e.g. name, address, contact numbers, names of significant others mentioned by the client) is kept on small file cards which can be readily removed from the premises by the counsellor, and especially overnight,

from where the lengthier records of sessions may be kept. As each of these cards is numbered or coded and this is the only identification on the records, someone will need access to both the card and the record to obtain significant information about the counselling. The cards on their own only indicate who is receiving counselling but not the issues raised in that counselling. The records on their own merely contain the contents of the sessions but cannot easily be linked to identifiable people. Splitting records is only necessary where there are concerns about how securely records can be kept from unauthorized access. A single record system that is kept securely is much more efficient and **accessible** for routine use – especially in large or busy services.

3. Some counsellors work in settings where they are expected to make entries on agency records which are available to all authorized personnel within the agency, and may even be passed on to another agency if the client seeks their services subsequently. For example, counsellors in medical settings may be expected to make an entry on a patient's health record or, in social services, on a client's case file. Best practice in these circumstances usually involves the counsellor in negotiating an agreement with both the agency and their clients. Ideally, the agreement will permit the counsellor to make brief entries on the agency files and to keep separately more detailed records of the counselling process and any information which is personally sensitive to the client. These latter records would usually be treated as highly confidential and therefore access to them may be restricted to the counsellor and/or the client in routine situations. There is a legal precedent for this arrangement under the Code of Practice issued by the Human Fertilization and Embryology Authority (HFEA, 2008) as required by the Human Fertilization and Embryology Act 1990. In this setting, it is usual for the offer of counselling to be recorded in the central records and the client's response to the offer. However, the counselling notes of individual sessions are stored separately and treated as confidential. Information obtained in counselling may be disclosed in certain circumstances, for example if it 'gives a team member cause for concern about the suitability of a person' to participate in fertility treatment. It is good practice to be clear with clients about how records are kept and the circumstances in which information might be communicated to other team members.
4. Increasing numbers of counsellors keep their records on computer. Such records can be protected by passwords which control different levels of access. Although the technology of computer records is different, the principles are much the same as for paper-based records and are set out in recent data protection legislation and government guidelines. However, there is an additional obligation to register the use of computerized records with the Information Commissioner's Office. For further **guidance** see www.ico.gov.uk.

Access to Records

The question of who ought to have access to records is frequently raised with regard to three situations. The first relates to situations where the counsellor is working in an agency in which the manager or employer is seeking access to

client records; the second relates to a client's access to their own records; and the third to police access to files. It is useful to consider each of these separately because the ethical issues and legal considerations are different.

Access by employers

The demand for access to records by an employer is only possible when a counsellor has an employer. Counsellors working on their own in private practice are free from this particular concern. In some circumstances this may be a key factor in a client's choice of counsellor.

Counsellors who have not clarified their employer's access to records in advance of counselling, and are working without a corresponding agreement with their clients about access, are likely to find themselves in a difficult situation. The employer's and client's rights may be in conflict and both may hold the counsellor accountable. The usual principle is that records made on materials provided by an employer or in the employer's time belong to that employer. However, the principles and law of **confidentiality** (see Chapter 10) suggest that there are restrictions on how an employer exercises that ownership. Ownership is not necessarily the same as unfettered control and access. Breaking a confidence without justification could create legal liabilities for a counsellor, even if the breach is to the counsellor's employer. A prudent counsellor will have established clear guidelines which are known to both the employer and the client about who will have access to counselling records and for what purposes in order to avoid conflicting responsibilities to the client and employer.

Access by clients

There is a strong ethical case for clients to be granted access to any personally sensitive information recorded about them in order for them to be reassured of its accuracy and to check that the information is consistent with the purpose for which it has been disclosed. In practice most clients will take records on **trust**, especially if their experience of the counselling is satisfactory. In some instances however a counsellor's **respect** for a client's **autonomy** over their records may be countermanded by a concern that granting access could destabilize the therapy and that access might be better delayed until that therapy is further advanced or completed. Such concerns can often be managed by negotiation. (Counsellors working in health settings may be able to enlist a doctor's authorization for restricting client access where the doctor considers such access would be seriously detrimental to the client's physical or mental health or condition, or indeed to any other person (see Data Protection (Subject Access Modification) (Health) Order 2000 5(1) implementing Data Protection Act 1998 s. 30(1): this is probably the only exemption to a client's right of access likely to arise in counselling provided in a statutory service.)

Generally, data protection law lacks subtlety. It prioritizes a citizen's right to know personally sensitive information held about them so that they can challenge any inaccuracies and know for what purpose it is being kept and how it is being used. All the client has to do is make the request for access in writing, provide proof of identity if this is in doubt, and pay the required fee. However, the data holder should withhold from disclosure parts of the information from which another person could be identified, unless that person's consent has been given.

There is a rather odd legal exception to a client's right to see their counselling records which is mostly restricted to non-statutory services. It is odd because there is no obvious ethical justification for this exemption. Indeed, it removes the right to see records in the very circumstances in which clients might be most concerned to see what has been recorded and how that information is being used and protected. The exception arises where the counselling records are held in an unstructured manual file. Such a file might be notes kept on paper and added to a cardboard envelope file in no particular order, so that finding a specific piece of information would require sorting and sifting through the file. Similarly, a file to which things are added in chronological order (e.g. the most recent item is added to the front or back of a ring binder) would be regarded as an unstructured file. The exact point at which a manual file turns from structured into unstructured is not precisely defined in law. It is determined by what is known as the 'temp test', which determines whether someone unfamiliar with the records, such as a temporary secretary, can easily find the information they are looking for by the way the record is structured (Bond and Mitchels, 2015: 61). It follows that a file which is divided into sections is more likely to be a structured manual file to which the client has a legal right to see their own notes. In other words, the client's right to see records ceases in just those situations where they might be most concerned because the counsellor seems disorganized and unsystematic. A client has less rights of access to a jumble of barely sorted papers than they have to a structured file (e.g. if the sections divide identification and contact details, session notes, discussions in **supervision**, correspondence, etc.), so that someone could easily find a home address, notes of session 3 or discover when this client was last discussed in supervision.

From a client's perspective they would be best advised to see a well-organized counsellor, because not only will they have the benefits of that level of organization they will also have the additional protection of access to the counsellor's records should it be desired under the data protection law. A client who sees a less well-organized counsellor may or may not suffer from their lack of organizational skills but will forego their right of access to the counselling notes.

If a client obtains access to their notes and disagrees with what has been recorded because it is considered misleading or incomplete, the counsellor has a number of options. They may agree to some changes. Alternatively, they can

record that there is a disagreement and record the client's version as an alternative version of events so that there are now two records of the same event.

Some counsellors will have legitimate concerns about granting clients access to their notes. Some will include personal notes about themselves and their own reactions as part of their process observations. A counsellor may then be concerned that these are too personally revealing to be shown to a client. Where such notes are integral to the counselling approach or methods, then the counsellor needs to ask why a client should not be entitled to see them. If they are too personal, could they be recorded in another way or held separately in a personal journal without any identifiable reference to the client? Clients are only entitled to access to records which refer to them as identifiable persons because they are named, or their identity can be inferred from the information recorded. A client's notes are arguably not the place for a counsellor to be working through personal processes in depth, especially if they go beyond what is directly relevant to the client or if the counsellor wants to preserve their **privacy**.

Some psychodynamic counsellors have expressed concern to me about clients seeing records prematurely before transferences have been worked through and how this might disrupt the therapeutic process. There would be nothing to stop a counsellor asking a client to delay access, but that client would be entitled to insist on prompt access in the case of computerized and structured manual records.

It is illegal to keep two sets of records relating to an identifiable client in order to grant access to one and keep the other away from the client. It should also be noted that the data protection law does not permit withholding records from a client because these are damaging to the professional. A government department was ordered to disclose records that described their subject as a 'prat' and 'out-and-out nutter'.

The use of counsellors' records in court

What can a counsellor do if a client asks them to supply a report that will help them in a legal action against someone else? For example:

Michelle has given birth to a severely handicapped child and is bringing an action for medical negligence. Her counsellor is asked to provide a report about his client's feelings towards the child. The lawyers acting for the medical staff seek access to the therapy notes on which the counsellor based his report.

This, in broad terms, was the situation which Stephen Jakobi and Duncan Pratt (1992), as lawyers acting for the Psychologists' Protection Society, were asked to

consider. In my experience, counsellors are also asked to provide reports following motor accidents, industrial accidents, and in marital disputes.

Many counsellors are understandably reluctant to provide reports, appear as witnesses, or supply case records on behalf of clients. To do so could be seen as a confusion of roles, with the counsellor being drawn into a public arena in ways that may compromise a client's autonomy or privacy. Counsellors may also feel that writing reports for courts is not part of their role and that they have not been trained in how to write these, in comparison to doctors and social workers who are usually more experienced in court work. So far as I can tell, there is no way a client can compel a counsellor to produce a report on their behalf. The choice is the counsellor's. However, refusing to provide a report may result in the client (or more likely the client's solicitor) requesting the court to issue a witness summons for the counsellor to appear in person at court to give evidence and that any records are disclosed to the court. Often preparing a report that answers the solicitor's questions and protects the rest of the information is the better option and, in many cases, makes appearing as a witness unnecessary.

If a counsellor is asked to write a report on behalf of a client, Jakobi and Pratt (1992) recommend that a number of precautions are taken:

- The request for a report is likely to be made by the solicitors acting for the client. Technically, this can be treated as the client's consent to disclosure provided that the request comes from the client's own solicitors and not from solicitors acting for another party in the proceedings. However, it is sensible for a counsellor to see the client to ensure that they realize that the production of the report could lead to a requirement for the disclosure of case records to the other party; that the counsellor may need to include sensitive information in the report; and that the client really is consenting to the production of the report (or client records) in full knowledge of what this entails.
- If a counsellor is asked to disclose records in addition to the report, this request should be refused unless either the client consents or a court order is made.
- If disclosure could cause serious harm to the client, then the counsellor should inform their solicitor so that an adequate explanation can be given for requiring disclosure. Again, through the client's solicitor, it may be possible to limit disclosure to matters which are highly relevant to the case or to restrict who sees the counselling records, such as a relevant expert. Alternatively, there may be other ways of obtaining the same information, perhaps by an expert examining the client independently.
- Sometimes it will be possible to request that an expert be appointed to examine the documents rather than have them considered in full in open court.
- If limitations on the disclosure of documents have been agreed, no reference should be made to the excluded material in court. Any limitations on disclosure will cease to have effect once the excluded material is referred to or read out in open court. A counsellor will need to bear this in mind if they are called to give evidence.

Once a client is engaged in litigation, a counsellor's notes are vulnerable to disclosure and use in proceedings. It is only in the most exceptional circumstances that a counsellor will be able to prevent disclosure. For a fuller account of the issues, see *Therapists in Court: Providing Evidence and Supporting Witnesses* (Bond and Sandhu, 2005) or seek legal **advice**. Whatever a counsellor does they should not delay seeking advice until the last moment. This will make the situation very hard to resolve by using any alternatives that might have been available even a few weeks earlier.

Access by the police

The law places counsellors' records in a special category, which excludes them from the usual search warrant and substitutes a more demanding procedure before the police can obtain access to them. The legislation that established these procedures is historically significant as being the first to recognize formally the personal sensitivity of counselling records and grant them legal protection. The Police and Criminal Evidence Act 1984 requires a search warrant, which must be signed by a circuit judge instead of requiring only the more usual magistrate's signature, a less demanding procedure, to access files. This legislation is particularly interesting because it makes several specific references to counselling in its definition of 'personal records'. Personal records are defined in section 12 as:

documentary and other records concerning an individual (whether living or dead) who can be identified from them and relating:

- (a) to his physical or mental health;
- (b) to spiritual counselling or assistance given or to be given to him; or
- (c) to counselling or assistance given or to be given to him for his personal welfare, by any voluntary organization or by any individual who –
 - (i) by reason of his office or occupation has responsibilities for his personal welfare;or
 - (ii) by reason of an order of a court has responsibilities for his supervision.

Counsellors' records therefore belong in the same category as those of doctors, vicars, social workers and probation officers, regardless of whether that counselling is paid or **voluntary**. Even if a circuit judge has signed a warrant, it is possible to go to the High Court to reverse this decision. In one case, the High Court ruled that an Old Bailey judge acted outside his powers when he ordered the Royal London Hospital to disclose someone's medical records to

help in a murder investigation. This case demonstrates that counsellors can resist disclosing records to the police. An exception to the requirement for a warrant may arise if the police are searching for documents in order to detect or prevent terrorism under the current Terrorism Act 2000. However, despite the sweeping power seemingly given to the police under this legislation, they are required to exercise their powers 'reasonably'. It would be wise for counsellors to seek a lawyer's advice whenever they become aware that they are holding information which relates to a serious crime.

The Contents of Counselling Records

APA
GUIDELINES



There are no fixed rules about what ought to be included in counselling records or how these ought to be written. Counselling records that I have seen have varied considerably in style, from brief factual accounts which focus on what a client reported to ones that include more of the counsellor's thoughts and responses. The guiding principle is that the type of record should be one that supports the therapy and enables this to be delivered to a reasonable standard of care. A good record is written as close as possible in time to the events it records. Some counsellors will set aside 10 minutes between clients for this purpose. If we have any reason to think that a record might need to be produced for legal purposes, it is good to distinguish between what was directly observed, what the client said, and the counsellor's own responses or thoughts. For example:

20 January 2010 Session 3

Bob arrived 10 minutes late, out of breath and looking rather flustered. He was more smartly dressed than for previous sessions and explained that a meeting with his boss at work had overrun and delayed him. He said that it had been his annual review. He had been dreading it – see previous session – but had decided to go in positively and make suggestions about how the administrative system that had been troubling him could be improved to everyone's advantage. He thought his boss was not interested initially but warmed to his ideas as he talked them through. This was not what he had expected. He said that he had expected his boss to dismiss his ideas out of hand. He had found the work on the similarities and differences between his boss and his father last week helped him to see them as different people who might react in different ways. He was pleased to be breaking a pattern of feeling silenced and deskilled. However, he is anxious about having to prepare a business plan for two weeks' time and has agreed to the next session being before this. I will monitor his anxiety, which he reports as 'half what it was when I first came to see you'. Noted

that he did not mention his girlfriend or difficulties with her this time. As he left, I noticed that I was feeling uncertain about his motivation – between being liked or being successful? Explore further next time?

This would be a reasonably full record and appropriate if the counselling benefits from this level of detail and the counsellor has time to make the record. A shorter record of the same session might be:

20/1/10 Bob arrived late due to ‘meeting with boss overrunning’. Bob thought meeting had gone better than expected. He said previous work on distinguishing his father and the boss had helped. Affirmed growing confidence. Consider exploring Bob’s motivation at work next time.

There is no single correct way of writing case notes. It still appears to be a neglected topic in basic training. Each counsellor has to develop a style that is sufficient to support the counselling but without being excessive in what is recorded. The primary purpose of good records is to support the work with the client. This will usually include a summary of significant content and processes. Other items to be included in the record are:



BASIC
RESPONSIBILITIES

- any written and signed consents to all treatment;
- any written and signed consents to all passing of confidential information;
- all appointments, including non-attendance by client;
- treatment contracts (if used);
- up-to-date record of counsellor’s reasoning behind decisions about significant interventions and general strategies;
- consultations with anyone else about the client;
- copies of any correspondence from the client or relating to work with the client;
- any instructions given to the client and whether or not the client acted on these.

Matters Not to Be Included in Records

Records ought not to include anything that could disrupt the therapy if seen by a client. **Prejudice** and abusive comments are to be avoided. Negative evaluations should only be included if they serve a therapeutic purpose, for example a negative countertransference would be justified if it is integral to the therapy and a statement about the counsellor’s internal processes rather than directly ascribed to the client (e.g. ‘I experience uncharacteristic boredom when Sue talks about her relationship with ...’, rather than ‘Sue is boring about ...’). Information about illegal behaviour, sexual practices or other

sensitive information which may embarrass or harm a client or others is rarely appropriate for the record.

Giving careful consideration to what to include and exclude is good practice. What is included should be written with the possibility of the client seeing the record at a later date and the possibility that the records may be required for use in a legal dispute. However, the overall principle should be to write only what is useful for the therapy unless the record is known to be needed for other purposes and these purposes have been consented to by the client.

The Format of Counselling Records

Very little has been written about how best to structure counselling records. Gaie Houston (1995) recommends that counsellors keep the records in two sections. The first section should contain useful background information about the client and the contractual terms that have been agreed. She suggests the following headings:

1. NAME [probably coded] AND MEANS OF REFERRAL.
2. PRESENT CIRCUMSTANCES [Mrs A is 28, living since she was 18 with Claud. Works at Boots.]
3. HISTORY [Leave plenty of room to put in facts about her life and her ways of dealing with its events. These can be added to as the weeks go by. Noting the date can be informative here.]
4. REASON FOR SEEING ME [Has changed jobs three times in the last few months, and reports that finds working relationships with colleagues difficult, in contrast she gets on 'perfectly', her word, with family and Claud.]
5. MY HUNCHES [She said forcefully and out of the blue that she was not thinking of leaving work and having a baby. I guess she is. Longer-term work probably needs to be about her daring to acknowledge her own needs, and hopes for the future. To be explored sensitively.]
6. TIMES AND PAYMENTS [Tuesdays at 11 am, with 3-week break at Easter when she will be abroad. One month paid in advance, next payment due at next session.]

One way of establishing the contractual relationship with a client is for the counsellor to send them a letter after the first session that includes what has been agreed to between client and counsellor. The letter could be attached to this section, as could copies of any subsequent correspondence.

The second part of the records would be the record of the actual counselling sessions. Houston suggests counsellors separate the factual account of what happened from their own personal responses and evaluations by using several vertical columns. The factual account of whether a client arrived on time, what

was said, etc., could be put down in the left-hand column. The commentary could then be written in a column to the right. There is a lot to commend this approach. My own system is slightly different, but has evolved out of a need to separate the background information from the session notes and within those notes to separate factual reporting from my observations and speculations. The system I have used is shown in Figures 15.1 and 15.2.

At times when a counsellor has been seeing lots of clients, or when time is at a premium, they may use pre-printed forms or a standard computer template.

Use of Records in Counselling Supervision

Some supervisors will recommend or require that counsellors keep records and use these in counselling supervision. The process of writing notes helps a counsellor to sort their various responses to the counselling session and therefore helps them to focus their attention on important issues. It is agreed that this makes for a much better supervision session. This view is not universal but it is gaining ground. Client consent should be sought for using records in supervision.

How Long Should Records Be Retained?

This is a difficult question to answer. Records may be relevant to present or future court proceedings, or to complaints, and so the time limits for legal

Name
Address
Contact tel nos:
Summary of counselling contract (e.g. frequency, duration, review periods, confidentiality, fees etc.):
.....
.....
Correspondence (attached) Code no*
.....
* for split records only – NB no need to split records that can be kept securely

FIGURE 15.1 *Counselling records: client background information*

<p>Date: Time/duration: Code no*</p> <p>Content: summary of client's narrative, behaviour, feelings and counsellor's interventions:</p> <p>.....</p> <p>.....</p> <p>Process: any comments made by client about process, counsellor's observations and/or speculations about the process:</p> <p>.....</p> <p>Notes for next session: e.g. any agreement about what the client or counsellor would do between sessions, issues to be raised during the session or for the counsellor to be aware of:</p> <p>.....</p> <p>.....</p> <p>Issues for counselling supervision:</p> <p>Notes about any correspondence or telephone conversations:</p> <p>.....</p> <p>* for split records only</p>
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FIGURE 15.2 *Counselling records: record of each session*

proceedings or complaints procedures may be relevant. The time limits for children and young people are different from those for adults (see Bond and Mitchels, 2015: Chapter 6).

The important thing is that a client should be aware of the amount of time that records are usually retained by a counsellor and agree to this. If a client wants their records retained for a longer period, this should be negotiated and agreed with the counsellor, or an alternative solution sought (perhaps that the records may be handed over to the client). In straightforward circumstances, where there are no other legal or professional considerations, the records could be destroyed any time after the end of the counselling relationship. One of the principles that informs good practice in record-keeping is that sensitive information should be destroyed when its usefulness has expired. A retention of one year might be appropriate where there is the possibility of a client returning.

However, where there are unresolved issues which might result in a complaint against a counsellor being made to a professional body or legal proceedings in which the records might need to be produced, a much longer period is required before the records should be destroyed. In the absence of any better guideline, seven to ten years would be appropriate, if this is both practical and the records can be kept securely. If any legal action involving a client is a possibility, it would be prudent for a counsellor to obtain legal advice about how long records should be kept, as the expiry time for initiating legal action varies according to the type of case. For a further consideration of how long to keep records see Bond and Mitchels (2015).

Conclusion

It is now regarded as essential to good practice to keep records of counselling as these are part of a systematic and professional approach to counselling. Clients deserve this amount of care. Records are a very useful source of information that not only provide more accurate information than memory alone but also support counsellors' professional accountability to clients and others with legitimate interests in their work as counsellors.

As in so many other areas of society, there is a steady and accelerating movement away from paper records and communications with clients in favour of computer or digital-based systems (see Chapter 11).

Multiple Choice Questions



Revise your understanding of this chapter with a set of multiple choice questions. To take the quiz, visit the interactive eBook version of this textbook and click or tap the icon.

Reflective Questions

1. Review your current arrangements for keeping records. How do you (and any colleagues with authorized access to them) use your records to support your work with your clients? What changes, if any, would you make to improve their usefulness?
 2. How secure are your records? What would you do if someone gained access to them by accident or wrongdoing? Is the balance between having records that support your counselling and their security appropriate to the service you offer as a counsellor?
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