

Guidelines for Client Records

Introduction

These Guidelines provide *good practice guidance* for keeping client records for helping professional client work.

Government, professional associations, employers and funding bodies require accurate and appropriate records to be kept of the contact counsellors and psychotherapists have with their clients. Record keeping is an important aspect of being professional and accountable for the services that practitioners provide to clients. Accurate and up-to-date records support quality service delivery and assist in making referrals to other health professionals, when reporting risks to clients or to other parties, and to ensure clients can receive continuity of care.

In addition to these consulting these guidelines, practitioners are responsible for considering the practice requirements of the modality or modalities in which they practice, and any applicable guidelines from the professional associations to which they belong.

Contents

1.	Codes of Conduct	.2
2.	Application of Guidelines	.2
3.	Purpose of client records	.2
4.	Disclosure of record keeping procedures	.3
5.	Content of client records	.3
6.	Responsibility for creating and maintaining client records	.3
7.	Confidentiality of client records	.4
8.	Ownership of client records	.5
9.	Access to client records	.5
10.	Client records and legal proceedings	.6
11.	Client access to records	.8
12.	Retention and disposal of records	.8
13.	References	.9

Codes of Conduct

In New South Wales and South Australia, Codes of Conduct have been legislated in relation to services provided by self-regulating health professions including counselling and psychotherapy. The NSW and SA Codes apply to all counsellors and psychotherapists practising in NSW and SA respectively. There are also plans to introduce a National Code of Conduct.

Where a Code of Conduct is in force, these Guidelines are to be read and implemented in conjunction with the requirements of the Code of Ethics applicable to the practitioner.

Application of Guidelines

These guidelines have been developed for counsellors and psychotherapists who are listed on the AGAPÈ National Register and can be adopted by AGAPÈ Member Associations to apply to their members or by other organisations when appropriate.

Practitioners providing supervision services to other practitioners are covered by these guidelines with the supervisee being the 'client' in these situations.

Where practitioners are employed by an organisation, or engaged as contractors, they should consider these guidelines taking into account relevant organisational policies and procedures. Organisations that provide counselling and psychotherapy services may find these guidelines a useful resource to inform their own policies and procedures.

Purpose of client records

Client records are maintained for a variety of reasons, the most important of which is for the benefit of the client. Conscious recording of current client needs, support and interventions is part of the practitioner's duty of care to the client. Records can provide a history and current status in the event that a client seeks services from another health professional. Maintenance of appropriate records may also be relevant for a variety of other institutional, financial, and legal purposes. The nature and extent of the records will vary depending upon the type and purpose of the services.

- Practitioners keep client records to enable practitioners to document and review the counselling and psychotherapy services provided.
- Practitioners keep well documented records to help protect themselves from professional liability in the event they become the subject of legal or ethical proceedings.
- Practitioners can only use client information for the purpose for which it was recorded, that is, the provision of counselling or psychotherapy services.
- Client information can be used for related purposes only where it is reasonable to expect that it would be used for these purposes, for example to provide other services to the client in a multi-disciplinary setting.

• Client information should only be used for other purposes, including research, where the client's informed consent has been obtained.

Disclosure of record keeping procedures

Clients may wish to know what kind of client records their counsellor or psychotherapist keeps.

- Practitioners inform their clients, when appropriate, of the nature and purpose of the records to be kept, the safekeeping of the records and the client's rights of access to their records, if any.
- Practitioners may charge a reasonable fee for review and reproduction of records.
- Practitioners do not withhold records that are needed for valid healthcare purposes solely because the client has not paid for prior services.

Content of client records

Client records include any information (including information stored electronically) used to document the nature, delivery, progress, or results of counselling and psychotherapy services.

- Practitioners keep client records that include:
 - Identifying data for the client
 - Referral information (if applicable)
 - Dates and types of services and fees
 - Details of services provided for example: intake or assessment information; details of the counselling or psychotherapy contract; intervention plans; consultation notes; reports; psychometric testing results.
- Practitioners maintain accurate, current, and pertinent records of services, as may be required by their jurisdiction and circumstances.
- Practitioners maintain records in sufficient detail to permit planning for continuity in the event that another practitioner has to take over delivery of services, including during periods of leave, or in the event of the practitioner's death, disability or retirement.
- Practitioners maintain records in sufficient detail for regulatory and administrative review of service delivery.
- Practitioners make reasonable efforts to protect against the misuse of records. They take into account the anticipated use by the intended or anticipated recipients. Practitioners adequately identify impressions and tentative conclusions as such.

Responsibility for creating and maintaining client records

Records may be created and maintained in a variety of media, including electronic systems, so long as their utility, confidentiality and durability are assured.

- Practitioners establish and maintain a record-keeping system that ensures confidentiality. Records are kept in a manner that is safe and secure, with properly limited access, and from which timely retrieval is possible.
- Practitioners are responsible for the content of their records. Records are organised in a manner that facilitates their use by the practitioner and other authorised persons.
 Practitioners ensure that records are legible and are completed in a timely manner.
- Practitioners take responsibility for their clients' records, taking into account the policies of any organisations where they practice.
- With the informed consent of the client, practitioners make appropriate arrangements for transfer of client records where the practitioner is no longer delivering a counselling or psychotherapy service and transfer of the records is required for continuity of care.
- When transporting client records, practitioners ensure records are kept safe and secure. For example, files are transported in a locked bag or box labelled 'Confidential' with a 'Return to Sender' address label.
- When using electronic, web-based systems for storing and transferring client files, practitioners are responsible for ensuring there are appropriate encryption and security systems in place. Web-based systems can provide a filing system that can be securely accessed anywhere while avoiding the risks associated with transportation, but care needs to be taken to ensure the security of electronic and web-based client records.

Confidentiality of client records

Rigorous respect for issues of confidentiality is fundamental to the ethical practice of counselling and psychotherapy.

- Practitioners store client records securely at all times to ensure confidentiality.
- Practitioners clarify and explain to clients the nature and extent of confidentiality from the start of the contract. As client records can be disclosed to other parties in certain circumstances, practitioners explain to clients that confidentiality is limited and identify the circumstances in which confidentiality may need to be breached.
- It may be necessary for practitioners to disclose part of their client records to a supervisor to ensure effective oversight of their services. It is a requirement of AGAPÈ registration that practitioners are supervised in the delivery of all services. Any records disclosed to a supervisor should be de-identified to protect the client's confidentiality.
- It may be necessary for practitioners to disclose client records, or information about a client, to third parties where there is a direct and imminent threat to the safety or health of the client or of another person. For example, a practitioner may be required to provide information to protect the client from suicide or self-harm, to assist in the care or treatment of the client, or to prevent harm to another person.

- When writing records of client sessions, practitioners should keep in mind that other parties, including the client, may access the records in the future.
- Practitioners make provision for appropriate access to their client records for the purpose of notifying clients in the event of the practitioner's death or incapacity.
- Agreements about confidentiality continue after a client's death unless legal or ethical considerations demand otherwise.

Ownership of client records

Ownership of client records does not imply the right to access those records. Confidentiality principles still apply. However, the guidelines below should be read in conjunction with relevant legislation and are not intended to override legislation applicable in any jurisdiction.

The ownership of records of client services will depend on the basis upon which the counsellor or psychotherapist is providing the service to the clients.

- Where the practitioner is self-employed in private practice, the records belong to the practitioner;
- Where the practitioner is employed, the records belong to the employer;
- Where the practitioner is a contractor, the records belong to the party specified as the owner of the records in the contract; and
- Where the practitioner is providing services on a voluntary basis in any of the above settings, these guidelines still apply.

Access to client records

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

- The practitioner who created the client records is responsible for ensuring the client's privacy and confidentiality are maintained.
- In keeping with the principles of privacy and confidentiality, access to client records is generally restricted to the practitioner who created them, even if the practitioner does not legally own them. In some works settings, practitioners may need to advocate for implementation of the principles in these Guidelines to ensure that client privacy and confidentiality rights are upheld.
- The terms of employment or other contract 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 contract relationship with the practitioner does not give an organisation or individual the automatic right to access confidential client records created by the practitioner.

To ensure privacy and confidentiality of client records can be maintained:

- Practitioners are responsible for determining whether employment laws in their state or territory takes precedence over privacy considerations.
- Practitioners are encouraged to discuss arrangements relating to restriction of access to client records when negotiating employment or other contracts.

In certain situations, client records may be shared with other professionals:

- Where care of the client is being transferred to another practitioner and the client has consented to the records being accessed;
- In a multi-disciplinary setting where the clients has consented to the records being accessed by other professionals to support the delivery of the service; and
- Where this is a legal requirement for disclosure.

Client records and legal proceedings

Practitioners are aware of the legal implications of their counselling and psychotherapy work. This includes responsibilities relating to record-keeping, subpoenas of client records, and access to records by clients or third parties.

- Practitioners seek professional support and guidance in relation to legal issues when necessary. Practitioners establish channels for discussing legal issues with appropriately qualified people, in advance of the specific need.
- Practitioners comply with applicable federal, state or local laws relating to privacy and record keeping. Where there are conflicts between these laws and organisational policies or these guidelines, practitioners give precedence to the legal requirements.
- Practitioners are informed of the legal requirements concerning the confidentiality of client records and access and refusal of access to information contained in client records.
- Applicable legislation (Thomson, 2004)

DISCLAIMER: This information is current as at August 2022. Practitioners should check government websites to ensure that there have been no legislative changes.

Jurisdiction	Public Sector	Private Sector - Health
Commonwealth	Privacy Act 1988 (Cth)	Privacy Act 1988 (Cth)
ACT	Privacy Act 1988 (Cth) Health Records (Privacy and Access) Act 1997	Privacy Act 1988 (Cth) Health Records (Privacy and Access) Act 1997
NSW	Privacy and Personal Information Protection Act 1998 Health Records information Privacy Act 2002	Privacy Act 1988 (Cth) Health Records information Privacy Act 2002
NT	Information Act 2002	Privacy Act 1988 (Cth)

Jurisdiction	Public Sector	Private Sector - Health
QLD	Information Privacy Act 2009	Privacy Act 1988 (Cth)
SA	Information Privacy Principles Instruction 2013	Privacy Act 1988 (Cth)
TAS	Personal Information Protection Act 2004	Privacy Act 1988 (Cth)
VIC	Information Privacy Act 2000 Health Records Act 2001	Privacy Act 1988 (Cth) Health Records Act 2001
WA	Section 81, Criminal Code 1913 Regulation 8, Public Service Regulation 1988 Section 314, Health Act 1911	Privacy Act 1988 (Cth) Confidentiality of Health Information Committee

- Access to client records may be requested in relation to legal proceedings under subpoena.
- It is an offence to alter, add or remove notes forming part of a client's records once a subpoena has been received by a practitioner or an organisation where the practitioner practices. All notes must be provided to the Court.
- Practitioners can request the Court to keep sections of the notes private in certain circumstances. 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 dependent on (Commonwealth Evidence Act 1995):
 - The relevance, value and importance of the records to the case;
 - Whether disclosure would be prejudicial to the client;
 - The likelihood of harm and the nature of the harm to the client if the information is admitted into evidence;
 - The means available to the court to limit such harm, for example, closing the Court during cross examination of witnesses;
 - Whether the information contained in the records is already known, for example by the client disclosing it to another person.
- Practitioners 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.
- Practitioners 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.

Client access to records

A client may ask for access to their client records. Depending on the situation, allowing access to records may be considered good practice. In some jurisdictions it may be a legal right (refer to legislation in your jurisdiction for details). Even where a client has the right to access records, there are some circumstances where it may be appropriate or necessary to refuse access.

- When writing records of client sessions, practitioners should keep in mind that clients may access the records in the future.
- Practitioners will facilitate a client's access to their records, or to those sections of the records that are relevant and appropriate to be accessed.
- A request by a client for access to their client records may have to be dealt with pursuant to the relevant privacy and health records legislation which varies for different jurisdictions. 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.
- It may be appropriate or necessary for practitioners to refuse clients access to their records in certain circumstances, or restrict access to part of the records only, where providing access to the records would:
 - Be unlawful (refer to any relevant legislation in your jurisdiction);
 - Pose a serious and imminent threat to the mental health or life of an individual;
 - Have an unreasonable impact on 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.

Retention and disposal of records

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.

- Practitioners are aware of any relevant federal, state and local laws and regulations governing records retention. Such laws and regulations supersede the requirements of these guidelines.
- In the absence of such laws and regulations, practitioners (or their employing agency, or alternatively, record owners) retain client records for a minimum of 7 years after the last contact with the client. If the client is a minor, the record retention period is extended until the minor reaches the age of 25.
- Practitioners exercise professional judgment when determining whether to keep records beyond the timelines required by law or recommended in these guidelines.

• Practitioners disposing of client records do so in an appropriate manner that ensures nondisclosure or preserves confidentiality.

References

- Evidence Act 1995. Commonwealth of Australia. Retrieved from <u>http://www.austlii.edu.au/au/</u> legis/cth/consol_act/ea199580/
- NSW Government (2012). *Code of conduct for unregistered health practitioners.* Schedule 3 of the Public Health Regulation 2012. Retrieved from <u>http://www.health.nsw.gov.au/phact/</u><u>Pages/code-of-conduct.aspx</u>
- SA Government (2013). *Code of conduct for unregistered health practitioners*. Schedule 2 of the Health and Community Services Complaints Regulations 2005. Retrieved from http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/safety+and+quality/governance+for+safety+and+quality+in+health+servicee+organisations/credentialling/unregistered+health+practitioners+code+of+conduct
- Thomson, C. (2004). *The Regulation of Health Information Privacy in Australia: A description and comment.* Commonwealth of Australia. Retrieved from http://www.nhmrc.gov.au/files_nhmrc/publications/attachments/nh53.pdf

Acknowledgment

AGAPÈ gratefully acknowledges the Australian College of Applied Professions for sharing their Client Note Guidelines which were used in the development of this document.