Record keeping in psychotherapy

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On being asked for an expert opinion on the quality and adequacy of notes maintained by a practitioner, ROBERT KING found that neither interrogation of relevant codes of practice, nor a search of wider published literature provided much guidance. In fact, there is remarkably little written on the subject of clinical records in psychotherapy. This article seeks to open up discussion on this topic and make some recommendations that might assist practitioners navigate this difficult territory. While codes of practice recommend the keeping of confidential, adequate, essential and relevant records, there is little to guide a practitioner as to what is 'essential and relevant', or how to strike a balance between records that meet the test of adequacy, but do not contain material that is unnecessary, irrelevant or inaccurate. More clarity is needed on the benefits and risks associated with record keeping. A minimum set of requirements are proposed with reference to three separate elements within a record of psychotherapy. Consideration is also given to record keeping in the context of supervision.

From time to time I am asked to provide an expert opinion on the professional conduct of practitioners in my own profession of psychology. These opinions typically relate to questions such as whether a practitioner entered into a dual relationship with a client or whether the services provided were appropriate. In such cases, I am able to refer to relevant codes of ethics and a substantial published literature when forming an opinion.

However, on one occasion, I was asked for an opinion on the quality and adequacy of notes maintained by a practitioner. To my surprise neither interrogation of relevant codes of practice, nor a search of wider published literature provided much guidance on the matter. There is remarkably little written on the subject of clinical records in psychotherapy.

The only reference to records in the Ethical Guidelines of the *Psychotherapy and Counselling Federation of Australia* (PACFA) is in relation to confidentiality. The code of the *Australian Psychological Society* (APS) requires members to *'keep and maintain adequate records'*, but gives no guidance as to what is adequate. The *APS Professional Practice Handbook* provides marginally greater guidance, stating: *'Psychologists should keep only such records as are necessary for optimal service delivery to the client and efficient provision of psychological services.'* The ethics code of the *Australian Association of Social Workers* (AASW) takes the matter a little further, stating that:

'Social workers will record information impartially and accurately, taking care to:

- *report only essential and relevant details;*
- *refrain from using emotive or derogatory language;*
- *acknowledge the basis of subjective opinions;*
- *protect clients' privacy and that of others involved in the situation.'*

However, there is little in any of these codes or handbooks that guide a practitioner as to what is 'essential and relevant', or how to strike a balance between records that have sufficient information to meet the test of adequacy, but do not contain material that is unnecessary, irrelevant or inaccurate. The purpose of this article is to open up a discussion on this topic and to make some recommendations that might assist practitioners navigate this difficult territory.

First, more clarity is needed on the benefits and risks associated with record keeping. It is only in the context of some kind of cost-benefit analysis that we can determine what is essential and what is best not recorded.

Why maintain records at all?

It seems to me that there are three good reasons to maintain clinical records:

1. For the therapist's own purposes

A record of initial assessment provides a reference point in relation to key personal characteristics, relevant background information and other matters that the therapist may find useful to revisit from time to time. For example, being able to refer to a genogram recorded during the initial assessment may be preferable to asking the client repeatedly to describe family connections. Depending on the form of therapy, session-to-session notes can remind the therapist about activities,

tasks or processes undertaken in a previous session. For example, in a course of systematic desensitization, it is important to know the level of exposure successfully achieved in the past session. Notes can also document important discoveries and/or decisions for which the therapist may later be accountable. Records may also assist in monitoring client progress—especially if supplemented by standardized scales or other reliable markers of current status.

2. For the client

Under Freedom of Information legislation and at least some relevant professional codes, clients have a right to information recorded about them (except in quite specific circumstances). This right partly arises because clients might reasonably wish to ensure that any information held by the therapist is accurate. More fundamentally, clients might seek information to better understand assessments and treatment plans, and may wish to review records as a means of evaluating their own progress in treatment. Aggrieved clients might wish to satisfy themselves that assessments and/or treatments were appropriate and in accordance with current standards of practice.

3. For third parties

There are a range of circumstances in which the therapist will need to communicate with third parties such as referrers, other clinicians or agencies involved with the client and sometimes police, coroners or other bodies with a legitimate right to information about the treatment they are providing (Gross, 2003). For example, in circumstances where a client harms self or other, a therapist may be called upon to provide an account of a risk assessment and explain why a course of action was or was not taken in response to this assessment. A record of assessment and decision making from the time will usually be more persuasive than a reconstructed recollection after the event.

Are there risks associated with the maintenance of therapy records?

While the reasons for maintaining records are strong, there are also reasons not to maintain records:

1. The record can get in the way of the treatment

Note-taking during a session is distracting for both therapist and client and is a potential threat to the bond that is at the core of the therapeutic alliance. When not making notes, the therapist might be distracted by making a conscious mental note to later record some information reported by a client (Platt, 2005). Even review of notes prior to a session may be problematic. The psychoanalyst, Wilfred Bion, famously suggested that the therapist should approach each session without memory or desire. What he meant was that the therapist should be

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receptive to the communication of the moment and should eschew any activity that reduces this receptivity. In other words, the therapist should avoid imposing his or her agenda or narrative on the therapeutic discourse. Reviewing notes of a previous session as preparation for a forthcoming session carries the risk that, instead of being optimally receptive, the therapist will be selectively attentive to client communications relevant to the therapist's own view of what is happening in the work. This is less of a problem in more programmatic therapies such as CBT, where continuity in the implementation of the program may be important. However, even in programmatic therapies, alliance is critical to outcome and excessive orientation to notes carries risks. In more exploratory and relational therapies it is arguable that reviewing notes of a previous session is always problematic.

2. Records increase the risk of breach of confidentiality

Information provided to psychotherapists is typically at the higher end of sensitivity and requires high levels of protection. In some cases, information has the potential to have catastrophic impact on career, marriage or other relationships. Practitioners are expected to maintain records for a minimum of seven years, and longer if the client is a child, and a lot can happen in that time. The best form of protection is not to record it at all. Physical and electronic records can and do get lost or stolen.

3. Detailed records are time consuming and wasteful

Time spent after a therapy session compiling a detailed record is time that is not allocated to other clients. Unless there is a clear reason to compile the record, it is not in the interests of either the therapist, the client or the wider public.

4. Records are likely to be distorted or even inaccurate representations of what is happening in the therapy

Records necessarily rely on the therapist's view of what is salient. We have evidence from a range of sources that client accounts of what was important in therapy are often at marked variance from those of therapists. Furthermore, the alliance literature suggests that client ratings and views are more relevant to outcome than those of therapists (Horvath & Symonds, 1991). Notes are typically compiled after a session and are a product of selective memory. Memory studies indicate that primacy and recency are important, meaning that therapists are likely to overlook important matters raised in the middle of a session in favour of matters raised at the beginning and the end.

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In summary, there are good reasons to apply two tests when deciding what to record. The first, as required by the APS Code, is a test of 'adequacy'. The second, as required by the APS Handbook and the AASW Code, is a test of 'essential and relevant'. These tests recognise that records are important but also acknowledge that they are potentially dangerous. The two tests set 'in principle' parameters for record keeping.

However, practitioners may need more than just 'in principle' parameters, and in some cases will seek guidance as to what we mean by 'adequate' and how we determine what is 'essential and relevant'. My focus here is on what consitutes 'adequate'—meaning, a minimum set of requirements that are applicable to most, if not all, forms of counselling and psychotherapy. I will then comment in more general terms on how we might determine what is 'essential and relevant' because I think it is likely that this will be more a function of the form or model of therapy.

A minimum set of requirements for psychotherapy records

We can identify a minimum set of requirements, having reference to three separate elements within a record of psychotherapy:

1. the ***initial assessment and treatment plan;***
2. ***contact records***;
3. the ***end of therapy summary.***

For each element, some basic requirements can be specified.

The initial assessment and treatment plan should include:

- date of assessment(s)—assessment may take place over more than one session;
- some basic identifying and demographic information—name, age, gender;
- an outline of the presenting problem;
- a summary of assessment including relevant background information and, where appropriate, diagnosis and/or risk factors. There will be some variability as to what kind of background is considered relevant, according to the therapy framework. However, any previous treatment for emotional, interpersonal or mental health problems should be documented, and there should be at least a basic summary of major developmental events and achievements. While a full mental state examination may not be necessary, any unusual features should be noted. Some kind of formulation in which the therapist links presenting problem, background and therapy needs should be included;
- an outline of therapy plan (this may be provisional) and an indication of the therapy approach, frequency and expected duration;
- any specific instructions or advice provided to the client.

Contact records are regular notations regarding client contact. These should be recorded in the event of standard appointments, telephone contacts or contacts with third parties regarding the client. At the minimum a contact record may simply note date of contact and continuation of a

documented treatment plan. However, there are certain other categories of information that should be included in a contact record:

- change of assessment, e.g., new risk assessment, different diagnosis or changed formulation of problem/therapy needs;
- evidence of significant departure from the anticipated trajectory of progress in therapy;
- change of therapy plan;
- major life events;
- contact records should not attempt to provide a detailed summary of the session because this unnecessarily increases the risks associated with record keeping as outlined above.

End of therapy summaries should contain the following information:

- date of last contact;
- reasons for termination, whether negotiated or unilateral;
- progress achieved, having reference to presenting problem and any other progress indicators;
- ongoing needs for therapy or other mental health services;
- any arrangements made for ongoing services (if service needs are identified but no arrangements made, the end of therapy summary should include an explanation such as 'referral to a psychiatrist recommended but client indicated he was not prepared to accept such a referral at the present time.)

Beyond the minimum set

While what is set out above might be taken as the minimum set of records, it does not follow that recording additional information is inappropriate or unethical. Therapists may have very good reasons for compiling more detailed records of progress in therapy. However, the burden is on the therapist to explain why such additional records are warranted. Recording a client communication because it was 'interesting' or 'notable' is not, in my view, a satisfactory explanation without additional reason why it must form part of a lasting client record.

Therapists may use working notes to assist in implementing or monitoring of a specific intervention without these needing to form part of the lasting client record. For example a therapist providing cognitive therapy may want to keep details of the dysfunctional thoughts, schemas etc. while the treatment is in progress. However, these do not need to be part of the lasting record, which should instead document the provision (including any major departure from standard implementation), duration and outcome of this intervention rather than details of its implementation. Working notes should be destroyed as soon as the intervention is complete.

Record keeping and supervision

The requirements for record keeping for psychotherapists receiving and providing supervision are somewhat different from those that apply to direct client-focused services.

Effective supervision may require access to detailed records of therapist-client interaction and in some cases to video or audio recordings of therapy sessions. Supervisors can reasonably require supervisees to provide such records. In my opinion, these records fall into the category of 'working notes' as discussed above and do not form part of the lasting client record. When substantial changes in assessment or therapy plan occur as a result of supervision, the therapist should document the role of supervision when noting the change of assessment or plan in the contact records. The detailed working notes or session recording should be destroyed when no longer required for purposes of supervision.

Record keeping requirements for supervisors vary, in my view, according to the role of the supervisor and the status of the therapist under supervision. If supervision is mandatory because the therapist has not achieved basic qualifications for practice (as in the case of a provisionally registered psychologist), then the supervisor assumes some responsibility for the conduct of the treatment and must keep a record that is sufficiently detailed to enable the therapy to be monitored. However, when supervision is with a practitioner who can be considered to have basic practice competence and to be in a position to assume full responsibility for the therapy, the role of the supervisor is to provide a 'learning space' for the therapist, and records are primarily required for billing purposes unless the supervisor has reason to doubt the competence or ethical practice of the therapist. In such circumstances documentation of the reasons for concern is important, as well as frank and open discussion of the concerns with the therapist.

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AUTHOR NOTES

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