

4

Record Keeping – Basic Responsibilities

Does the law say that I have to keep case records?

Is it considered good practice to keep case records, and what would happen if I did not want to comply?

What should I include in my notes? Is there anything that I should leave out?

I had a client who absolutely refused to allow me to keep notes. I refused to take her on as my agency requires note taking. I am still not sure that that this was fair to the client or what happened to her.

A client was in therapy for PTSD after an accident. The accident triggered other memories and she disclosed a history of severe child abuse which she worked through in the course of her therapy. This was recorded in her notes. When her personal injury case came up in court, the lawyers asked to see the therapy notes. She did not want her family or the other parties in the case to know about her past. I did not know what to do and I really wished that I had not kept such detailed notes.

I am quite puzzled about what to do about keeping notes. I usually keep brief factual notes with a few reminders of things that I might need for my session with the client. Is this good enough?

I don't keep notes of sessions as I work in shared premises and can't be sure of adequately protecting them when I am not there. I used to take my records to and from home where I could lock them away. Unfortunately, as I was returning home after seeing several clients, my car was stolen with all the notes locked in the boot. (I was just paying for the petrol.) It was an awful experience telling those clients. I decided that their distress was so much greater than any benefits of keeping records.

This chapter addresses the issues raised by therapists above, and explores the basic responsibilities of record keeping, including the rationale for keeping records, issues to consider if a client does not want notes kept, ownership of client notes, what client records might contain, and the perennial dilemma of what to do with process notes. Chapter 5 explains data protection, and Chapter 6 explores the legal issues relevant to deciding how long client records should be kept.

4.1 Current practice

Current practice by therapists over record keeping is very varied. Some therapists keep extensive notes that combine the information communicated by the client

(i.e. client material) and the therapist's professional comments and interpretations of what has been communicated. Some practitioners include reflections on their own subjective responses to the client's communications in order to distinguish their client's material from their own and inform their interpretations. This element of therapists' records is sometimes referred to as 'process notes', which are an essential component of some approaches to therapy. Box 4.1 gives examples of various approaches to keeping records and process notes.

Box 4.1 Examples of therapists' different approaches to note keeping

- Full notes which combine process and content (e.g. similar to the full notes that a trainee might be expected to take as the basis for an in-depth case study, or for detailed discussion with a trainer or supervisor).
- Shorter notes that focus almost exclusively on the content of the client's communications, key events in the session and any therapeutic plans or strategies. These may also be combined with keeping a separate set of process or supervision notes (see 4.8).
- Separate notes may be kept relating to reflections on the therapist's subjective responses in the therapy (process notes).
- Separate supervision notes.
- Some practitioners may not make or keep any notes at all (see para. 4.2).

This diversity of record keeping practice is the inevitable outcome of different approaches to therapy and different ways in which therapists exercise their professional care for their clients. For some, note taking is an essential activity that provides time for reflection and a useful support to assist in accurately recalling earlier sessions. Others place more emphasis on what the client takes from sessions and brings back with them to the next, and therefore are less concerned with maintaining an independent record. Some are concerned that the details in any records held may have the potential to drag the client back to experiences that therapy has helped the client to leave behind, for example if the records were stolen or required in legal proceedings. Therapists walk a tightrope between providing effective care, with all the different interpretations of what this could be, and protecting a client's privacy.

The context also matters. Some settings, such as clinics, place greater emphasis on record keeping than other types of service which offer community support or personal development. Therapists who work across a range of practice contexts may have experienced a wide range of expectations and practice regarding record keeping and how these vary according to context, not least the availability of resources to make and store them securely. So it is not surprising that different

therapists may reach different conclusions about how best to keep records to support their work or they may vary their practice for different aspects of their work. Such diversity in practice creates the potential for many different legal concerns about record keeping. Chapter 5 deals with data protection and freedom of information, Chapter 6 with how long to keep records, and Part III of the book looks at a variety of situations and dilemmas in relation to disclosure.

4.2 Are therapists obliged to keep notes?

4.2.1 Law

There is no specific overarching legal requirement at the moment that every therapist should keep records of all their work with clients. However, there is a growing expectation from the courts and other professionals that therapy records are kept. As we will see below, the legal and practice necessity of keeping accurate records is to some extent dependent on factors including professional expectations, the therapy work context, the therapist's modality and client needs, and certain specific legal and agency requirements relevant to the therapy work. There are also certain situations, for example in forensic work and in therapy with children and vulnerable adult witnesses, where there is a clear expectation that records of the therapy will be kept. This is discussed further below in 4.2.2, and Chapter 13 looks specifically at working with victims and pre-trial therapy with vulnerable adults and children.

4.2.2 Ethics

Since the circumstances of the provision of therapy are many and varied, some professional bodies are cautious about creating an ethical requirement to keep therapy records in all circumstances. The British Psychological Society, in 2006, required that psychologists 'should keep appropriate records' as an expression of the ethical principle of respect (BPS, 2006: s. 1.2). However, the Health & Care Professions Council now makes record keeping an absolute duty for practitioner psychologists and its other registrants: see *Standards of Conduct, Performance and Ethics*, 'You must keep accurate records' (HCPC, 2012: 10).

Similarly, the British Association for Counselling and Psychotherapy encourages practitioners 'to keep appropriate records of their work with clients unless there are adequate reasons for not keeping records' (BACP, 2013: 6, paras 20–24). This ethical statement assumes that it is generally desirable to keep records in line with public expectations of professionals, but recognises that there may be some circumstances in which keeping no records may be justifiable. Such circumstances are likely to be very rare. Since the inception of voluntary registration and the BACP Register in 2013, therapists are likely to be expected to keep records as a matter of their general professional responsibilities, in line with the general expectation of other professionals in the health care system. The courts will generally

expect that therapists will keep appropriate records, and in any court case, a therapist appearing as a witness in court is likely to be asked for justification of any failure to keep records, because accurate recording provides the evidential basis for professional accountability, and courts will look to therapy records for an accurate account of the events of therapy. The same rationale is likely to apply to a disciplinary or complaints procedure, in which a lack of accurate therapy records could constitute a disadvantage for the therapist concerned.

Keeping appropriate records enhances the quality of work undertaken by the therapist by providing an opportunity for reflection when compiling the notes and recording treatment plans and a point of reference to assist the therapist's recall of significant moments during therapy.

4.2.3 Legal requirements to keep records

See Chapter 3 for a discussion of the legal requirement for confidentiality generally in relation to client information. In relation specifically to therapy records, although there may be no general legal requirement that notes should be kept in all circumstances, a legal obligation to keep notes might arise in a number of ways, such as:

- a requirement of the therapist's contract of employment in an agency or organisation;
- a term of a contract agreed with a client who is contributing towards the cost of his or her own therapy;
- a term of a contract agreed with an organisation (e.g. an insurance company, which is paying for work with a client);
- a statutory duty imposed on public bodies or agencies within which the therapist is working; or
- an obligation to the courts when the therapist is working with witnesses; see the current guidance on working with victims and witnesses. For example, the Crown Prosecution Service (England and Wales) requires that 'Records of therapy (which includes videos and tapes as well as notes) and other contacts with the witness must be maintained so that they can be produced if required by the court' (CPS, 2001: s. 11.4). This requirement concerns the provision of therapy for vulnerable or intimidated adult witnesses. There are comparable stipulations for therapists working with child witnesses (CPS, 2001: ss 3.7–3.14). The Scottish Government has also issued guidance for therapists in Scotland, in the form of its publications *Interviewing Child Witnesses in Scotland* and *Code of Practice to Facilitate the Provision of Therapeutic Support to Child Witnesses in Court Proceedings* (Scottish Executive, 2008a, 2008b). Both of these publications are available on the Scottish Government's website at www.scotland.gov.uk.

Recording any breaches of confidentiality is a requirement in some agencies and a wise precaution when working in private practice or as a volunteer. Such a record should include:

- date of the disclosure;
- a note of the information that has been disclosed;

- person to whom disclosure made;
- method of disclosure (e.g. letter, phone call etc.);
- whether or not the client has consented;
- any evidence of consent; and
- the justification for the disclosure if it has not been authorised by the client affected.

4.3 Can a therapist refuse to work with a client who does not want notes kept?

A therapist who is either under a legal obligation to keep records or is ethically committed to doing so may decline to work with a client who refuses to permit the keeping of records.

Some therapists may decide to see clients without keeping any records, if they have the discretion to exercise this choice. The ethical reasons that they may have for doing so might include the deterrent effect of record keeping on some potential clients, for example those people who live at the margins of society and mistrust the authorities. In some circumstances, the therapist may have no secure way of protecting records from unauthorised access where they are known to be vulnerable to burglary. In some cases, this may be an exceptional arrangement for a particular client who will accept therapy only on the basis that records are not kept.

The presumption in favour of keeping records means that in any court context, therapists can expect to be asked by lawyers and courts why they have not kept records. The therapist should make their decision upon the basis of best practice in the prevailing situation, and formally record that decision and the reasons for it. It is wise to have written confirmation that a client has agreed to or required that no records are kept, especially where this is an exceptional arrangement in a service that normally keeps records. In agencies and organisations where not keeping records is routine practice, it is wise to ensure that this practice is included in any agency policy statements or service agreements, and communicated in information to clients and other interested parties in order to avoid misunderstandings. The absence of records will not prevent the therapist being required to give evidence in legal proceedings. On the contrary, anecdotal evidence from therapists indicates that the absence of notes makes it more likely that a therapist will be required to appear in person as a witness for cross-examination. The court has no other way of obtaining the evidence. Where notes exist, it is possible that the submission of those notes or the alternative provision of a comprehensive report based on those notes (which, if possible has been read and approved by the client as accurate) may obviate the need to attend court.

4.4 What are the basic legal obligations when records are kept?

Most countries in the European Economic Area (EEA) have already produced legislation or are in the process of producing legislation which regulates almost all aspects of storage, use and disclosure of clients' records by professionals. This

creates a shared framework for the management of records across Europe and requires additional safeguards for communications beyond the EEA. This legislation serves two purposes:

- to protect the privacy of people; and
- to ensure that people about whom information has been collected can check the accuracy of that information.

The Data Protection Act 1998 (see www.ico.gov.uk) and the Freedom of Information Act 2000 are examples of legislation to protect sensitive personal data. For details of these statutory provisions, see Chapter 5. Briefly, most of the information held by therapists will be regarded as 'sensitive personal data'. Sensitive personal data contains information about:

- racial or ethnic origin;
- political opinions;
- religious beliefs or beliefs of a similar nature;
- trade union membership;
- physical or mental health condition;
- sex life;
- criminality, alleged or proven; and
- criminal proceedings, their disposal and sentencing.

The legal right to process sensitive personal information requires greater attention to the data subject's rights. The most significant of these rights is that the recording and use of sensitive personal data require the client's explicit consent. The client has to actively state that they are agreeing to a record being kept and used in the knowledge of the purpose(s) for which the record is being made, how it will be used and any limitations on confidentiality. This should be the routine practice of therapists who hold computerised records or who hold manual records in any form of organised filing system.

The Data Protection Act includes eight principles that guide the legal use of all records of personal data.

Personal data shall be:

1. Processed fairly and lawfully.
2. Obtained only for one or more specified and lawful purposes, and shall not be processed in any manner incompatible with that purpose or those purposes.
3. Adequate, relevant and not excessive.
4. Accurate and, where necessary, kept up to date.
5. Not be kept longer than necessary.
6. The clients' rights must be respected.

7. Take appropriate security measures.
8. Personal data shall not be transferred outside the European Economic Area (All EU Member States plus Iceland, Liechtenstein and Norway).

This may be an issue for clients who move outside the EEA and desire a referral or for therapists whose work requires them to move between the EEA and other countries. A client's consent permits the transfer of personal data.

When working internationally outside the EEA, there are considerable variations in how each country approaches data protection. As the legal penalties and costs for breach can be considerable, this is an important issue for consideration in how you establish any services outside the EEA. For the latest guidance, search for reputable recent guidance under <data protection international> or <data protection + country>. A useful starting point is DLA Piper (2014) *Data Protection Laws of the World*.

4.5 Clients' right of access to their own notes

The sixth principle of data protection requirement gives the subject of personal data a right to access to the information which is being held about them. This right is referred to as a 'subject access right' to all computerised records and data held in structured manual files. The aim is to enable any citizens to know what information is being processed about them. A written request, proof of identity (if required) and payment of the prescribed fee entitles the data subject to be informed about what data are being processed, for what purpose, to whom it has been or may be disclosed, and to be provided with a copy of those data. This information should be provided within forty days.

Any therapist who is concerned about the client's response to seeing the records may offer to be present and explain the records or to arrange for another suitably qualified person to be present, but cannot insist on this. Nor can the release of records be made conditional on the client paying any outstanding fees. The client is entitled to unconditional access.

A client who considers that there is an inaccuracy in the record may ask for it to be corrected with the agreement of the therapist. If there is disagreement about what would be a correct record, it is good practice to include a record of the client's objections in the notes.

If the therapist is concerned that access to the notes would cause serious harm to the physical or mental health of the data subject and that the notes constitute a health record, it may be possible to refuse or defer access with the authorisation of the health professional who is currently or was most recently responsible for the clinical care of the person concerned (Data Protection (Subjects Access Modification) (Health) Order 2000: s. 7). The legal presumption in favour of access to personal data makes this an exceptional provision that ought not to be sought or granted lightly.

A client may have a contractual right to see her notes even when there is no statutory right of access to the therapeutic notes (for example because they are 'unstructured' and thus fall outside the requirements of the Data Protection Act). The therapist and client may have agreed access to the notes as part of the therapeutic contract between them. The client may insist on their production as part of the disclosure of documents for a court case, possibly by the use of a court order. In the last resort, it may simply be unconscionable in the eyes of equity, a long-standing set of legal principles, to withhold access.

4.6 Access to notes by others

4.6.1 By other members of the client's family

Adults can insist that a professional protects the confidences contained in records from other members of the family unless the professional is legally required to disclose them, for example as part of the disclosed documents required by the court in family proceedings. Where children or young persons are considered to be sufficiently 'competent' to give their consent to receiving therapy on a confidential basis *and* both the young person concerned and the therapist agree that it is best that the parents are not informed, then the information may be lawfully withheld from someone with parental responsibility (*Gillick v West Norfolk and West Wisbech Area Health Authority* [1985]). Similarly, information may be withheld from other family members. Possible exceptions to this general principle arise where the disclosure would protect others from serious harm or where a young person's life or safety is at serious risk.

A young person who is not competent to give consent to therapy cannot be assured of total confidentiality with regard to those with parental responsibility. The therapist ought to take into account the best interests of the young person and also be aware of the generally positive view that courts take of involving parents unless there are good reasons for not doing so, for example increasing the risk of further abuse. If the therapist is concerned that the child may be subject to abuse, then refer to the government guidance issued under the Children Act 1989 and the Children Act 2004 listed at the end of this book, including *What to Do if You are Worried a Child is Being Abused* (DfES, 2006a); *Information Sharing: Practitioner's Guide* (DfES, 2006b); *Working Together to Safeguard Children: A guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children* (DfES, 2013); and *Confidentiality: NHS Code of Practice* (DH, 2003a) and its accompanying Guidance (DH, 2010b); see also Chapter 12.

4.6.2 After a client's death

In England there is no statutory protection of confidences about someone following their death, nor may a breach of confidence following the death of the confider be actionable (Pattenden, 2003: 639). Despite this lack of legal protection, the normal ethical requirement for health workers and psychological therapists is that

respect for confidentiality continues after the death of the person concerned. This is an example where professional ethics aim at a higher standard than strictly required by law. For the powers of the Coroner to order disclosure of notes in proceedings before the Coroner’s Court, see Chapter 7 at 7.2.1.

4.6.3 Other clients, when several clients are being seen at the same time

Information can be disclosed to more than one person at the same time on the basis that it will be treated as confidential by all the recipients. The laws concerning confidentiality would apply. Therapists should have a clear confidentiality sharing agreement in place when working with teams, groups, families and couples and so on.

4.6.4 By journalists and members of the public

The Freedom of Information Act 2000 is a major piece of legislation that requires public bodies and companies functioning as public bodies to respond to requests for information. This legislation has proved invaluable to journalists wanting to discover information held by public bodies, particularly non-personal information such as public policy decisions. Individual citizens can also request information of this type. However, personal information is exempt from this legislation and should be sought under the data protection procedures through the data subject.

4.6.5 By police

The police are not normally permitted access to counselling records (unless the client explicitly consents, or they are acting under a court order). Section 11 of the Police and Criminal Evidence Act (PACE) 1984, as amended, excludes material from a search, stating that:

- (1) Subject to the following provisions of this section, in this Act “excluded material” means—
 - personal records which a person has acquired or created in the course of any trade, business, profession or other occupation or for the purposes of any paid or unpaid office and which he holds in confidence.

Section 12 of PACE gives further detail of the definition of personal records:

In this part of this Act “personal records” means 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 the purposes of his personal welfare, by any voluntary organisation 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.

This definition specifically includes counselling records, giving them additional protection. This protection is not absolute. Police may obtain a court order which, when granted, will entitle them to access to the client's records. If the police are investigating a 'serious arrestable offence' they may obtain a warrant from a circuit judge, a more demanding process than the usual search warrants issued by magistrates.

In addition, under the Serious Crime Act 2007, police or other law enforcement officers can apply for a Serious Crime Prevention Order requiring a person, including a therapist, to disclose information or records (see Chapter 3 at pages 30–31 at 3.3).

4.6.6 By lawyers

Lawyers have no greater rights of access to therapists' notes than any other citizen. Typically, they ask for access to their client's notes on the basis of their client's consent, but they may seek a court order that entitles them to access to the notes of their client or possibly to the client notes of another person. Full details about how to respond to a lawyer's request for therapeutic notes can be found in an earlier volume in this series, *Therapists in Court* (Bond and Sandhu, 2005).

4.6.7 By courts

The courts, at all levels, carry the power to order the disclosure of therapists' records and may order the therapist to appear as a witness. Child protection and road traffic legislation give courts additional powers of ordering disclosure, and the Serious Crime Act 2007 created additional powers for courts, for example to make a Serious Crime Prevention Order which may require disclosure of information or records (see Chapter 3 at pages 30–31 at 3.3). For discussion of working with children and vulnerable witnesses in court, see Chapter 13, and for details about working in the context of judicial process alongside lawyers and the courts see *Therapists in Court* (Bond and Sandhu, 2005).

4.7 Who owns therapy notes?

The question 'Who owns the notes?' is usually asked in therapeutic contexts because there is concern over the control of the contents of the notes. The question may arise in organisational contexts because someone more senior in an organisation is seeking access to the contents of the client notes. We are aware of this question being asked in health care, education and employee assistance schemes. Behind

the question lies an assumption that ownership determines who has control of access to the contents of the notes. This is a mistaken assumption because the law distinguishes between ownership and authorised use of those notes. Ownership of records is usually governed by ownership of the material they are recorded on. Use of records (including confidentiality) is usually governed by the therapeutic contract. It is therefore possible to physically own the notes but to be constrained from having access to them or being able to use them because they are held on the trust that they are confidential. For example, a company may employ a therapist, pay the therapist's salary and provide the stationery or computing facilities to compile the client records. It therefore owns the records in law. However, the company may have required that (and typically will have required that) those records are treated as confidential to the therapist or to the staff who work in that section of the company and the therapist will have worked with clients on this basis. No matter how senior the member of staff, it would usually be a breach of confidentiality for someone outside the 'circle of confidentiality' agreed between the client and therapist to seek access to those notes. Conversely, where there is an agreement that the contents of sessions are made known to or are accessible by other members of an organisation, then the therapist may be required to establish a client's consent to this prior to offering therapy. Both the therapist and agency have a vested interest in striking a balance between deterring clients from accepting a service because client information will be made too freely available and being too restrictive when communicating information. Any changes in practice should be prospective rather than retrospective and will require client consent. Therapists need to ensure consistency between what is agreed with clients and their employer if they are to avoid potential liabilities for either breach of confidentiality or breach of their terms of employment.

In private practice, the notes will usually belong to the therapist unless there is a contractual agreement to the contrary. If the therapist gives the notes to the client as a client-held record, it is wise to clarify whether the therapist retains ownership or is content for the client to hold both ownership and possession. Ownership of patient-held records in the health service is typically retained by the NHS.

When clients ask about the ownership of notes, they are typically concerned about control over the personal information they contain. In English law, there is no ownership of information, because once it is imparted by one person to another it belongs equally to them both. The clients' best protection lies in their legal right to privacy and confidentiality, which is governed by the common law, contract law, and the law of tort (see Chapters 2 and 3). Clients can create additional protection for themselves by reaching agreement with the therapist on issues about confidentiality and privacy which can be clarified and preferably recorded in the therapeutic contract.

4.8 Process notes

Process notes (by which we mean a therapist's reflections on their own process and that of the client relevant to the therapy) are a feature of some areas of professional

practice and integral to some approaches to therapy. We make a distinction here between process notes made for the purposes of the therapy (and from which the client may be identifiable); and those purely personal reflections which, for example, a trainee therapist might keep in their personal journal, and from which the client cannot be identified.

Process notes have raised some interesting legal questions over the years but there is no case law from which to give authoritative answers. The perennial questions from therapists are:

- Do I have to give my clients access to my process notes?

and

- Am I required to include my process notes if a court requires that I submit all my counselling records concerning a named client?

There is sufficient uncertainty over the answers to each of these questions for a variety of opinions to exist. We will add our opinion by answering each question in turn. In practice, what happens will depend on the circumstances of a specific case. Nonetheless, it is helpful to consider the general legal principles that are likely to be applied.

The distinctive feature about process notes is that they contain information about the subjective processes of the therapist. Some therapists appear to be wary about releasing these notes to legal scrutiny on two accounts. First, these are subjective notes that are being used in a legal culture where objectivity rules, and therefore, are potentially likely to be misunderstood and sometimes even ridiculed. Sometimes they are merely tolerated. But this tolerance is often in short supply in an adversarial system with rigorous testing of the evidence by both sides. The therapist may be making reference to her own life story or subjective processes as a basis for understanding her client better. Sometimes this personal reflection strengthens the empathy for another person's experience. On other occasions it is used as a way of separating out the therapist's sense of herself from her client's experience so that she can hear another person's experience more clearly. The therapist's sense of herself is a key point of reference in understanding many aspects of the client in most of the psychoanalytic and humanistic approaches to therapy. As a consequence, the process notes are an essential component of some therapeutic approaches but are often more revealing of the therapist than the client. This has led some therapists to ask whether they can withhold them from scrutiny by their client and courts.

When pressed hard, some therapists will argue that they are very uneasy about releasing information gained in the privacy of therapy into a potentially public contest between opposing parties in the courtroom. This unease exists even when the case involves a client and events concerning a third party in which the therapist has no direct involvement other than being a witness to the psychological

consequences of the event for the client. In such circumstances, it is argued that it is unfair to the therapist and a violation of her privacy to include those parts of records that are primarily about herself.

Similarly, therapists are reluctant to give clients access to private personal material that they may have included in their notes but used only indirectly in communications with their client to inform their interventions. Again some therapists argue that this is an invasion of their own privacy and makes them vulnerable to those clients who may be persistently intrusive or predatory.

Our sense from being involved in workshops throughout the UK is that there is a widespread and considerable sense of unease amongst therapists about the disclosure of process notes. It is one of the most contentious issues for therapists about their involvement in any legal processes. What we are about to say is unlikely to ease these concerns.

Under data protection legislation (see Chapter 5), in specified circumstances, a person is entitled to have access to personal information held about them. In our view, if the process notes identify the client, or contain information from which the client may be identifiable from their circumstances etc., or if they are contained in the named client's file, or contain named references to a client in another file (such as a supervision file), we consider that when data protection legislation applies, the client is entitled access to these process notes in response to a data subject's access request. A client may also be entitled to records where their identity is not explicitly named but which can be inferred. A brief passage from a most thorough study of confidentiality indicates the strength of the duty to disclose:

Maintaining dual records – one version for the client and another for the use of the professional – is illegal. Files have to be disclosed no matter how damaging to the professional. Thus the Department of Trade had to disclose records that described the applicant as a 'prat' and an 'out-and-out nutter'. (Pattenden, 2003: 650)

Current trends in the discovery of documents as part of the process of litigation are against the protection of process notes in order to protect the privacy of the therapist, or the client. The law has progressively moved over the last few decades towards a requirement that everything that is discoverable ought to be made available to all the parties in a court case unless the court directs otherwise. This openness of evidence is believed to comply with the right to a fair trial under Article 6 of the European Convention on Human Rights, also providing the best chance of an out of court settlement in civil cases and increasing the likelihood of a fair and decisive hearing should the case be heard in court. It lowers the risk of new evidence being found after the case has been decided. From this perspective, the balance of public interest in ensuring justice outweighs the privacy of both client and therapist. These developments reduce the opportunities for withholding therapeutic documents from court proceedings. However, many documents or parts of documents will not be used if they are not considered relevant to the issues that the court has to address in a particular case. Article 8 of the European

Convention on Human Rights establishes the right to respect for private and family life. Where there are significant issues of privacy involved for either the client or the therapist, the therapist could request leave to attend a Directions Hearing, in which a judge can be asked to review the evidence and decide what is relevant and therefore should be made available for use in the case, making appropriate directions regarding the evidence. A more complete account of the legal issues and process can be found in *Therapists in Court* (Bond and Sandhu, 2005: 19). The therapist may incur legal costs in asking a judge to review documents.

Probably the best way of avoiding or minimising the difficulties posed by process notes is to review one's record keeping practices. Active weeding out of process notes that are not an essential part of the client record and are no longer relevant to the therapeutic process and securely destroying these is a viable option. This destruction must take place *before* a legal request for disclosure is received. Ideally, it should be a routine practice as part of a record keeping policy. Destroying evidence after receipt of a legal request or court order to disclose it is a serious offence.

It may also be worth considering whether any of the material included in the process notes goes beyond what is directly relevant to the work with the client and might be better written in a personal journal with no reference to a particular client. Provided that the client is not identifiable from the process notes, it is highly probable that this material would not need to be disclosed to either the client or the courts. The usual test for whether something must be disclosed is based on whether the material is linked to a named client or whether the identity of the client can be inferred from information in the notes. The adoption of these practices reduces the possibility of process notes being problematic but does not totally eliminate the risk for process notes that remain in existence because they continue to serve a therapeutic purpose. The personal journal is not totally immune to discovery. It could be required in cases that directly involve the therapist, such as criminal or civil offences committed against clients, because of the insights such a journal might offer into the therapist's motives and psychology. However, for ethically conscientious therapists, rethinking the management of process notes is probably the best way to strike a balance between the professional benefits of keeping a record of the subjective therapist's processes while minimising unwanted or damaging disclosures. It is salutary to realise that if a document exists, it is vulnerable to disclosure. There are probably no documents in existence that have total immunity to disclosure in current law.

There is an alternative line of argument in favour of keeping process notes on the same basis as any other notes about a client because they form part of the therapeutic process. If therapists could be confident that these notes would be treated respectfully within the legal process, then this would cause less concern. During the preparation of this book we have met a small number of therapists who have either chosen not to weed out this aspect of their records or have been required to disclose records including their process notes, and that these records

have been treated respectfully in court. Being able to explain the purpose of the process notes in clear and non-technical language greatly helps in earning the respect of the court. When writing their records, therapists should constantly ask themselves:

- Can I explain clearly and stand by all that I have written down in my client records and process notes?
- If I should be asked to explain them in court, could I do so with confidence that they accurately reflect my work with the client and also convey a reasonable standard of therapeutic practice?

If the answer is negative to either of the questions above, it is the therapist's practice that needs to be changed, not the record.