Ethics in Client Record Management

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Introduction

- Why is this topic important?

- What does the research say? (Petrović, 2019)

On a sample of 1071 psychotherapists (79.4% of them psychologists):

- 51% of the respondents forgot to get the client's informed consent at the start of treatment.

- 46.7% admitted to not have kept proper records related to clients

- 33.9% are working as a psychotherapist 'off the books' (they avoid paying taxes).

Record-keeping practices of clinical and counseling psychologists: A survey of practitioners.

Fulero, Solomon M. Wilbert, Jeffrey R.

Sample (n = 331)
Done in 1988 in the USA (before clear regulations about record keeping existed)

The researchers concluded that there is confusion and a wide variability of practices among psychologists.

Some behaviors like omitting evidence of dangerousness were considered as malpratice.

Table 1
Reported Information Excluded From Client or Patient Records

Type excluded	% excluding
Nothing	50.3
Speculation or opinions	9.0
Others' names	8.3
Keep no or minimal records anyway	7.6
Anything damaging	6.2
Highly personal information	5.5
Infidelity	5.5
Sexual preference/behavior	4.8
Process notes	4.8
Diagnostic labels	2.8
Criminal behavior	2.1
Raw test data	2.1
Evidence of dangerousness	0.7

Note. Multiple responses were possible; thus responses total more than 100%.

Table 2
Reported Policy Regarding Client Access to Records

Policy	% reporting
At client's request	27.3
Never or only to insurance companies or other professionals	24.7
Issue has never arisen	17.5
With therapist present	15.6
Only reports or summaries	10.4
Only if not countertherapeutic	7.1
No restrictions on client access	5.2
With court order only	3.9
With prior editing	1.9
Other	5.2

Note. Multiple responses were possible; thus responses total more than 100%.

Research Article

A survey of the record-keeping practices of clinical psychologists

Joyce M. Scaife, Michael Pomerantz

Sample (n = 123)

Done in 1999 in the UK

Table 2. Numbers who on average record these items in notes

Item	Always record	Usually record	Sometimes record	Occasionally record	Never record
Client ID data	118	2	1	0	1
Correspondence with referrer	116	4	1	1	1
Other correspondence	104	12	4	2	0
Test results	101	11	5	3	1
Test interpretations	91	21	6	2	2
Information provided by client	89	27	3	2	0
DNAs	86	26	6	2	0
Case conference information	72	31	6	5	3
Data recorded by client	59	33	21	6	2
Information given by other professional	55	51	13	4	0
Telephone contact with client	54	43	16	7	2
Information given by 3rd party	50	34	28	7	2
Process notes	46	28	33	12	1
Indirect contacts	34	35	28	16	5
Speculations and hypotheses	31	41	33	14	2
Information about a 3rd party	30	17	50	22	1
Your own opinions	27	30	36	23	7
Information about other professional	22	21	27	40	8
Reported speech	18	27	60	9	2
Audio/video tapes of client	15	10	14	35	42

Table 6. People stated as having physical access to psychologists' notes (number of respondents)

	Access	No access	Not sure
Self	123	0	0
Secretarial/nursing staff	90	17	7
Other psychologists	84	31	2
Trainees	72	37	2
Client	47	60	9
Medical staff	35	70	10
Relative/representative of client	7	90	15

Table 4. Factors reported as influencing why notes are kept

Item	Highly signif. influence	Signif. influence	Moderate influence	Little influence	No influence
Part of your professional behaviour	95	25	3	0	0
Aide memoire	76	36	9	1	1
To help your thinking	73	32	11	6	0
Employer requirement	56	33	20	8	5
Notes may be required by legal system	51	35	30	5	2
To 'cover your back'	28	37	43	13	2
For audit purposes	24	29	42	19	7

Table 3. Frequency of reported recording of specific examples of data (numbers of respondents)

Item	Always record 1	2	3	4	Never record 5
Your client hints that s/he is abusing her/his child	104	11	1	0	1
Your client offers you a bribe or inducement to bias your report in a direction advantageous to the client	85	9	5	3	3
A client indicates that she had a legitimate termination of pregnancy recently and suffers with guilt and depression	82	29	5	0	0
A dependent speaks in great detail about the extent of domestic violence which is a family secret	81	28	7	1	2
A client tells you that his twin is talking seriously of suicide unknown to a parent/partner	73	25	9	5	4
The secretary returns to you a file for your client that was taken from your office by another client of yours	69	14	4	1	1
A client tells you that a carer of a relative has done something that calls into question their ability to care. The client may have a vested interest in showing the carer's incompetence (e.g. a custody dispute over a child)	61	29	12	8	6
Your client tells you that he/she is a drug dealer	50	23	11	11	11
The relative of a client provides detailed current info about your client but insists that this be kept from another relative with whom you are also working (e.g. ex-husband who is father of your child client)	49	24	15	7	8
A close relative of a client tells you that the client has a terminal medical condition about which the client has not been informed	40	25	10	8	30
A colleague expresses an opinion that the previous treatment provided to a client by a colleague in the service was harmful	35	18	14	18	25
The client alleges that a colleague of yours grossly offended him/her yesterday but s/he does not want this reported to anyone	33	29	16	13	20
The client reveals that s/he is a refugee living illegally in the country	25	12	8	15	45
A client's relative gives you info about your client because they think it is important but you think it irrelevant (e.g. about a previous medical condition)	17	27	30	26	18
A colleague tells you that your client stole from a previous therapist but this was denied and unsubstantiated	16	20	15	22	40

The researchers concluded that many issues with regard to note-keeping are unresolved, ambiguous and subject to individual and local decision-making.

The majority of respondents reported that they viewed note-keeping as an indicator of professional behaviour.

Original Article

What's in the File? Opening the Drawer on Clinical Record Keeping in Psychology

Liza Bradford & Bruce Stevens

Research done on a small sample (n = 17) in Australia (2012)

Respondents were concerned about the accuracy of the records. Also they viewed records as a means to be held accountable for their work.

The records were useful as a „memory“ to be viewed before sessions.

Psychologists were not aware about the issue of distinguishing opinions from facts.

Table 1 Type and Frequency of Data Present on Clinical Records

Item	Present	Absent
Referral/intake information	16	0
Signed consent form	15	1
Signed fee agreement	10	6
Client contact details	16	0
Next of kin contact details	12	4
Other treating practitioner details (i.e., general practitioner)	16	0
Evidence of a completed full assessment	14	2
Genogram	9	7
Documented diagnosis	12	4
Treatment plan	10	6
A summary log of the dates and types of services provided	10	6
Case progress notes for every session	15	1
Records of supervision or consultation	3	13
Psychological test data	15	1
Authorisation for release of information	9	7
Discharge summary or document of termination of treatment	5	3

Note. Discharge summaries were not present on eight files as the patients were still actively engaged in therapy.

Why we keep records?

- Records form the basis of sound diagnoses and appropriate treatment plans
- They provide for continuity of care, e.g. transfer of “cases” between practitioners
- Records are necessary for clinical supervision
- They satisfy contractual obligations, e.g. insurance
- Records provide accurate recall, help in treatment planning…

Why we keep records?

- Records are best protection against allegations of unethical and harmful treatment
- They are sometimes required in a legal process
- They assist in the comparison of similar cases and assessing treatment approaches
- They support accounting processes and keeping statistical data

How are records kept?

- In a logical, prompt (made soon after the session) and chronological manner.
- The documentation should be up to date, complete, relevant, and not misleading.
- Write client notes or data summaries from the perspective that they may be read by the client or another party.
- EFPA Meta ethics code requires:
- Adequate storage and handling of information and records, in any form, to ensure confidentiality, including taking reasonable safeguards to make data anonymous when appropriate, and restricting access to reports and records to those who have a legitimate need to know.
- Maintenance of records, and writing of reports, to enable access by a client which safeguards the confidentiality of information relating to others.
- Clarification for clients of procedures on record-keeping and reporting.

Record management

- Reasons for visit, appointment times, recommendations given to the client
- Copies of documents issued to clients, e.g., confirmation that the person attended sessions, confirmation that the person needs an emotional support dog on a plane, etc.
- Assessment results
- Supervision discussions
- Treatment plan
- Questionnaires for tracking treatment progress (eg. CORE-OM)
- Why it should be meticulous?
- What else is in the notes?
- *Different country regulations but the logic is the same*

Informed consent

- Has to be valid (competence to understand and to give consent / assent, voluntariness, comprehension, with adequate information in clear non-technical terms with culturally sensitive language)
- Given by the client of legal guardian / institution
- Problems with oral consents?
- This is not a one time event but an ongoing process (can be revisited or withdrawn)
- Information about who will have access to files
- Adequate information: qualifications of the psychologist, nature of treatment (risks and benefits, alternatives), responsibilities of the client, responsibilities of the psychologist, limits of confidentiality, contact outside of sessions, information about when can treatment end abruptly and possibility of complaints and withdrawal of consent

Biographical data

- Name and surname
- Date of birth
- Gender and preferred pronouns
- Emergency contact / next of kin
- Contact information (current address, phone, email)
- Other info: cultural background & religion, marital status and family structure, occupation & education, medical and mental health history, medications, alcohol or drug abuse, current problems, etc.

Sensitive information examples

- Identifiable Information
- Client Relationships
- Clinical Details
- Personal history (trauma, abuse, criminal history, substance abuse)
- Sexual Orientation or Gender Identity
- Cultural or Religious Beliefs
- Disabilities
- Crisis
- *Minimization - Record only what is necessary for treatment and avoid including irrelevant details*
- *Work within the GDPR framework*

Billing and insurance information

- Fee-for-Service vs. Managed Care
- Raising the price without notification in advance
- Pro bono work and debts
- Charging missed appointments
- Sliding scales
- Explaining deductibles and copays to clients
- Insurance:

a) confidentiality
b) frauds - upcoding, splitting the money with the client
c) managing denied claims

- Working off the books (cash payments, no tax)

Treatment completion data

- Date of completion
- Summary of treatment goals and outcomes
- Unresolved issues
- Attendance
- Client feedback
- Follow up plan (referrals, self-help strategies, open door policy)
- Reasons for termination of treatment e.g. successful goal completion, who initiated it, external factors, breaking the rules, etc.

Session notes

- Purpose:

- To record the psychologist's thoughts, hypotheses, or impressions that may not be included in formal documentation.

- Serve as memory aids for future sessions.

- Used for professional development, supervision, or refining the treatment process.

- May include subjective observations, personal reflections and speculative material.

- Usually not part of the client’s record, not shared with clients

Contact outside of the office

Reasons:

- Emergencies, scheduling changes, accidental meeting on the street
- Doing sessions out of the office

- Printed relevant email and telephone correspondences should be in the records especially in cases of potential suicide emergencies

Ways to keep records

- Paper (in files and in notebooks)
- Regular electronic (folders for every client)
- Specialized programs and apps
- Hybrid systems

Other:

- Audio and video recordings
- Dictation Software
- Cloud Storage Systems

How to safely keep paper records?

- Lockable Fireproof Filing Cabinets
- Vaults
- Separate room for records
- Using sealed envelopes for psychological assessments
- Limit access to authorized personnel only (lock & key)
- Organized Filing System (active and inactive clients)

- Other measures: scanning everything to have a backup copy

How to safely keep digital records?

- Encrypted drives or USBs
- Strong passwords with two-factor authentication
- Keeping records on an offline hard drive
- Limit access to files
- Using Firewall and Antivirus systems

Other measures:

- Schedule automated backups
- Enable remote wipe capabilities on devices in case they are lost or stolen

How long should records be kept?

- Depending on the country's retention laws (sometimes a few years after completion of treatment e.g. 7 or 10, sometimes after the death of the client, sometimes there are permanent electronic records)
- Audio and video recordings should be destroyed after using them for example for supervision purposes
- How to safely destroy records?
- Cross-cut shredder or incineration
- For digital records simply deleting files is insufficient - they can still be recovered. You have to use software tools that overwrite data multiple times to ensure it is irretrievable. Other options are for example physical destruction of USBs or exposing devices to strong magnetic fields to erase data.
- For data stored in clouds work with IT professionals to confirm complete data erasure.

Who can ask for access to records?

- Clients (not raw test data or sensitive notes)
- Parents or legal guardians for minors (has limits)
- Individuals with legal authority to act on behalf of the client
- Other healthcare professionals with the client’s written consent
- Insurance companies
- Courts
- Regulatory bodies when the psychologist is under investigation
- In work organizations where there is an obligation to submit a written report about a client (e.g. fitness-for-duty assessments)
- Reports to expert commissions (forensic, retirement, etc.)
- Extreme cases: client's immediate best interest where non-disclosure could result in harm (e.g. client in coma, doctors and family members want to harvest organs and prematurely end life support, but the psychologist knows it is against the client’s wishes)

Client’s rights

- Right to access files
- Right to rectification of inaccuracies in the files
- Right to erasure of files unless retention is legally required
- Right to data portability (in a format that allows transfer to another psychologist)
- Right to object, e.g. using client records or session recordings in supervision or training contexts without consent.

Untimely death of the psychologist

- Professional will:
- leaving written and digital documentation to another psychologist (designated professional executor) or organization
- must include information about where to find records, where are the keys, what are the passwords, etc.
- informing clients (accessing records for continuity of care or referrals)
- transfer or destroy records (depending on the client)
- Similarly the psychologist needs to ensure that the records will not fall into the wrong hands when he is retiring

Common pitfalls and unethical behavior

- Technical errors (wrong date of birth)
- Messy and illegible handwriting, shorthands
- Fabricated documentation (e.g. because of a subpoena)
- Insufficient or incomplete documentation (e.g. omitting treatment decisions, client progress, setbacks or risk assessments)
- Overdocumentation (irrelevant information such as personal opinions, speculation, e.g. “The client was very dramatic today”)
- Poor security practices (leaving paper files unattended, using unsecured electronic platforms or inadequate encryption for digital records or email communication)
- Sending sensitive or confidential client information by electronic means

Common pitfalls - continued

- Disorganized record-keeping (missing dates of sessions or inconsistent note formats across clients)
- Delayed record-keeping (leading to inaccuracies or forgotten details)
- Releasing sensitive information that may harm the client (e.g. raw test data, subjective comments, sexual behavior, diagnosis, etc.)
- Failing to document referrals or consultations with supervisors
- Mixing personal and professional notes
- Falsifying treatment progress to meet insurance or organizational requirements
- Repeating the same verbiage or same notes (known as “cloning”) for several consecutive sessions
- Not keeping any records at all

Shared reports

- Psychologists who work in settings where files are shared or reports are co-authored among members of multi-disciplinary, or other types of teams, may have special responsibilities to maintain sensitive confidential information.
- The clients need to be informed.
- If there is a separate file, clearly note in the main files that another separate file is maintained, providing details of how this file may be accessed.

Ethical issues - conclusions

- Ensuring confidentiality, accuracy and honesty in records
- Staying updated on legal requirements and best practices
- Preparing for and responding to cyberattacks or accidental data exposure

Concluding remarks

- Record keeping is not just an administrative task it is the cornerstone of ethical practice
- Records provide psychologists with a valuable tool for reflection on treatment progress, self-assessment, and professional development
- It’s crucial to stay informed about secure digital tools and platforms
- As professionals, we must stay updated on legal, ethical, and technological advancements to ensure our practices remain compliant and effective

Questions?

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Thank you for your attention!