Notes on notes: Note-taking and record-keeping in psychotherapy

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Abstract

This article offers information and views about note-taking and record-keeping in the practice of psychotherapy in this country, in the context of the limited literature on the topic. It provides a brief review of what principal figures wrote about taking notes and making records, specifically Sigmund Freud and Eric Berne. It considers the purpose of making notes and keeping records, and presents key terms and conditions on the subject. Finally, it reviews relevant declarations and legislation regarding notes and records pertinent to the practice of psychotherapy in Aotearoa New Zealand.

Whakarāpopotonga

Ko tā tēnei tuhinga he whakatau koha mātauranga me ngā tirohanga whakapā ki te tuhi kōrero me te pupuri hopu puoro i roto i te haratau whakaora hinengaro i tēnei motu i runga i te tirohanga o te torutoru o ngā pukapuka mō tēnei kaupapa. Ka horaina he aromatawai poto a ngā kaituhi matua mō te kaupapa nei, inarā ā Hirimana Whereuta rāua ko Ērika Peene. Ka āta whakamātauhia te take o te tuhi kōrero me te pupuri puoro, ka whakaatu ake i nga whakaarohanga matua me ngā āhuatanga kai runga i te kaupapa. I te mutunga, ka tātarihia ngā whakataunga e hāngai ana me ngā ture whakapā atu ki te tuhi me te hopu kōrero e ai ki tā te haratau whakaora hinengaro i Aotearoa Niu Tīreni nei.

Keywords: notes; note-taking; records; record-keeping; privacy.

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Introduction

There are different perspectives on, as well as some confusion about, the nature and purpose of client (or patient) notes; the status of the practitioners' own notes, which may take the form of a private, reflective journal; and, more broadly, the nature and status of health records (and the extent to which all notes are part of health records). This is further complicated by the fact that different associations and accrediting bodies have different views and requirements, such that practitioners, who may be members of a number of such associations and bodies, are often confused about what is mandated and what is permitted. A final layer of complexity concerns the context in which practitioners work with regard to sector (public and/or private); organisation (commercial, education, health, justice, voluntary, etc.); third parties, e.g., when working for the Accident Compensation Corporation (ACC); and location (i.e., different jurisdictions): each of which may have specific policies and procedures about notes and records.

Somewhat surprisingly, there is very little clear guidance as to precisely what psychotherapists must do with regard to note-taking and record-keeping. In her book on *Record Keeping in Psychotherapy and Counseling*, and writing in the context of the United States of America (USA), Luepker (2022) comments that:

> … few mental health professional organizations or states define and describe the characteristics involved in competent clinical recording keeping. There is little written about the therapeutic process of record keeping. This leaves practitioners to use what little they can learn in graduate schools or internships or to devise their own policies and methods in a virtual vacuum. (p. 19)

There is also very little literature as to what practitioners actually *do*. One survey of the record-keeping practices of clinical psychologists working in one region of the UK's National Health Service found:

> … much individual diversity and uncertainty as to what constitutes good practice … [and that] despite [then] recent guidance from the Division of Clinical Psychology and the Department of Health, many issues with regard to note-keeping are unresolved, ambiguous and subject to individual and local decision-making. (Scaife & Pomerantz, 1999, p. 210)

Accordingly, we have sought to adopt an interdisciplinary and collaborative approach to seek to identify whether relevant legal sources provide guidance. Based on a review of the literature, and of the law and relevant health policies as they stand in this country, this article clarifies the current situation with regard to notes, note-keeping, records and record-keeping in psychotherapy. We introduce this with a brief history of the place and purpose of notes and records in psychotherapy, following which we identify a number of purposes for taking notes and keeping records. In the third part of the article, we clarify various terms and conditions used in requirements and policies about this aspect of practice; and, in the fourth and final part, discuss the implications of this for practitioners and health care providers working in this field.

A brief review of the literature on notes and records in psychotherapy

Freud was an assiduous note-maker, an inveterate letter-writer, and the originator of the psychoanalytic case study. It is clear from a comment in a letter (written in 1896) to Wilhelm Fleiss, an early collaborator and friend, that this derived from Freud's personal habit or discipline: "I have booked lodgings in Obertressen near Aussee. I make daily notes about my health, so that they can be used to check special dates" (Freud, 1985a, p. 180). With reference to his clinical work, he wrote (in another letter to Fleiss, written in 1899) about "making notes on the results of my four analyses every evening" (Freud, 1985b, p. 384). An aside in *The interpretation of dreams* — "The dream — it is the only one of which I possess no careful notes" (Freud, 1900/2009, p. 599) — suggests that he usually made careful notes; though, in a letter to Carl Gustav Jung (written in 1907), Freud (1974) writes that "I am again taking notes on my analyses" (p. 58), which suggests that he didn't always make notes on patients, or had periods in which he didn't. In a letter to Karl Abraham (written in 1910), Freud (2002) refers to having the results of a case but not the notes, which suggest that he destroyed his case notes after a certain time. With regard to the nature of notes, in a letter to Sándor Ferenczi (also written in 1910) he refers to his notes having "intimations and confusions" (Freud, 1993, p. 147), which is why he says he couldn't show them to anyone, though he also refers to reading other analysts' notes (notably Fliess', Jung's and Ferenczi's) and to sharing his own case notes with them.

Interestingly, in his "Recommendations to physicians practising psycho-analysis", Freud (1912/1924) discusses the problem of keeping in mind all the details of patients and their lives and suggests the technique of "evenly-suspended attention" (p. 110). "In this way", he suggests, "we spare ourselves a strain on our attention which could not in any case be kept up for several hours daily, and we avoid a danger which is inseparable from the exercise of deliberate attention" (p. 110). He continues:

> deliberately concentrates his attention to a certain degree, he begins to select from the material before him; one point will be fixed in his mind with particular clearness and some other will be correspondingly disregarded, and in making this selection he will be following his expectations or inclinations. (pp. 110-111)

Berne (1966) echoes this in his comment on note-taking: "notes taken during the session are apt to recount in the most detailed way the least important aspects of the meeting, while the substance is only sketchily outlined" (p. 51).

Freud acknowledges that this technique suits his individuality. Elsewhere, Freud (1932/1973) refers to the fact that he "still possessed the gift of a phonographic memory" (p. 33) — and that others who are "quite differently constituted" (Freud, 1912/1924, p. 110) will adopt different attitudes and methods. Nevertheless, for him, this technique "rejects the use of any special expedient (even that of taking notes)" (Freud, 1912/1924, p. 110).

Writing in the same paper about taking notes, he advises against doing this in the session, not only because of "the unfavourable impression which this makes on some patients" (p. 112) but also because it would compromise the nature and quality of his attention, a point he had made in an earlier paper in commenting on the difficulties the physician has conducting:

> ... six or eight psychotherapeutic treatments of the sort in a day, and [who] cannot make notes during the actual session with the patient for fear of shaking the patient's confidence and of disturbing his own view of the material under observation. (Freud, 1905/1977 p. 38)

Berne (1966) makes a similar point about not taking notes during the session and extends Freud's point about attention, arguing that:

> Notes written after the meeting are subject to the same criticism in a diluted form. If the therapist is distracted during the meeting by trying to remember what he is going to put in his notes, to that extent his therapeutic efficiency is diminished, and probably his effectiveness also. (p. 51)

For Freud, the exceptions to this rule are "in the case of dates, the text of dreams, or particular noteworthy events which can easily be detached from their context and are suitable for independent use as instances" (Freud, 1912/1924, p. 112), though he also says that he is not in the habit of doing this. Finally, he acknowledges that taking notes during a session "might be justified by an intention of publishing a scientific study of the case" (pp. 112-113), though he goes on to argue that "exact reports of analytic case histories are of less value than might be expected" (p. 113). Rogers (1942) took a different view when he published the first complete and unedited transcript of work with a client, Herbert Bryan, over eight sessions, together with his accompanying notes.

Writing about the supervision of group treatment, Berne (1966) suggests certain advantages to recordings of sessions, noting that: "Tape recordings are useful for beginners because the proceedings can be analysed transaction by transaction, and the therapist can develop his skill in observing and interpreting vocabularies, inflections, and nonverbal phenomena such as coughs, laughs, and grunts" (p. 52). He develops the link between supervision and the development of theoretically-informed practice of the transactional analyst in his next point:

> For more advanced students, notes taken after the session are most helpful because it is possible within the supervisory hour to get a quick view of the whole meeting so that games and other ongoing forms of social action can be picked out. (p. 52)

Also, writing in the context of supervision and promoting theoretical integrity, Mearns (1995), a person-centred counsellor, expresses his concern about the flight on the part of both therapist and supervisor into analysing the missing client, and asserts that "supervision as it is normally practised tells us absolutely *nothing* about the client" (p. 422). In order to prevent this flight, Mearns suggests:

> ... conduct[ing] supervision sessions under a strict policy of relating all statements about the client back to the counsellor. This not only serves to minimise the dangers of early closure on judgements about the client, but also increases the questions which the counsellor asks about himself or herself in relation to the work. (p. 423)

Mearns notes three ways in which the supervisor can have direct awareness of the client: through live supervision, which is rare, and usually only takes place in the context of training; by means of written verbatim, which used to be common in social work training, but is rare in therapy training; and through the use of recordings, which is more common but again, predominantly in the context of training.

With regard to the nature of notes, their confidentiality (or otherwise), storage, disposal, etc., in these brief references about notes, note-taking, recordings, and record-keeping, with their implications for method, we see the origins of current practices and concerns, at least as they are expressed in some of the current guidelines. In the next part of the article, we attempt to broaden and deepen these references by offering an overview of the purpose of making notes and keeping records.

The purpose of making notes and keeping records

In two articles on practical approaches to note-taking, McMahon (1994a, 1994b) suggests a number of specific purposes to this, including: as a memory aid; to monitor the client's progress; to aid the process of referral; for training and/or accreditation purposes; to assist therapeutic audits; for internal complaints procedures; and as a tool for reflection. Based on a study of clinical psychologists' note-taking practices, and writing from a more critical perspective, Newnes (1995) identifies three covert reasons for taking notes:

- as part of monitoring, that is "observing others and writing it down [which] become a prelude to observing ourselves or being observed, as if such observation is good for people" (p. 33);
- as a means to contain the anxiety of inexperienced practitioners and give the illusion that no harm results when "cases" are passed between practitioners; and
- as access to notes is seen as a consumer right.

Most recently, Luepker (2022) views systematic clinical records as "essential" (p. 20) as they:

- facilitate communication between therapists and clients;
- form the basis of sound diagnoses and appropriate treatment plans;
- provide for continuity of care;
- are necessary for clinical supervision;
- satisfy contractual obligations (she cites third-party payers or funders); and
- are best protection against allegations of unethical and harmful treatment.

From our reading of the literature, it appears that there are four main purposes for notes and records: accurate recall, planning treatment, professional development, and defending practice. There is also an underpinning value of acting so as to respect rights and dignity.

Accurate recall

Having adequate notes on a client enables the practitioner to recall information about them

accurately. This encompasses practical information (such as contact details), personal information (such as names of their significant others, other health practitioners with whom they are working, personal history, etc.), as well as other details of the sessions. In this sense, notes as an aide-mémoire may help refresh the practitioner's memory of relevant details about the client. Though, of course, this raises the question of what is relevant — and why? Whilst such information (as above) may appear innocuous, at least while it remains under the practitioner's lock and key, it becomes more problematic in the context of court proceedings in which context, as Jenkins (2002) observes: "the client cannot restrict or limit the disclosure of sensitive personal information …. This choice rests ultimately solely with the authority of the court itself" (pp. 6-7). The lack of legal protection for therapy records against an order for their disclosure (Cristofoli, 2002; Jakobi & Pratt, 2002), and clients' rights of access to therapists' notes under data protection legislation (Pollecoff, 2002) might suggest that practitioners — and clients — are better off relying on memory than on written record.

Planning treatment

Depending on the practitioner's approach to therapy, some plan their work with, or treatment of, the client more than others. For instance, transactional analysis, originally heavily influenced by the medical training of its founder, Eric Berne MD, has a number of treatment planning sequences (see Clarkson, 1992). In this context, having notes helps to plan "What next?" (Stewart, 1989, 1996). Other therapeutic modalities or theoretical orientations take different approaches to therapy and, therefore, note-taking and recording-keeping. Indeed, in its *Code of Ethics and Professional Practice*, and its only reference to notes, the United Kingdom Council for Psychotherapy (UKCP) (2019) privileges this when it states: "Make notes appropriate to the modality of therapy being practised" (p. 3). At the same time, UKCP acknowledges that clients' confidential information should be kept "subject to legal and ethical requirements" (p. 3). In the New Zealand context, the Psychotherapists Board of Aotearoa New Zealand (PBANZ) (n.d.b) is clear that "Legal precedence [sic] implies an obligation on all health professionals including psychotherapists to have health records relating to identifiable individuals" (p. 1). We outline the core legal obligations below.

Professional development

Notes are used at all stages of professional practice and development, from initial training to professional wills. Luepker (2022) writes positively about the benefit of competent record-keeping: "It becomes a dynamic aide in developing a framework for supporting the therapeutic relationship from the outset and through various stages of our collaborative clinical work with clients" (p. 19). Notes and records — and, indeed, recordings of sessions — are generally viewed as helpful, even essential for supervision, especially for students/trainees; and recordings of clinical work are required for examination (e.g., International Transactional Analysis Association International Board of Certification, 2022; New Zealand Association of Psychotherapists [NZAP], 2022).

Defending practice

We see this both in the positive sense, akin to the academic concept of defending a thesis, as well as the defensive sense of having to cover oneself in anticipation of criticism and,

potentially, litigation — which, Clarkson (2003) argues, leads to "defensive psychotherapy" (p. 60). The former is captured in the following: "All psychotherapists will be … able to articulate, and provide a substantive rationale for, their own professional opinion through verbal and written communications in clear, concise and accurate form, for example, in report writing and client records" (PBANZ, 2019, Section A.6d, pp. 4-5). The latter is captured in the guidelines of the New Zealand Psychologists' Board (NZPB) on the subject. Of the ten purposes of record-keeping identified by the NZPB (2017), only two relate to the process of the (clinical) practice, i.e., "to aid appropriate ongoing intervention … [and] As an aid to memory for the psychologist."(p. 1). One is "for the client's personal use" (p. 1). The other seven are for external or, we would suggest, defensive purposes, i.e.,

- … for any legal process, and to provide documented evidence in the event of any subsequent complaint or competence concern…
- To provide a record of contact for the client's use for insurance reimbursement and other health-related claims.
- To enable the transfer of care to another psychologist should that be desirable.
- To assist in the comparison of similar cases and assessing treatment approaches.
- To comply with relevant legislation.
- To support accounting processes and keeping statistical data. (p. 1)

Given the concerns that there might be legal pitfalls with regard to records of therapy, Cristofoli (2002) considers that therapists might adopt "a minimalist approach to note taking [which] would serve both an efficient record of the therapy provided to the client and would reduce the risk of detailed notes being used in later court proceedings" (p. 32). However, he also offers the alternative view, that:

> Detailed record keeping, particularly where the contractual and therapeutic relationships with the client become problematic and conflicted, may well be a necessary safeguard to provide evidence of the therapist's level of professional service, and of attempts to resolve points of contention that may have arisen. (p. 32)

There are a number of formulations and templates for record-keeping, of which Luepker's (2022) essential contents of "good records" (p. 40) is the most comprehensive as she includes: demographics (18 items), evaluation (13 items), treatment progress notes, termination or closing summary, other essentials (11 items), and preventative action taken (9 items).

Terms and conditions with regard to notes and records in psychotherapy

In this part, we identify and summarise key terms used in this field (see Table 1), following which we consider the conditions under which these terms may be understood.

Table 1. Key terms used with regard to notes and records in psychotherapy, their definitions and descriptions

Term	Definition(s) and descriptions
Access	In terms of access to personal information, the PBANZ (n.d.b) notes that: *The Health Information Privacy Code 2020* (Privacy Commissioner, 2020) states that an individual is entitled to receive from a health agency …upon request: • confirmation of whether the health agency holds any health information about them; and • access to their health information. When an individual is given access to personal information in response to such a request, that person shall be advised that they may request correction of the information. (p. 1)
Agency	The PBANZ also adds a note to the word "agency" (throughout), that this would include practitioners working in private practice.
Beneficence	A key ethical principle by which the taking, maintenance, and storage of notes and records may — and, arguably, should — be assessed (see Layman, 2020; Tudor & Grinter, 2014).
Clinical notes	The PBANZ (n.d.a) states that these are health records and that they include "a record of the therapeutic process and clinical thinking" (p. 1), and thus does not distinguish between health records/clinical notes and psychotherapy notes.
Destruction or disposal	In terms of the disposal of health information, PBANZ (n.d.b) notes that: "Health agencies … [including] practitioners working in private practice] need to be careful to dispose of patient records securely, either by shredding or otherwise destroying records themselves or by hiring a secure destruction contractor" (p. 2).
Good records	Luepker (2022) defines these as being "a clear 'picture' or 'mirror' of a patient" (p. 42) and discusses a number of characteristics of such records, i.e., that they are: legible, germane, reliable, logical, prompt (made soon after the session), and chronological.
Health information processes	In its *Information Sheet* on the subject, and based largely on the *Health Information Privacy Code 1994*, the PBANZ (n.d.b) considers health records in terms of access, protection, retention, and disposal. While this is a useful description of part of the process, it misses out the first stage, collection.
Open notes	The concept and movement that patients and clients (should) have complete access to all records about them.

Practitioner notes	Reflective notes, which are still subject to a process of discovery in a civil action.
Protection	In terms of the protection of health records, the PBANZ (n.d.b) notes that: *The Health Information Privacy Code 1994* states that an agency … that holds personal information shall ensure that the information is protected, by such security safeguards as it is reasonable in the circumstances to take, against: • loss; • access, use, modification, or disclosure, except with the authority of the agency that holds the information; and • other misuse.
Psychotherapy notes	Those usually more detailed notes made about a session which often include the practitioner's own reflections and feelings, and for the purpose of supervision and/or education/training. They may be distinct from an official or regular record, and kept separately. In the United States of America, the Privacy Rule in 45 CFR §164.501 defines psychotherapy notes as "notes recorded by a mental health professional that document or analyze the contents of a counseling session and that *are separated from the rest of a medical record*" (Department of Health & Human Services, 2005, our emphasis). In the New Zealand context, the PBANZ (n.d.a). does not distinguish between clinical notes and psychotherapy notes.
Retention	With regard to the retention of health records, the PBANZ (n.d.b) refers to the *Health (Retention of Health Information) Regulations 1996* which states that: • All providers must retain records of health services **for a minimum of 10 years**, starting from the day after the most recent treatment. • If the records are transferred to another provider or organisation, this obligation transfers with the records. • If the medium in which the records are held is likely to deteriorate to an extent that it places in doubt that the records will be able to be read or retrieved during the 10 year time period, it is sufficient to keep an accurate summary or interpretation of the original records. (p. 2; original emphasis)
Storage	*The Health Information Privacy Code 2020* (Privacy Commissioner, 2020) states that a health agency (and, therefore, a practitioner) that holds health information must "ensure (a) that the information is protected, by such security safeguards as are reasonable in the circumstances to take, against— (i) loss; (ii) access, use, modification, or disclosure that is not authorised by the agency; and (iii) other misuse" (p. 8). Even if the practitioner keeps separate health records/clinical notes and psychotherapy notes, the spirit, if not the letter of the *Code*, suggests that both are subject to the same rule.

By conditions, we refer to the various obligations, requirements, and guidelines as far as client notes and health records are concerned. These range from legal requirements contained in statutes, to requirements and guidelines for best practice of professional associations and organisations. In Table 2 we present them from the general and broad to the particular and specific, i.e., from those which encompass everyone, through those that apply to health care providers, to those that cover health practitioners.

Table 2. Conditions with regard to notes and records in psychotherapy in Aotearoa New Zealand

Framework	Application	Notes
Code of Rights under the *Health and Disability Commissioner Act 1994* *Privacy Act 2020*	To the whole population	This is of significance to the making and keeping of notes and records.
Health Information Privacy Code 2020 (Privacy Commissioner, 2020) *Pae Ora (Healthy Futures) Act 2022*	To all health care providers, including health practitioners	This is of significance to the making and keeping of notes and records.
Health Practitioners Competence Assurance (HPCA) Act 2003 *Health Practitioners Competence Assurance Amendment Act 2019* *Psychotherapist Standards of Ethical Conduct* (PBANZ, 2022) *Clinical notes information sheet* (PBANZ, n.d.a) *Health records information sheet* (PBANZ, n.d.b)	To all registered health practitioners, including psychotherapists	The HPCA Act refers to but does not define "clinical records" or "records". The PBANZ provides certain standards with regards to notes (see below), as well as relevant information sheets about notes and records.
Code of Ethics (NZAP, 2018)	To members of the NZAP	There are no references to notes or records in this Code; there are references to the management of electronic communication, digital records (and record-keeping) as one of the criteria for assessment for its Advanced Clinical Practice Pathway and membership (NZAP, 2022) — and to the recording of clinical work to present for this assessment.
Code of Ethics (New Zealand Association of Child & Adolescent Psychotherapists [NZACAP], 2018)	To members of the NZACAP	There are no references to notes or records in this Code.

In addition to this, health care providers, psychotherapists, and psychotherapy students/trainees may be members of other professional associations and, with regard to our current interest, specifically accrediting bodies. Ones that represent the different therapeutic modalities in which it is possible to study currently in this country are: the Australia New Zealand Association of Psychotherapy, the Australia New Zealand Psychodrama Association, the Australia New Zealand Society of Jungian Analysts, the International Association for Analytic Psychology, the International Hakomi Institute (USA), the International Psychoanalytical Association, the International Transactional Analysis Association, the New Zealand Institute of Psychoanalytic Psychotherapy, the New Zealand Society for Bioenergetic Analysis, and Psychosynthesis South Pacific. Each of these also have terms and conditions for membership and accreditation, some of which may indicate what a member may or has to do with regard to notes, note-taking, records, and/or record-keeping.

Here we take the principal frameworks (noted in Table 2) and discuss their conditions with regard to notes and records.

Privacy Act 2020 and the Health Information Privacy Code 2020

The right to privacy is a key feature of the international human rights regime, which in turn informs domestic laws. *The Universal Declaration of Human Rights* ("the *UDHR*", United Nations [UN], 1948) was part of an attempt to reset the world not only after the atrocities of World War II and the Shoah (Holocaust) but also following decades of eugenics which proposes that, on the basis of genetics, some people are inherently superior to others. The *UDHR* indicates that people should be protected by law against "arbitrary interference with … privacy, family, home or correspondence," and against "attacks on honour and reputation" (Article 10). This informed Article 17 in the *International Covenant on Civil and Political Rights* (UN, 1966), which was designed to be a treaty with standards enforceable in international law and requiring states to modify their own laws to be compliant.

It should be noted that privacy rights are not absolute: "arbitrary" interference with privacy is precluded. Arbitrariness is not defined in the *Covenant*, but has become associated with needing to have a balance which requires the state (the government) that has breached, or allowed the breach of privacy, to show that there was a valid countervailing aim for breaching privacy, that the breach of privacy supported this aim, and that the fact of the breach was justified and a proportionate way of meeting the aim. The latter may lead to grey areas where reasonable people can differ, and where states can decide to draw slightly different boundaries. The need for the law to protect privacy means that the topic must be regulated in an adequately clear way, and in a way that draws a boundary that meets the relevant test for a breach of privacy.

So, in this context, what is "privacy"? It clearly covers matters relating to a person's health, both physical and psychological. For example, considering the "right to respect for his private life" in Article 8 of the *European Convention on Human Rights* (Council of Europe, 1963) (which is structured differently to Article 17 of the *International Covenant on Civil and Political Rights [ICCPR]* (UN, 1966) but, substantively, has the same effect), the European Court of Human Rights has noted that it is an undefinable but broad concept that covers a person's identity and autonomy. It also includes some aspects of interactions with others (such that, for example, the criminalisation of begging breached the right to contact others to seek help) (Registry of

the European Court of Human Rights, 2021). It has also been recognised that the right to privacy extends to the protection of data that is being generated in such a fulsome manner in modern society (Registry of the European Court of Human Rights, 2022).

The substantive test of arbitrariness means that not all information about a person is treated in the same way. Accordingly, some types of material are more deserving of protection than others and so require much stronger reasons for a breach of privacy. In the data protection context, this gives rise to the idea that there is data that is "sensitive", which includes health-related data. This has higher levels of confidentiality attached to it, not only because of its centrality to the sense of privacy of the person, but also because of the societal value attached to people having the confidence to discuss matters with health professionals.

To illustrate, take the following facts: the image of a person carrying a knife in public is captured on CCTV, the police are called, and the person is detained and referred for medical assessment because they are suicidal; the images from the CCTV are subsequently used in press releases and also in a reality television programme, thereby allowing the person to be identified. Although the original incident took place in public, it was determined that, without adequate steps to cover the identity of the person, the recording and its release was a breach of their right to privacy because it revealed their distress and state of mental health at the time. This case (*Peck v UK*, 2003) makes it clear that the recording and use of the record of something that occurs in public can be covered by the concept of privacy, since the use of the recording goes to a much wider audience. It could have been manipulated (by removing identifying details) to allow the story to be told without revealing that Mr Peck was the person involved.

This background explains the need for the New Zealand *Privacy Act 2020* (which has replaced the *Privacy Act 1993* with additional provisions) and the regime that is in place, through the Privacy Commissioner, to take privacy seriously. However, a caveat should be noted: the *New Zealand Bill of Rights Act 1990* does not fully replicate Article 17 of the ICCPR as it limits the main aspect of privacy to covering protection against unreasonable search and seizure (in Section 21). Thus, the principal statutory protection of privacy derives from the Privacy Act 2020, which is a dedicated regime, rather than through legislation setting out the broad requirement to protect fundamental rights.

Central provisions of the *Privacy Act 2020* are those setting out the "information privacy principles" ("IPP", in Section 22); allowing codes of practice to be issued in relation to them (Section 32), such as professional codes of ethics and practice; and allowing the Privacy Commissioner to investigate complaints about a breach of privacy (sections 70 and following), which may end up at the Human Rights Review Tribunal, to issue compliance notices in relation to breaches of the principles or a code (Section 123), and to enforce those notices through the Human Rights Review Tribunal (Section 130).

The IPP are set out in Table 3 below. They set out what an "agency" should do, and so its meaning is central: it includes individuals who are resident in New Zealand. In addition, one of the consequences of the introduction of the *Privacy Act 2020* was that the *Health Information Privacy Code 1994* has been replaced by the *Health Information Privacy Code 2020*. This is arranged around the privacy principles. It applies to such matters as information about health (including medical history), disabilities, and services being provided or provided in the past; and it applies to a wide range of professionals who provide health and disability services, which, for the purposes of the *Accident Compensation Act 2001* includes

public health services; units within larger agencies; psychotherapists and other psychological therapists; professional bodies; training agencies; insurers; district inspectors; and those who supply medicines or medical supplies. Thus, Table 3 sets out the general principles of the *Privacy Act 2020*, and the more specific rules of the *Health Information Privacy Code 2020*, together with some commentary about their implications for you the reader/practitioner.

Table 3. Information privacy principles applied to psychotherapy notes

Principle	Focus	Description	Implications for practitioners
1	Purpose of collection	The *Act*: Only information that is necessary for the lawful purposes or functions of an "agency" may be collected. The *Code*: Similar, in the context of lawful health functions, but with the indication that if information that can be collected without identifying information, the latter must not be required.	That you consider the relevance of the information you collect. Is it fit for purpose or suited to your task, or do you ask about it because you always do? For example, is a person's sexual history and identity relevant to the reason they have come to see you?[1] The *Code* provision relating to not collecting identifying information may be relevant particularly to public health functions, but it applies to all health agencies and so requires consideration.
2	Source	*The Act*: The individual must be the source of the information about them unless good reasons exist not to abide by this. *The Code*: Similar, and with clear instances of the good reasons, including that the person is not able to give their authority, or that the information is collected for statistical or research purposes and does not identify anyone.	That you have good reasons to speak to others (such as their family members or health professionals) about your client, and that they have given their informed consent for you to do so.
3	Information about collection	The *Act*: That reasonable steps are to be taken to make the person aware that information is being collected, why, who can access it, and how the person can access and correct it; this is subject to various exceptions for good reasons. The *Code*: Similar, rephrased for the health context.	That you consider this and have a standard or consistent way of providing this information.
4	Manner of collection	The *Act* and the *Code*: The means of collection have to be lawful, fair and not unreasonably intrusive.	That you consider these three elements in the collection of information about your client, as well as the balance between gleaning the information necessary in order to work therapeutically, and the impact of the client's experience of intrusion.

5	Storage and security	The *Act*: Reasonable security of storage and against misuse is required, and reasonable steps are taken when information is shared when that is necessary. The *Code*: Similar, with the addition that documents containing information are disposed of so as to preserve privacy, and making clear that IPP5 (above) applies to information obtained prior to the *Code* becoming effective.	That you have secure storage of information, and some protocol about sharing information. That you make use of secure processes for deleting information. That you have considered how this applies to information collected recently and prior to the new *Code* becoming operative.
6	Access by the person	The *Act*: An "agency" must confirm whether it holds information about a person and how to access and correct it, though subject to various good reasons to refuse. The *Code*: Similar, and confirming that it applies to information obtained prior to the *Code* becoming effective.	If you hold such information about clients (and supervisees), that you have a process for confirming this, and for them to request, access, receive and, if necessary, to correct it; and criteria for refusal to share this information with them. That you have considered how this applies to information collected recently and prior to the new *Code* becoming operative.
7	Correction	The *Act*: A person may ask for information to be corrected, and an "agency" must take reasonable steps to ensure that information is accurate, up to date, complete and not misleading; and if a request to correct is refused, the request must be attached to the information. This is subject to various good reasons to refuse. The *Code*: Similar, and confirming that it applies to information obtained prior to the *Code* becoming effective.	See 6 above.
8	Checking accuracy before use or disclosure	The *Act*: Before using or disclosing information, an "agency" must take reasonable steps to ensure it is "accurate, up to date, complete, relevant, and not misleading". The *Code*: Similar, and confirming that it applies to information obtained prior to the *Code* becoming effective.	What process do you have for reviewing and checking the information you have, whenever obtained, before you make use of it or pass it on?
9	Retention	The *Act*: Personal information can only be kept for as long as needed for any lawful purposes. The *Code*: Similar, and confirming that it applies to information obtained prior to the *Code* becoming effective.	What process do you have for removing redundant personal information, whenever it was obtained? How often do you review older files?

10	Limits on use	The *Act*: Personal information can only be used for the purpose for which it was obtained (with various exceptions, including for research purposes if a person cannot be identified, and based on necessity). The *Code*: Similar, but with a proviso for health information obtained before 1 July 1993.	Note the link with Principle 8. What process do you have to ensure that you use information only for the purpose for which you sought it?
11	Limits on disclosure	The *Act*: Disclosure of personal information must be directly linked to the purpose for which it was obtained, authorised by the person concerned, or necessary for various reasons. The *Code*: Similar, and giving instances of what might be proper, such as disclosing to a caregiver that someone has been detained under the *Mental Health Act 1992*, or for professional accreditation or risk management purposes, or reporting by health practitioners to a Medical Officer of Health.	Note the link with Principles 8 and 10. What process do you have to pause and check before disclosure that it is lawful?
12	Limits on disclosure outside New Zealand	The *Act* and The *Code*: Supplements Principle 11 and requires consideration of whether there are equivalent protections or whether the person concerned has been informed that the protections may be less strict.	What process do you have for investigating whether disclosure may be to someone not governed by New Zealand law and whether there is similar protection or not and what to do if not?
13	Assigning unique identifiers	The *Act*: Unique identifiers can be used only if necessary (and cannot be the same as one used by another agency only in limited circumstances). The *Code*: Similar, but with provisions for the use of the National Health Index number.	What checks do you have for this requirement, particularly if you work with other agencies?
* In terms of working with other health professionals, it is useful — and, in an emergency, essential — to have your client's full name, date of birth, and NHI (national health index) number.			

Health and Disability Commissioner Act 1994

The *Health and Disability Commissioner Act 1994* provides an additional element of the framework for those providing health services (widely defined and expressly including psychotherapy and counselling services). A central function of the Commissioner is to prepare and enforce a *Code of Health and Disability Services Consumers' Rights* (Health & Disability Commissioner, 1996); this is contained in secondary legislation, emphasising its status. Right 1(1) sets out the right of every consumer "to be treated with respect", and Right 1(2) is the "right to have his or her privacy respected". This means that there is an additional

method of enforcing privacy, though this turns on an assumption that the reference to "privacy" here indicates the rights as defined in the *Privacy Act 2020*.

There are other aspects of the *Code* that might have implications for notes, reflecting how notes might be drafted and what should feature in notes:

- Right 1(3) sets out a right to have services that reflect cultural and social beliefs and values: a professional approach to meeting this requirement will note what was considered, what was concluded, and why (including what discussion was held with the client and perhaps with others if appropriate — and without breaching privacy rights — to determine how to meet this right).
- Right 3 is the right to respect for dignity and independence; see above as to how this was ensured.
- Right 5 is the right to effective communication, which may include interpreters; again, notes about the process of deciding that there was no need for support in communication or what was contemplated and ultimately decided on will ensure that this right is respected.
- Right 6 is the right to be fully informed, including making informed choices and having relevant information provided, including a written summary of information provided; Right 7 is the express right to informed choice and consent (including issues of capacity to consent and steps to take if there is no capacity). Evidencing that these rights have been met without having adequate notes of the steps taken may be a significant hurdle.
- Right 10 is the right to complain and have a fair and speedy process of resolution; adequate notes, made contemporaneously, will play a central role in this.

There are also rights that ensure that the standard of care is of an appropriate standard (Right 4), non-discriminatory, exploitative or otherwise problematic (Right 2), and with support persons present, unless there are good reasons (Right 9).

Naturally, there is a need to ensure that this does not become a tick-box exercise; nor should there be the move to unnecessarily defensive practices whereby treatment is rendered ineffective because of the concern that rights have been accorded. At the same time, a reminder of issues that arise in the context of compliance with rights, in the form of a template, cannot be problematic: and the provision of treatment should be in accordance with the right to treatment, and these various subsidiary rights can be seen as designed to secure this primary right.

Pae Ora (Healthy Futures) Act 2022 (The Act)

The Guide to He Korowai Oranga: Māori Health Strategy (Ministry of Health, 2014), notes that:

> Pae ora is a holistic concept and includes three interconnected elements: mauri ora — healthy individuals; whānau ora — healthy families; and wai ora — healthy environments. All three elements of pae ora are interconnected and mutually reinforcing, and further strengthen the strategic direction for Māori health for the future. (p. 3)

The *Act* itself sets out certain principles by which the health sector will operate, the implications of which for psychotherapy we plan to discuss in a separate article. With regard to notes and records, we suggest that the following principles are relevant to psychotherapy practice:

- engagement with Māori and other population groups in a way that reflects their needs and aspirations (Section 1b);
- providing opportunities for Māori to exercise decision-making on matters of importance (Section 1c);
- providing services that are culturally safe and responsive (Section 1d(ii)); and
- providing services that reflect mātauranga Māori (Section 1d(vi)).

Health Practitioners Competence Assurance Act 2003 (HPCA Act)

The *HPCA Act* does not refer to notes and, although it refers to records and clinical records, it does not define them. However, the various references to clinical records (Sections 40(3e), 41(3d(iii)), 42, and 44) suggests that there is an expectation that a health practitioner has, and maintains, such records, and can make them available should they be required, for instance by a professional conduct committee (Section 77), or a Disciplinary Tribunal (Schedule 1 Sections 7, 8, 11(1), and 12). In this, such notes may be useful for justifying a course of action. Also, as Section 16 ("Fitness for registration") refers to the practitioner being able to communicate effectively, this may also imply the presence of notes or records on which the practitioner can base their communication. That said, with regard to compliance with the requirement to provide information or document(s), the *Act* also states that:

> No person is required to produce to a committee any papers, records, documents, or things if compliance with that requirement would be in breach of an obligation of secrecy or non-disclosure imposed on the person by an enactment (other than the Official Information Act 1982 or the Privacy Act 2020). (Section 78(3))

The PBANZ

The PBANZ has information sheets on health records (PBANZ, n.d.b) and on clinical notes (PBANZ, n.d.a), and also refers to records and information in its *Psychotherapist Standards of Ethical Conduct* (PBANZ, 2022) in a section (8) on respecting privacy. This includes the imperatives to:

- keep appropriate records that are accessible and legible;
- take all reasonable steps to ensure that the client's personal information is collected, stored, used and disposed of in a manner that protects the information;
- take all reasonable steps to ensure that information remains retrievable for at least 10 years from the date of the last provision of services to the client;
- make adequate plans for access to and disposal of records in the event of retirement, serious illness, or death of the psychotherapist; and
- take all reasonable steps to maintain the anonymity of clients, colleagues, supervisees or trainees when clinical material is used in education and training, or in research and publications, unless consent to disclosure has been obtained. (pp. 7–8)

Implications

From our reading of the literature, law, policies, and guidelines regarding notes, note-taking, records, and record-keeping, we conclude the following:

1. That, whilst there is no legal mandate that health care providers must make notes and/or keep records, it may be considered unprofessional not to so do, especially if your notes are subsequently required in a legal or disciplinary process. Moreover, if you are a psychotherapist, you have an ethical obligation to keep records (PBANZ, 2022).
2. That there are no legal definitions of what constitutes appropriate notes or records, although the context in which you work may determine this and may, for example, require you to obtain and record certain information about clients. Whilst you may question this, any failure to do so, could lead to sanctions under your terms and conditions of employment.
3. That there is some ambiguity about the distinction between clinical notes and psychotherapy notes, which warrants further research, in the context of which, it may be prudent to separate them. It appears that, in practice, most therapists do make a distinction but the origin and effect of such a distinction is not clear and also warrants further research. However, subject to the clarification as to whether there is a legal distinction between clinical notes and psychotherapy notes, and as the PBANZ (n.d.a) state that health records include "a record of the therapeutic process and clinical thinking" (p. 1), this may be problematic for some psychotherapists. An alternative is to make only those notes that you are willing to share with clients; and, indeed, we know one colleague who writes up notes on each session and emails them to their clients.
4. That, assuming you do keep notes and records, there are clear guidelines about all aspects and phases of the practice: from the purpose of collection, and the source of information, through to the disposal of notes and records (as we have detailed and referenced above), and that these have implications not only for the education/training of psychotherapists, but also for the time involved for practitioners to follow and apply these in their practice.
5. That, ultimately, and as Freud himself acknowledges, the nature of such notes and records are as much if not more to do with the individual constitution and character of the practitioner.

Public statutes

Accident Compensation Act 2001
Health and Disability Commissioner Act 1994
Health Practitioners Competence Assurance Act 2003
Health Practitioners Competence Assurance Amendment Act 2019
Mental Health Act 1992
New Zealand Bill of Rights Act 1990
Pae Ora (Healthy Futures) Act 2022
Privacy Act 2020

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