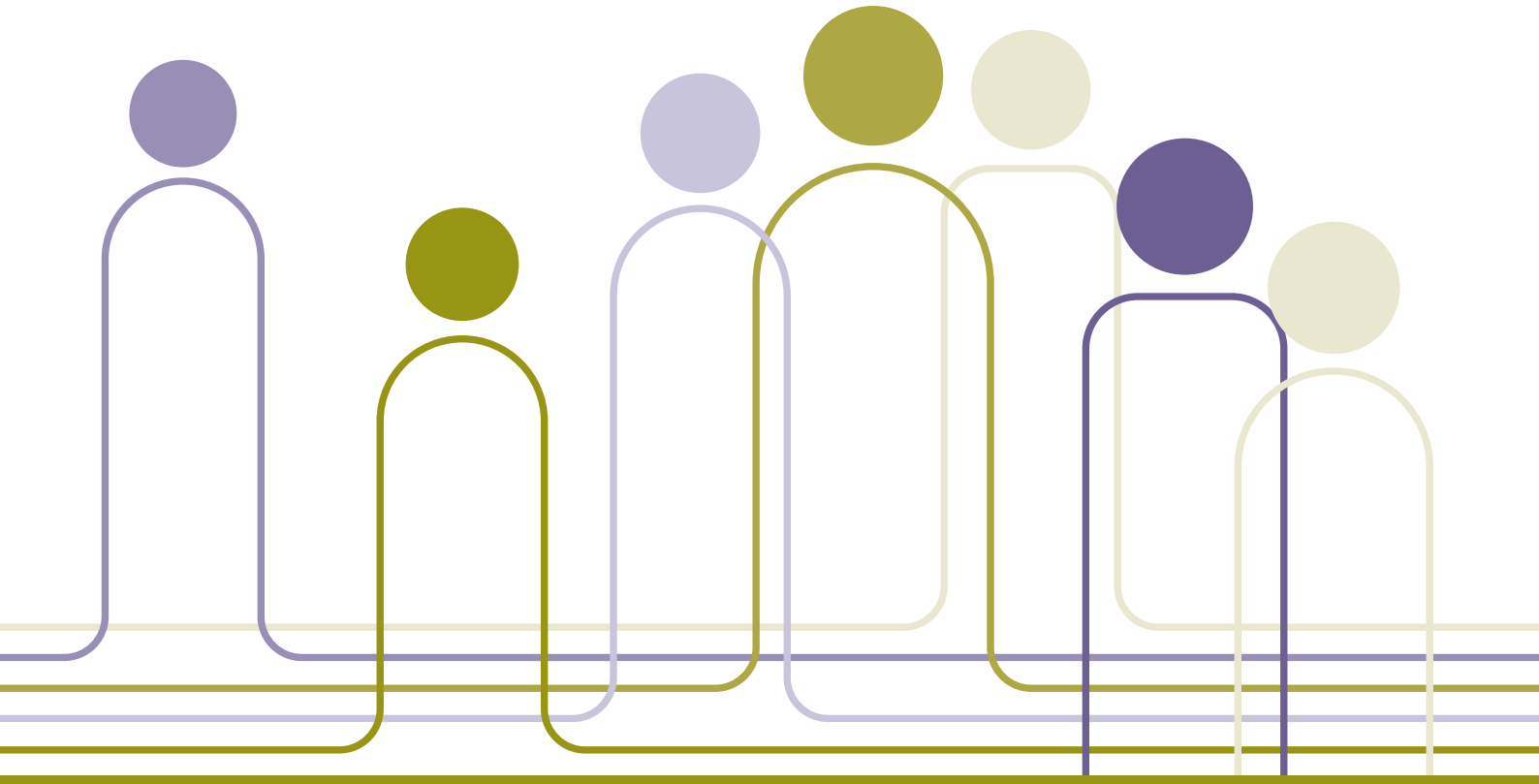
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002

Records and record keeping within the counselling professions



Fact sheet

Ethics in Practice

Ethics in Practice 002
Fact Sheet

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Using Fact Sheet resources

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1 Introduction

This resource begins with an overview of what is meant by record keeping, before moving to examine record keeping in relation to ethical principles and core responsibilities in more detail in section 2. Then, there is opportunity in section 3 to apply this learning to your own practice and reflect on how the points raised in this resource relate to your own work, using the case studies, and points for reflection.

There are a range of Ethics in Practice resources to support good practice in record keeping including EiP 002.1 *Confidentiality and record keeping in the counselling professions*. These can be found on the BACP website. There are also legal resources which are listed under Further reading.

2 Record keeping in the counselling professions

2.1 What is a record?

A record is a document or piece of information about an individual or individuals, which will be stored or processed (including electronically) and from which the individual can be identified using the data within the document. It also applies when the individual can be identified by using the information within that document in conjunction with additional information.

2.2 Who keeps records and what type of record?

Everyone working in the counselling professions will be required to keep records of some kind. Consider as examples private practitioners, counselling services, training providers or researchers employed within counselling organisations. Each different context will have different elements to consider when keeping records in relation to their work. Organisations will need a comprehensive record-keeping policy, while for individual practitioners this may be simpler.

Clients must give explicit consent for information to be kept about them, and must be informed about how the record will be used, stored and destroyed.

Clients also have the right to request they view the records held in relation to them by making a data subject request – see Legal Resource 069 *Sharing records with clients, legal professionals and the courts in the context of the counselling professions* and Legal Resource 071 *Ownership and storage of client notes and records in the context of the counselling professions*.

The differing needs of client groups and the variety of settings keeping records means there are lots of different kinds of record to consider. These will include factual client information, perhaps from referral or assessment forms, along with process notes, outcome measures or visual records such as client artwork. Records may be kept in different formats, such as in languages other than English, via verbal recordings or in Braille.

The *Ethical Framework*

The *Ethical Framework* commits us to working relationally with our clients integrating the principles and core responsibilities it contains into our practice.

Record keeping is not only an essential part of maintaining our legal and professional responsibilities (Core Responsibilities 3.2) but also in meeting the Ethical Principles particularly those of integrity, transparency, best interest and to do no harm.

In this section we consider record keeping in more detail, including different types of record and record keeper, and why record keeping is important. We will also consider record keeping in relation to good practice and the *Ethical Framework*, specifically our Ethical Principles and Core Responsibilities.

While many of our core responsibilities can be applied to records and record keeping, a central section of the *Ethical Framework* (2026) in this regard compels us to keep appropriate records.

To achieve this, we must ensure that the records:

a) are factual, adequate and relevant for the type of service offered.

b) are stored securely and comply with the data protection requirements of the country where the record is stored.

c) include all communications, notes and other information relating to clients or service users working with us within the records we keep of our work.

Who is keeping a record, the type of record being kept and the record-keeping process will depend on the individual context in which the work takes place. The kind of client you are working with will also influence what might be appropriate. Whatever the context in which we work, we must be accountable for the rationale behind our record keeping (Core Responsibility 3.2, EF 2026).

For example, an individual working in private practice with adult clients will need to develop their own system of record keeping, which would be suitable for them and their clients while ensuring the records are kept securely (whether paper or electronically) and in line with all legal requirements around safeguarding and data protection. The kind of record being kept might include client contact details, notes covering session content, and a signed working agreement.

Considerations around safeguarding and data protection legalities will also be a feature for a charity offering counselling sessions to children, as another example. Here too the record keeping required will likely include contact details and notes covering session content, but the overall record-keeping policy might need to be more complex than with an individual practitioner, given the scope of the service and the type of client (in this case, under 18 years). There may be additional records required such as referral and assessment forms, signed consent from both client and their guardian, or the results of outcome measures required by funding or commissioning bodies.

If a practitioner is working as part of a large organisation, for example a school or the NHS, record-keeping practices and styles need to be in keeping with wider organisational policies.

Organisations must consider policies and practices which cover employees, associates, affiliates, students or volunteers as well as their client base. As with all decisions regarding record keeping, policies and processes must be built around the principles of good legal and ethical practice, including considering the purpose for which information is collected, the appropriate amount of detail required and with whom it is necessary to share the information in order for a particular process (such as a counselling relationship) to be carried out.

As a final example, a student counsellor on placement will be required to complete records, perhaps including session notes or client information forms. These will often be stored in line with the policies of their placement provider, and the student may have little involvement in this process other than to ensure they comply. However the student counsellor may still need to consider their individual approach to record keeping with regards to additional records required by their training provider in order to obtain their qualification. These could include client consent to record the counselling sessions, or for therapeutic material to be included in a case study.

In such cases, while training providers, supervisors and placements will undoubtedly be able to offer guidance, it remains the responsibility of the student counsellor to demonstrate their professional competence (Core Responsibility 2.1, EF 2026) by ensuring they have correct record-keeping processes in place in order to meet ethical and legal requirements.

Factual records

Some records will deal in factual information about our work (Core Responsibility 3.2, EF 2026). These might include assessment or referrals forms, the contact information of clients/supervisees, guardians, referrers or other professionals, working agreements with clients or supervisees, details of sessions such as the date, time and fees or the details of any outcome measures completed by the client. Factual information recorded might also include important between-session communication such as emails or text messages with clients (though we should remember we are only to collect necessary information and retain it only as long as needed for the original purpose) or a written account of a specific conversation with a client, or with another professional about a client.

This might include a record of action taken following a safeguarding concern (Core Responsibility 2.4, EF 2026), the outcome of discussions around an ethical decision-making issue (Core Responsibility 1.4, EF 2026), or documenting an agreed change to a working agreement after discussion with a client.

Bond (2015) helpfully details specifics of professional matters that should be recorded:

- any written and signed consents to all treatment
- any written and signed consents to all passing of confidential information
- all appointments, including non-attendance by client
- treatment contracts (if used)
- up-to-date records of counsellor's reasoning behind decisions about significant interventions and general strategies
- consultations with anyone else about the client
- copies of any correspondence from the client or relating to work with the client
- any instructions given to the client and whether or not the client acted on these.

Session notes and journal or process notes

Session notes and journal or process notes differ in content and purpose, but both are important to consider in the context of record keeping.

'Session' (or case) notes is often the term used for notes kept by a practitioner as a professional summary record of the therapeutic work of an individual client. This may include a brief summary of session themes or content, record of a particular point of discussion such as exploring reference to suicidal ideation, or any points agreed following a review of the ongoing therapeutic work. For some practitioners, this may also include their own observations of the clients presenting mood, such as angry, distracted or hopeless. In these cases, it is important the practitioner makes clear this is their subjective interpretation of the client rather than a statement of fact. This is because session notes may be subject to the same legal implications as factual contact notes if a client can be identified from them.

It is good practice to store contact notes, or unique details (for example address, telephone number, referrer etc.) separately from session notes.

This is called pseudonymisation. This might be especially important when considering the administration of your clinical will and how the executor will access your client details (Core Responsibility 4.5, EF 2026); see other resources about clinical wills on the BACP website. Process or journal notes is often the term used for notes kept by a practitioner for the purpose of personal reflection on their therapeutic work. This may include personal opinion, metaphor, imagery, creative writing or personal artwork.

Some practitioners keep process or journal notes separate from session notes, and do not include any identifiable information concerning clients or colleagues.

These anonymised notes do not form part of a client or supervision record (Reeves and Bond, 2021). However, the practitioner may need to consider how this would fit with their commitment to collaboration and the ethical principle of transparency (EF Ethical Principles). If these notes contain information which allows identification of another individual, either from that document or in conjunction with another document, they should be considered part of an official therapeutic record and retained in line with agreed record-keeping processes. A final point to consider is the potential for the subjectivity of process or journal notes to be either beneficial or detrimental to client or counsellor should they be taken out of context by a non-practitioner, such as if presented in a court of law. Therefore if including reflective practices such as metaphor, fantasy or projection, it would be important to note this in the record, to avoid misinterpretation by others as fact or intent.

It is acknowledged that practitioner style regarding session and process or journal notes will vary due to preference content or modality, but whatever the choice, good ethical practice should be adhered to (Core Responsibility 3.2, EF 2026), to avoid bringing the profession into disrepute with inconsistent or ineffective approaches to record keeping (Core Responsibility 1.3, EF 2026).

Supplementary and creative records

Supplementary materials including photographs, timelines or creative representations could still be classed as part of the therapeutic record, with consideration given to their retention in the same way as factual information or session notes.

This is even more the case if any aspect of the supplementary record includes material which could be linked to the identity of a living individual, in which case considerations around data protection apply. It should be noted that the British Association for Arts Therapists' Code of Ethics states that creative work should be named and dated before being safely stored for the duration of the therapeutic relationship (point 14.1).

Before storing supplementary or creative material as a record, the practitioner should first consider the purpose; is the retention of this type of record necessary (Core Responsibility 3.2, EF 2026)? If the practitioner is confident it is, then there should be discussion with the client and in supervision around retention and its implications, ensuring collaboration and informed consent (Core Responsibilities 1.1, 4.3, EF 2026). This is especially important when there is scope for misinterpretation of an image or metaphor from external third parties, such as if it were included as part of a legal case. What might provide material for rich therapeutic exploration, such as an image containing violent themes, might be interpreted as a statement of intent by a court of law. Therefore should a client wish for a creative or supplementary record to be retained, it is important both the benefits and risks of such retention are discussed with them first, and a record is kept of the outcome of this discussion.

Finally, it would also be good practice for the discussion to include whether a client would like the work destroyed or returned to them at the end of therapy, and a note made of both the decision and the date on which this destruction or transfer of material occurred.

Variations on written records

On occasion there may be a need to create a bespoke type of record, often for EDI purposes. Clients have a right to access records kept about them, and we must make reasonable adjustments to ensure fair provision (Core Responsibilities 1.1, 4.4, EF 2026), so it is important these are made available in a format which is accessible to them if possible. This might include large print, audio-recorded versions, versions in languages other than English, or braille. Additionally, practitioners working with children will need to consider how to ensure the records they collect from clients are age appropriate.

2.3 Why do we need to keep records?

While there is no consensus among UK practitioners regarding records and whether/how they should be kept, it is considered good practice (Reeves and Bond, 2921) and an ethical requirement (Core Responsibility 3.2, EF 2026; Bond, 2015) to keep records of our therapeutic work.

It is suggested by Reeves and Bond (2021) that record keeping helps evidence care and professionalism by practitioners, enhances the quality of practice, and reveals client change over time. However, they also acknowledge arguments against keeping records, including the lack of guaranteed secure storage in certain counselling settings, the impact on trust-building with some clients, the fear of records being used against a third party or requested by the client, and simply the time they may take to make and maintain appropriately.

We also have a duty to adhere to the legal and ethical responsibilities of the territories in which we work (Core Responsibility 3.1, EF 2026) (in the UK, this would include the UK GDPR) and of our membership bodies (such as, BACP).

An important aspect of record keeping is the destruction of the records after an appropriate length of time. The decision on the timeframe may involve assessing factors including individual practitioner insurance requirements, organisational data policies, or specific client agreements. Reeves and Bond suggest that 'sensitive information should be destroyed when its usefulness has expired' (2021, p251) while GDPR legislation does not offer set timeframes but instead mandates information is kept only as long as is necessary for the specific reason that you originally collected it.

GDPR and legal requirements

While the law around data and records is complex and is subject to change, we must remember that record keeping in the counselling professions in the UK must adhere to requirements of data protection and GDPR legislation (Core Responsibilities 3.1, 3.2, EF 2026).

In brief, when it comes to data protection for records, clients have a right:

- To be informed
- To access
- To rectification of records
- To 'erasure'
- To restrict processing
- To data portability
- To object.

For up-to-date information you can consult the Information Commissioner's Office website www.ico.co.uk and also Legal Resource 105 *The United Kingdom General Data Protection Regulation (UK-GDPR) – amendments, legal principles and practice notes for the counselling professions.*

It is likely the records you keep will mean you must register with the ICO and pay a fee; all businesses who keep records must register, including sole traders and those who keep only paper notes, as it is almost inevitable that some personal data will be collected electronically, such as email addresses or text messages.

2.4 How do we store records securely?

All records need storing securely, you will need to ensure that any paper records are locked away in a non-portable container, and in the case of any electronic records:

- they should be password protected, ideally at both the level of the individual document, as well as on the device used
- consideration should be given to how you will encrypt documents, especially if the documents are to be stored remotely such as in 'cloud-based' storage systems
- virus protection should also be used in order to protect files from being corrupted or hacked since this supports appropriate professional handling of the records.

If you use your smart phone or tablet, you need to ensure that any data held there, as well as on your laptop or desk top computer, are secure and cannot be accessed or inadvertently shared with others. The ICO offers helpful guidance to assist you with this, which you can find at: www.ico.org.uk.

For those working in schools or other organisations, they might expect all documents to be processed and retained through IT systems, and the documentation style would probably be specified by the organisation. Ensure you are familiar with all relevant processes and policies around record keeping before beginning therapeutic work.

There may be exceptional circumstances in which you might have to change your 'normal' ways of working. For example, working from home instead of seeing clients in an office, due to building works taking place in your usual clinical space, or working remotely when you would usually see your client in-person.

You should consider any impact this may have on your record-keeping, for example, if you work for an agency, whether you can access the organisation's secure server from home to store records safely. If in private practice, consider how you would store information at home in a way that meets data protection guidance and legislation.

2.5 How do we communicate about record keeping?

In line with both GDPR and the *Ethical Framework* (Core Responsibilities 1.1, 1.2, 3.1, EF 2026), clients must be informed about your record-keeping policy before work has begun, in order for them to give informed consent. They must be told:

- what records you keep
- how these are kept
- who else may have access to them
- how long you will keep them for.

This is often done in writing, such as via a privacy notice on your website (Core Responsibility 3.1, EF 2026), or within your working agreement, though you may also share the information verbally during contracting.

Sometimes additional explicit consent may be required, such as for a trainee to use part of the client record in their assessment (i.e. a case study), or if a researcher was going to use any part of the client record as data for their research project.

Considering the importance of working collaboratively and communicating effectively about our record keeping, it is worth reiterating that it is good practice to keep a record of any rationale or decision following an ethical discussion, and it is also important to update your records to show any discussion with clients or supervisees about the records which are kept.

Collaboration with clients is key, as is promoting their autonomy (Core Responsibilities 1.1,1.2, EF 2026). However, this may mean on occasion a client refuses permission for you to retain records about them. In this situation, practitioners must reflect carefully on whether they are still ethically able to work with the client given the implications of not keeping records.

This may include discussing the issue with their supervisor and the client (Core Responsibilities 1.4, 4.3, EF 2026).

2.6 Record keeping and the Ethical Principles

How might we consider record keeping in relation to the Ethical Principles?

The principles underpinning all therapeutic services are:

Confidentiality: Consider record keeping in relation to data protection, GDPR, informed consent, cyber-security and record sharing.

Transparency: Be clear about record-keeping processes, including access to records and length of retention. Ensure specific informed consent is obtained for additional use of records such as use in assessments, research or for feedback following counselling.

Do no harm: Make sure records required are not intrusive, are kept for an appropriate time, are accessible for clients to understand, and that you adhere to GDPR and good cyber-security practice to keep records kept safe.

Best interest: This could mean approaching records in a different way e.g. recording verbal consent, sourcing braille versions. This could also cover working collaboratively with clients to ensure their autonomy is promoted.

Respect: A client may not want to complete a record or may refuse permission for you to keep it. This right should be respected, however it might mean you can't continue work until an ethical discussion to resolve the situation has taken place, or continued refusal may mean you cannot work with them at all.

Fairness: Consider how you will ensure all clients can offer informed consent and full understanding of your record-keeping policies. This may include translating records and information in different languages or offering it verbally.

Anti-oppression: Is there opportunity for client collaboration and discussion even within established record-keeping processes? Does the wording of your records aim to reflect a broadly diverse society, minimising potential for exclusion or othering?

This may include offering all available gender options in Title boxes, current good practice around language concerning race and ethnicity, or using plain English to keep documents accessible for those whose literacy in that language is less confident.

Trust: Clients must be able to trust we will do what we say with the records we keep, so adherence to our stated policies is important.

Collaboration: The conversations outlined in Respect, Fairness and Anti-oppression would also help us meet the principle of Collaboration.

Compassion: By taking time to attend to these ethical principles in the full spectrum of our working relationships, including in administrative processes like record keeping, we aid adherence to Compassion.

Integrity: We will say what we are going to do, follow through on this agreed process and take action on the practical and emotional impact if anything goes awry.

3 Application to practice

The following section is aimed at translating the theory covered in this resource into practice with short case studies. It also gives you the opportunity to think about your own therapeutic practice by offering questions for you to reflect on.

This section introduces you to Ted, a counsellor in private practice. He also works a day a week as a sessional worker in a charity setting, usually seeing clients online from home.

You will read about his working practices with two clients that illustrate his approach to record keeping and to what degree he fulfils his ethical and legal commitments. This is followed by looking at how this is applied to practice where links are made to the *Ethical Framework for the Counselling Professions*. It will help to have the *Ethical Framework* with you as you read this resource, as the relevant sections are contained within brackets following each section. Questions for reflection regarding your own practice follow that you may wish to discuss with your supervisor or colleagues.

Whilst this resource focuses on ethical thinking around record keeping and confidentiality, you may notice other ethical, legal or therapeutic issues that could usefully form the basis of supplementary thinking and discussion.

3.1 Case study 1

Ayo is a private client working with Ted for eight months, working on Ayo's self-worth and anxiety. Three months ago Ayo was diagnosed with cancer, and began treatment immediately. While she is keen to continue their work, recently Ayo has been ending the sessions increasingly early. Ted noticed this pattern when writing up and reviewing his case notes. He had also documented his frustrations around this in the same notes. After noticing this pattern and his feelings, Ted spoke about it in supervision. They discussed boundaries, client engagement and Ted's feelings towards the client and the work. Feeling clearer, Ted introduced the topic with Ayo in the next session. Together, they reflected together on why Ayo was leaving early; she was exhausted from her cancer treatment. They also reflected on the work being done in shorter sessions; both Ayo and Ted agreed shorter sessions were still being therapeutically useful given Ayo's circumstances, and they agreed to deliberately shorten sessions for the next six weeks when they would then review. Because he keeps paper records of client work and their original working agreement was locked away at home, Ted made a note of this amendment on a separate sheet, intending to add it to the client record later.

3.1.1 How does it apply to my practice?

Here we see a number of issues relating to record keeping represented in this case study about Ted and Ayo. First, consider good practice – Ted is clearly making effective notes about the facts of their sessions, and this helped him to recognise a pattern was forming in Ayo's engagement. Following their discussion, he was quick to document their agreed change. He keeps his client record locked away and secure (see Ethical Principle Confidentiality, EF 2026).

Less relevant to record keeping, we also see him making good use of supervision to resolve ethical and practice issues (Core Responsibility 1.4, EF 2026), remain aware of the importance of boundaries while respecting the client's individual situation, and work collaboratively with the client (Core Responsibilities 1.1, 4.4, EF 2026) to maintain the therapeutic relationship and ensure the work is beneficial (see Ethical Principles Collaboration, Best Interest, Respect, EF 2026).

However, some questions are raised about aspects of Ted's approach. There may be a significant issue with the fact Ted seemingly combines his factual session notes with more personal reflections on the work (Core Responsibility 3.2, EF 2026). Ayo has the right to request all records relating to their work, and this will include her session notes.

How might it impact her to see Ted's frustration towards her? Especially perhaps given that her early departure is the result of intense medical treatment, which may already have brought up difficult feelings for her, and also given her initial referral was to work on problems with her self-worth. A second question may be about Ted documenting the amendment to their working agreement on a separate sheet. He intends to add it to the record, but how soon will this be done? (Core Responsibility 3.2, EF 2026). The longer he waits, the bigger the chance the lone sheet might get lost, be found by someone else or he may even forget which client it relates to, if he has not added a name.

3.1.2 Further questions for reflection

Consider any questions which arise for you on reading about Ted and Ayo:

Do I review my session notes periodically to look for patterns or for reflection?

Do I keep session notes and process notes in the same document?

Can I easily make amendments to my clients' original working agreements if needed?

How soon after a session do I write up my notes, is this soon enough for full recall of fact and feeling?

Anything else?

3.2 Case study 2

Tapani is a client working online client with Ted as part of his work with a charity. Tapani has had two of his six allotted sessions, but Ted suspects they might extend the work somewhat as permitted by the charity. In their previous session, Tapani had used a computer programme to draw a timeline of his loss experiences, including Childhood Sexual Abuse. In this most recent session, Tapani informs Ted he found that process really difficult; he feels it was an important step to acknowledge the events of his life and wants to be able to access the timeline when ready, but he struggled with knowing it was saved on his device. He asks Ted to keep it for him, and emails it over as soon as Ted agrees. Tapani doesn't want to return to the timeline once this request has been completed, so Ted does not mention the document again. The charity keeps all client records online but uses a bespoke system and Ted doesn't believe there is capacity for additional documents to be added to individual client records. He decides to keep Tapani's timeline in his own filing system at home, so he prints it off and adds it to a 'miscellaneous' folder in his filing cabinet, ensuring there is no name or date attached to protect Tapani's identity.

3.2.1 How does it apply to my practice?

Again, we see a number of issues relating to record keeping represented in this Case Study about Ted and Tapani.

Considering good practice, we see Ted collaborating with his client (see Ethical Principle of Collaboration, EF 2026) and agreeing to amend his record-keeping practice in line with the client's individual needs and autonomy (see Ethical Principles of Respect and Best Interest, EF 2026).

His commitment to client confidentiality means he does not name or date the timeline, which means Tapani cannot be identified in the event Ted's paper records are accessed by a third party.

However, there are also elements of Ted's approach to record keeping which could benefit from further reflection. Firstly, Ted agrees to Tapani's request to keep the timeline for him.

He does this without discussion, but they are engaged in short-term work, so it could be the case that Tapani might soon need to have the timeline returned to him. Could this have been discussed, both from a therapeutic and practical point of view? Also, if he received the timeline via email, has Ted taken care to ensure Tapani's email address is not automatically saved anywhere, and has Ted deleted the email he received and any email sent in response, to ensure any unnecessary digital records are not being kept? (Core Responsibilities 2.1, 3.1, EF 2026). Ted printed the timeline off – did he then delete the computer file from his device for the same reason? Also, did Ted document anywhere that he and Tapani made this agreement regarding the timeline? (Core Responsibility 3.2, EF 2026). Does Tapani understand what it means for Ted to keep the timeline, especially as Ted is not including it as part of the official client records held by the charity? What if something happens to Ted and his clinical will has to be set in motion (Core Responsibility 4.5, EF 2026). How will the timeline be returned to Tapani if he does not appear anywhere in Ted's private practice records and the timeline is anonymised? Given Tapani felt this document would be an important one to return to, it might impact negatively for it to be lost to him in this way (consider the Ethical Principle Do No Harm, EF 2026). What are the implications of holding client records outside an organisation's policies (consider the *Ethical Framework*, External Factors in Ethical Decision-Making, EF 2026)? Could Ted have discussed the matter with the charity to see if their record-keeping policy might have accommodated Tapani's wishes?

3.2.2 Further questions for reflection

Consider any questions which arise for you on reading about Ted and Tapani:

How soon do I delete unneeded text messages, emails or voicemails from clients? How about computer documents relating to clients?

Do I feel confident to discuss my record-keeping processes with clients, including agreeing to or refusing requests to hold additional records temporarily?

Do I know how to add supplementary material to my client record if required?

Do I have a clinical will in place which will ensure all supplementary material held for clients can be returned?

Anything else?

Conclusion

Records may be paper or electronic, they can be purely factual or may include subjective opinion, metaphor or creative works. As a BACP member, you will need to be accountable, and able to show clear, ethical decision-making in respect of any records that you keep (or do not keep). You will also need to bear in mind that keeping records has legal implications in terms of data protection, and people's rights to see what is written about them. Because your own approach to record keeping will depend on your individual context, it is important you understand what is meant by record keeping in order that you can act ethically and professionally.

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As well as new content, this resource includes information from a previous resource, and the contribution of the author - Madi Ruby - is gratefully acknowledged.

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Bond, T. (2015) *Standards and Ethics for Counselling in Action* (Counselling in Action series) 4th. ed. London: Sage Publications.

British Association for Arts Therapists' *Code of Ethics* www.baat.org/about/code-of-ethics (accessed 8 February 2026).

Further reading

Further resources from BACP on record keeping can be found at: www.bacp.co.uk/gpia.

Ethical Guidelines for Research in the Counselling Professions, available to members to download from the BACP website www.bacp.co.uk/events-and-resources/research/publications/ethical-guidelines-for-research-in-the-counselling-professions.

Mitchels, B. and Bond, T. (2021) *Confidentiality and Record Keeping in Counselling and Psychotherapy*. 3rd Edition. London: Sage.