Psychotherapists Board of Aotearoa New Zealand (the Board) Information Sheet – Clinical Notes

The Board acknowledges that psychotherapists often work in different organisations[1] and with different client groups[2]. All psychotherapists should be aware of their organisation's requirements or guidelines as well as their statutory obligations.

All psychotherapists are required to work within the standards[3] set by the Psychotherapists Board of Aotearoa New Zealand.

Health records

Psychotherapists are required to meet standards of clinical competence and ethical conduct as set by the Board. Legal precedence implies an obligation on all health professionals including psychotherapists to have health records relating to identifiable individuals.

A health record is a record of any health information that relates to an individual regardless of how it is recorded. For example: handwritten, typed on paper, typed electronically, and/or recorded electronically. Notes should be written for therapeutic purposes with clear assessment and diagnostic information.

Please note that clinical notes are health record(s) and therefore subject to legal requirements[4].

Clinical Notes

Clients may request access to their notes and it is advised that notes are written with this in mind[5]. Clinical notes are a record of the therapeutic process and clinical thinking and in some circumstances, with client consent, may be used for communicating with other health professionals to support continuity of care.

There are some useful principles that apply to clinical notes:

- Writing should be legible;
- Include date and time of all interactions and any alterations;
- In general records should not be altered, additions should not be disguised;
- Use terminology familiar to psychotherapists and other mental health practitioners;
- Should not use language that might be considered disrespectful or judgemental of clients or colleagues;
- Should not use ambiguous abbreviations.

It is expected that clinical notes will typically include all communications relevant to a specified client, for example:

- Client biographical data[6], as necessary;
- Data collected through the assessment process;
- Formulation;
- Treatment plans and any changes, actions or recommendations;
- A record of each therapy session. For example: significant events, issues, or themes;
- Relevant notes from clinical supervision relating to therapeutic work may be included;
- Communication to and from the client including non-scheduled contact with client;
- Planning for termination should be noted and actual termination of work should be noted and dated.

The Board has an Information Sheet on Health Records - Access, Protection, Retention and Disposal.

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[1] For example: DHBs, PHOs and/or in private practice
[2] For example: adults children, adolescents, and/or families.
[3] See the Board's Standards of Ethical Conduct – section 7
[4] Such as: The Health Information Privacy Code 1994 and the Health (Retention of Health Information) Regulations 1996.
[5] See Information Sheet on Health Records - Access, Protection, Retention and Disposal.
[6] For example: client contact details, general practitioner and any other health specialists involved, with contact details as appropriate. Children and adolescents will also need to have parents' names and addresses recorded, and where relevant the name and address of the person with whom they are living.