

Practical aspects of record keeping within the counselling professions

Good Practice in Action 067 Commonly Asked Questions

Practical aspects of record keeping within the counselling professions

Good Practice in Action 067 Commonly Asked Questions

Updated September 2023

Copyright information

Good Practice in Action 067 Commonly Asked Questions: *Practical aspects of record keeping within the counselling professions* is published by the British Association for Counselling and Psychotherapy, BACP House, 15 St John's Business Park, Lutterworth, Leicestershire, LE17 4HB.

T: 01455 883300 **E:** bacp@bacp.co.uk **www.bacp.co.uk**

BACP is the largest professional organisation for counselling and psychotherapy in the UK, is a company limited by guarantee 2175320 in England and Wales, and a registered charity, 298361.

Copyright © 2016-2023 British Association for Counselling and Psychotherapy.

BACP and the BACP logo are registered trade marks of BACP.

Permission is granted to reproduce for personal and educational use only. Commercial copying, hiring and lending are prohibited.

Design by Steers McGillan Eves.

Contents

Context	5
Purpose	5
Using Commonly Asked Questions resources	5
1 Introduction	6
2 Initial contact	7
2.1 What is a 'record'?	7
2.2 When and how shall I record a client's initial enquiry?	7
3 Record keeping during the therapeutic process (session notes)	9
3.1 What is good practice regarding the format and content of session notes?	9
3.2 What is meant by a clinical will?	11
4 Sharing records	12
4.1 What if my client asks to see their record?	12
4.2 I participate in a practitioner peer support group – can I share my client records?	12
4.3 I need to refer a client to another professional or agency – can I send the notes?	13
4.4 What if I'm asked for access to a client's records by a legal professional?	13
5 Storage of records	13
5.1 I keep all my records in a locked filing cabinet – is this enough?	13

5.2	All of my records are kept digitally and password protected – is this sufficient?	14
5.3	I work from a number of different locations and carry all my records with me	15
6	Keeping records after therapy has finished	15
6.1	How long should I keep records?	15
6.2	Destroying records	16
	Summary	17
	About the author	17
	References and further reading	18

Context

This resource is one of a suite prepared by BACP to enable members to engage with BACP's *Ethical Framework for the Counselling Professions* in respect of confidentiality and record keeping.

Purpose

The purpose of this resource is to provide information for therapists and counselling service providers in respect of commonly asked questions about what is meant by records and record keeping.

Using Commonly Asked Questions resources

The membership agreement with BACP establishes a contractual commitment by members to abide by the *Ethical Framework for the Counselling Professions*, which includes a responsibility for members to keep the skills and knowledge relevant to their work up to date.

The BACP Good Practice in Action resources are solely intended to support good practice by offering general information on specific topics based on legal principles and policy applicable at the time of writing. They are intended for information purposes only and are not a substitute for professional advice. BACP and the author accept no responsibility for and accept no liability as a result of any person acting or refraining from acting on the basis of the resources.

Practice issues and dilemmas are often complex, and may vary depending on clients, particular models of working, the context of the work and the therapeutic interventions provided. We therefore strongly recommend consulting your supervisor, and also, wherever necessary, a suitably qualified practitioner or lawyer. Some professional insurers will provide legal advice as part of their service.

BACP and the author make no representation or warranty as to the completeness or accuracy of the information contained in the resources.

References in this resource were up to date at the time of writing but there may be changes in particular to the law, government departments, government policies and guidance, websites and web addresses. Organisations and agencies may also change their practice or policies, so please be alert for any changes that may affect your therapy practice.

In this resource, the word 'therapist' is used to mean specifically counsellors and psychotherapists and 'therapy' to mean specifically counselling and psychotherapy. The terms 'practitioner' and 'counselling related services' are used generically in a wider sense, to include the practice of counselling, psychotherapy, coaching and pastoral care.

1 Introduction

The *Ethical Framework for the Counselling Professions* commits members to work to professional standards by keeping accurate and appropriate records (Good Practice, point 2e). Keeping accurate records contributes to professional standards, demonstrates commitment to clients and enhances overall competency.

Every practitioner will have developed their own individual methods of practice, largely dependent on the context in which they are working. Record keeping forms part of this i.e. the method, format and style of record keeping will depend on the context in which they are working. A practitioner working in private practice may develop their own methods, drawing on ideas from a number of sources. For those working in an agency setting or working as part of an affiliate or Employment Assistance Provider (EAP) network, the ways of working may be different and more defined.

Practitioners need to gain the explicit consent of their clients to keeping records, which contain personally identifying information. The client needs to know what records are being kept, the purpose for which they are being kept, how long they will be kept, who may have access to them and how they are stored. If the client does not give permission, then the practitioner will need to consider carefully whether they are able to work with them on the basis of not keeping records. Discussions with a supervisor can be helpful here.

In *Standards and Ethics for Counselling in Action, 4th edition*, Bond talks of the primary purpose of good records being 'to support the work with the client' (Bond, 2015, p4). This resource looks at key considerations for practitioners, including supervisors in a variety of settings and answers some commonly asked questions about record keeping.

It addresses the topic from an enquiry from a potential client, first meeting and contracting through the therapeutic work itself to the ending and beyond.

It recognises that therapeutic contact between practitioner and client frequently takes place across a number of communication 'channels' for example, face to face, online, email and text. It is common for a practitioner to work using a mix of these 'channels' for example receiving an email enquiry, making appointments by text followed by face-to-face, telephone or online session work.

2 Initial contact

2.1 What is a 'record'?

A 'record' is any information that will be processed about a person by an automated system or held in a relevant filing system where the data could be used to identify a person. This is because they are named, or their identity can be worked out from the information recorded.

The General Data Protection Regulation 2018 (GDPR) sets out the main principles of data protection and the responsibilities individuals and organisations have when handling personal data. It protects individuals' personal information and improves their control over how it is collected, stored, shared and used.

It is important to remember that data protection requirements and the General Data Protection Regulation (GDPR) apply to the work of counselling professionals (Good Practice, point 15). The law in this area is complicated and still developing. However, the Information Commissioner's website has up-to-date information and guidance (see <https://ico.org.uk>). See also, GPiA 105 for more information, and further information about what is meant by records, can be found within GPiA 066 Commonly Asked Questions: *What do we mean by records?*

2.2 When and how shall I record a client's initial enquiry?

BACP's *Ethical Framework for the Counselling Professions* sets out a 'commitment to clients' and states that in order for clients to participate freely in the therapeutic process, and work towards their desired goals, they must feel able to 'trust their practitioner with their wellbeing and sensitive personal information' ('Our commitment to clients'). Consideration therefore needs to be given to building this trust from the very first contact. It is:

- a. considered good practice to make a 'good record as close as possible in time to the contact' (Bond, 2015, p248) and to safely store the record in an appropriate place as quickly as possible

- b. important to recognise that initial contact notes, differ from session notes. A contact note may simply contain the client's name, preferred method of contact and the outcome of that contact (for example '13.1.17 Client appointment attended'). It is good practice to keep contact notes, or details (for example address, telephone number, referrer etc.) apart from session notes. Some practitioners write two sets of notes, the first are fact-based 'content notes' which may contain brief information but not any opinions held by the practitioner. The second set are 'process notes' which may contain the practitioner's opinion about the therapeutic relationship and any thoughts, feelings and fantasies they have about the client and the work. Other practitioners combine both types of notes into one. For more information see GPiA 066.

This has the benefit of:

- helping put into action a clinical will if required (see point 3.2)
- allowing the therapist to remove client contact details from the place where therapy takes place, to take 'off site' where necessary
- allowing the practitioner to demonstrate how 'a client's confidentiality and privacy will be protected'. (See Good Practice, point 31c.)

There are a number of different ways that an initial enquiry may be recorded.

The method will be determined largely by the setting in which the practitioner works, the method of contact selected by the client, and the preference of the practitioner for paper or electronic records.

Examples of paper-based systems are card files and alphabetical notebooks; while electronic storage most commonly means computer storage, or storage within cloud-based servers. Data protection legislation and government guidelines need to be followed for both paper-based and computer-based records.

All businesses (including sole traders) that process personal information electronically must register with the ICO and pay a fee. Even if the practitioner only keeps records on paper, it is almost impossible not to keep some personal data electronically (for example in emails, text messages or an audio recording).

To check if the legislation applies to you, see the ICO's Data Protection Self-Assessment Toolkit at <https://ico.org.uk/for-organisations/data-protection-fee/self-assessment>.

3 Record keeping during the therapeutic process (session notes)

3.1 What is good practice regarding the format and content of session notes?

Session notes, where they can be linked to an identifiable person, will form part of the formal records, and as such could be subject to the same legal implications as factual records. It is important, therefore, that notes distinguish between what was expressed by a client or observed directly by the practitioner (e.g. if the client arrived late, stated they felt very anxious) and the practitioner's own subjective responses and thoughts such as 'Priti seemed very distracted today'.

Individual practitioners will naturally have different styles and methods of note taking in order to be as effective as possible. Context, preferences and therapeutic approaches will influence this, but there are commonalities.

The *Ethical Framework* sets out guidance to ensure that a practitioner works to professional standards stating, 'we will keep accurate records that are adequate, relevant and limited to what is necessary for the type of service being provided' (Good Practice, point 15). Bond says that 'the guiding principle is that the type of record should be one that supports the therapy and enables this to be delivered to a reasonable standard of care' (Bond, 2015, p254).

The therapeutic setting will influence, and in some cases dictate, format and content. Some agencies provide ready-made forms or templates for practitioners to use on a session-by-session basis, e.g. EAP and/or agency settings. (See GPiA 068 for more information on work in organisational settings.)

All practitioners should prepare adequately for supervision. Making notes can be helpful in this preparation, although it should also be borne in mind, that with few exceptions, the client can be granted access to any information held about them (see section 4.1).

Given that the primary purpose of note taking is to support the work with the client, the notes may typically contain:

- a summary of what was said by the client, and directly observed by the practitioner
- a record of the practitioner's intervention, strategy and any action taken plus a note of the reasoning behind this
- attendance or non-attendance and session number.

Dependent on the setting, context and therapeutic approach, Bond suggests that other items to be included are:

- written and signed contracts
- other written and signed consents
- copies of correspondence from the client or relating to work with the client (e.g. email)
- copies of correspondence, or notes about consultation with anyone else about the client (e.g. possible referral, or discussion by the practitioner with a peer group or supervisor)
- copies of any handouts or information sheets given to clients together with any notes about how the client acted on these
- artwork, drawings, or other material produced, brought or used during a session.

This is not a complete list. The context of the therapeutic relationship will mainly determine what records are made.

Notes should be written in a professional manner. As in most cases, clients have a legal right to see their notes, these should contain commonplace words, use short sentences and limit the use of technical terms.

GPiA 004 reminds us that when keeping records, it is important 'to recognise that language in relation to equality, diversity and inclusion (EDI) changes regularly and preferred terms can vary between people. BACP's EDI strategy, found at www.bacp.co.uk/about-us/edi/edi-strategy, comments on how important it is to use terms that are sensitive and generally considered to be acceptable by individuals within the demographic groups being referred to. BACP states for example that it has chosen to use identity-first language such as 'disabled people' rather than people-first language such as 'people with disabilities'. This is because identity-first language with regards to disability 'recognises that a disabled person's experience is formed not only by their impairment but largely by how society excludes and segregates'.

3.2 What is meant by a clinical will?

A clinical will is an emergency plan that is acted upon when a practitioner is unable to practise at short notice, in unforeseen circumstances and where the practitioner themselves is unable to contact their client(s). For example, this may be if they become seriously ill or die.

It provides details of how to find the necessary information to carry out the practitioner's instructions regarding their clients and practice. The person who puts your 'wishes into action' is often called our 'clinical executor'.

Keeping contact notes apart from session notes can help the clinical executor to contact a practitioner's clients. It is important that all contact details for clients are up to date so that this named professional can contact clients as easily as possible.

Details of this arrangement need to be included within the initial therapeutic agreement that the practitioner makes with their client. The client must give their consent to their records being accessed in this way and to them being contacted by your clinical executor. This consent is separate from that required by the practitioner before they can provide therapy to the client.

A useful instruction to the named professional would include clear instructions about how to find and access client records and contact information. Clients have a right to give or withhold informed consent for release of this information. Documentation of consent for providing the named professional with client contact information and access to client records can be kept with the client contact information. It is useful to note that the named professional will be 'bound by the confidentiality agreed between the practitioner and client, and will usually be a trusted colleague, a specially appointed trustee or a supervisor' (Good Practice, point 42).

Most practitioners will store at least some of their records digitally such as on a laptop, PC, tablet or mobile. For more information see section 5.2.

For further information about clinical wills, see GPiA 104 *Clinical wills and digital legacies in the counselling professions*.

4 Sharing records

4.1 What if my client asks to see their record?

Clients have the legal right to access their records under a 'Subject Access Request'. They can also ask for information to be corrected or removed. Discussions within supervision can be helpful when a client makes such a request and there are legal exceptions. When working for an organisation, it is important to abide by organisational policies. For more information, see GPiA 069 *Sharing records with legal professionals*, and the courts, 071 and 105.

Carys Williams in GPiA 004 reminds practitioners that 'Notes should not be provided to anyone else unless a court order is in place, or the request comes from a statutory agency. If in any doubt, private practitioners should contact their legal advisor or insurer for advice before making the disclosure.'

4.2 I participate in a practitioner peer support group – can I share my client records?

Practitioners may meet in groups for a variety of purposes, e.g. as part of Continuous Professional Development (CPD), for training within their organisation or as a supervision group.

It is not enough to assume confidentiality within the group. The group should consider its own contract, which would include how client notes should be used and shared.

Furthermore, the *Ethical Framework* states 'All communications concerning clients made in the context of supervision will be consistent with confidentiality agreements with the clients concerned and compatible with any applicable agency policy' (Good Practice, point 64).

If the peer group work, or supervision takes place 'off site' then it will be important to separate session notes from contact notes and remove only one record so that in the event of loss of any information client confidentiality is protected. See section 6.2 for more information on data breaches.

4.3 I need to refer a client to another professional or agency – can I send the notes?

Notes should only be shared with the client's knowledge and consent.

A secure medium for sharing information should be used – email or other electronic communication is not necessarily secure see GPiA 047 Ethical Framework supplementary guidance: *Working online* and GPiA 040 Commonly Asked Questions: *Social media and the counselling professions* for more information.

4.4 What if I'm asked for access to a client's records by a legal professional?

While this does not happen routinely, a practitioner may be asked for access to a client's records by various bodies e.g. by solicitors acting for clients, by the courts or by the police.

There is a legal basis for confidentiality in therapy, including basic rights for the client and also exceptions to the duty of confidentiality. These topics are discussed in full within Legal Resources GPiA 014 *Managing confidentiality*, GPiA 030 *Safeguarding vulnerable adults*, GPiA 031 *Safeguarding vulnerable children*, GPiA 052 *Child protection (Scotland)*, and GPiA 069 *Sharing records with legal professionals, and the courts*.

5 Storage of records

5.1 I keep all my records in a locked filing cabinet – is this enough?

This may depend on the setting. It may be acceptable in private practice where the practitioner has sole access to the counselling room. It is unlikely to be enough in a rented space, or agency setting, where multiple users have access to the therapeutic space.

Practitioners regardless of context and setting have within the *Ethical Framework*, a duty to protect the confidentiality of clients by 'actively protecting information about clients from unauthorised access or disclosure' (Good Practice, point 55). Securing contact notes in a different place from session notes reduces the risk of client confidentiality being breached by unauthorised access. Again, there is further information in GPiA 065, 071,105 and at www.ico.org. Regarding clinical wills, consideration should be given as to how the person a practitioner has named to carry out their wishes will gain access to clients' contact records.

5.2 All of my records are kept digitally and password protected – is this sufficient?

Whilst 'absolute security in the digital world does not exist' (GPiA 047 *Working online in the counselling professions*) every effort should be made to protect the clients' records from unauthorised access.

As a minimum standard all digitally held records should be password protected. Where records are held on a shared computer, consideration needs to be given to ensure that 'they can only be accessed by trained staff contracted to maintain client confidentiality' (GPiA 040 *Social media (audio and video) and the counselling professions*).

As stated in point 2.2, if you are a practitioner who stores any personal client data within paper records that are kept in a logical and structured filing system, or on computers, laptops, cloud-based servers, mobile phone or tablet you must register with the Information Commissioner's Office (ICO) as a data controller, see www.ico.org.uk on how to register.

Any information you store digitally, such as on a PC, is your 'digital legacy'. Online services will have their own individual privacy or end-of-life policies in the event that a practitioner's clinical will is put into action. More information about digital legacies can be found at <https://digitallegacyassociation.org/for-the-public>.

See also GPiA 124 Fact Sheet: *Social media, digital technology and the counselling professions*.

5.3 I work from a number of different locations and carry all my records with me

The *Ethical Framework* requires a practitioner to protect the confidentiality and privacy of clients by 'using thoroughly anonymised information about clients where this provides a practical alternative to sharing identifiable information' (Good Practice, point 55g).

For the practitioner who needs to physically take client records with them to different locations, a 'split system of record keeping' (Bond 2015) is recommended.

Contact details are kept apart from session notes so that in the event of loss or malicious damage outside the practitioner's control, the session notes cannot be linked to identifiable people.

Loss or damage to records, even when the information can't be recovered, may be regarded as a data breach. Whether a breach has happened or not can be checked by using the self-assessment tool at <https://ico.org.uk/for-organisations/report-a-breach/personal-data-breach-assessment/y>.

Accountability and candour must also be considered (see GPiA 073 and 113).

6 Keeping records after therapy has finished

6.1 How long should I keep records?

There are several factors, which can influence how long the practitioner keeps records, including what has been agreed with the client at the start of the work, the context and setting in which the practitioner works and the type of work being undertaken. Therapy described as 'long term' would, by definition mean that records would be kept longer than a few weeks.

One of the principles that inform good practice here is that 'sensitive information should be destroyed when its usefulness has expired' (Bond 2015).

GDPR legislation does not set specific time limits but requires that you only keep information for as long as is necessary for the specific reason that you originally collected it.

Practitioners may want to consider on an individual basis:

- is the client likely to return, and within what time frame?
- may it be useful to retain records that might help the work if the client does return? Might records be required for present or future legal proceedings? If so, the time limits for legal proceedings and complaints procedures may be relevant. See Good Practice in Action Legal Resources for further details
- what was agreed with the client when the practitioner contracted with them at the start of the work?

Practitioner working with children and young people will need to consider:

- the organisational context and requirements of where they are working together
- what is appropriate for the service they offer – for example schools or Child and Adolescent Mental Health Services (CAMHS) may have specific policies on record storage and how long records are kept after the therapy has finished. However, a practitioner in private practice may not. (See GPiA 046 Commonly Asked Questions: *Working with children and young people for more information.*)

In all cases, the client should be aware of the amount of time that records are usually kept after the therapy has finished and agree to this.

6.2 Destroying records

Once a decision has been made to destroy all client records (including contact records, session notes, notes made in preparation for and during supervision and anything else connected to the work – for example drawings) this should be carried out as soon as possible so that they cannot be viewed or, in the case of information stored in audio form, listened to.

For digital records, it is not enough to simply use the 'delete' button on a computer, tablet, or mobile telephone and expect the information to completely disappear from the system. Some computers allow you to undelete accidentally deleted files. Also, back-up files may be created in order to avoid accidental data loss. Some systems will allow you to 'permanently' delete files but even this information is likely to be recoverable by an expert (whether it be for legal or illegal purposes). Practitioners need to ensure that they are 'sufficiently competent in the use of technology in their work to be able to provide reliable and adequate services to clients and colleague' (GPiA 047, p6). For more on competence when working online see Online and phone therapy (OPT) competence framework, user guide and training curriculum (2021).

The ICO regularly updates its information on destroying digital records for those registered as a data controller.

A practitioner may wish to keep notes from supervision as part of their CPD records and/or evidence of supervision for an extended period of time. Care should also be taken that client contacts are not included in this type of record and that details of the client are recorded anonymously.

Summary

It is the ethical responsibility of the practitioner to keep, maintain, store, and destroy records in an ethical and timely manner, reflecting the channel and setting in which the practitioner works. Practitioners must work lawfully and in compliance with data protection legislation and the GDPR.

Practitioners should understand their responsibilities as set out in the *Ethical Framework for the Counselling Professions* and the supplementary guidance Good Practice in Action 047 *Working online* for those working online.

Practitioners are committed to accountability and candour and must act appropriately whenever a breach of security or privacy arises that could impact on clients. The *Ethical Framework for the Counselling Professions* states: 'We will ensure candour by being open and honest about anything going wrong and promptly inform our clients of anything in our work that places clients at risk of harm or has caused them harm, whether or not the client(s) affected are aware of what has occurred' (Good Practice, point 52). See Good Practice in Action 073 and 113 for more on accountability and candour.

The practitioner, regardless of context and setting should be aware that this applies as much to record keeping as to the therapeutic work itself.

About the author

This update was originally authored by Judith Gentry. Her initial career was in retail and retail consultancy, which remains part of her portfolio. She discovered the world of psychotherapy in 2004 and studied in this field, holding a Bachelor of Science degree with First Class Honours in Reflective Therapeutic Practice. Judith is now retired but was a founding member of the BACP Coaching Division in 2010. She is an accredited Belbin® team practitioner. She is an experienced Trustee and Non-Executive Director, and continues to coach individuals and teams across a variety of sectors.

Reviewed by Karen Stainsby who is BACP registered and senior accredited as a counsellor and supervisor and works in private practice. She contributes to various groups and panels, and provides other professional services to BACP.

References and further reading

BACP (2018) *Ethical Framework for the Counselling Professions*. Lutterworth: BACP. www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions (accessed 5 October 2023).

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

Information Commissioner's Office: www.ico.org.uk (accessed 5 October 2023).

Online and phone therapy (OPT) competence framework, user guide and training curriculum (2021) (accessed 9 October 2023).

BACP (2023) Our EDI strategy. See BACP EDI strategy (accessed 29 September 2023).

Good Practice in Action resources are available at: www.bacp.co.uk/gpia.

BACP (2016, updated 2022) GPiA 014 Legal Resource: *Managing confidentiality within the counselling professions in England and Wales* (Content Ed. Mitchels, B.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2015, updated 2023) GPiA 030 Legal Resource: *Safeguarding vulnerable adults within the counselling professions in England and Wales* (Content Ed. Mitchels, B.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2016, updated 2023) GPiA 040 Commonly Asked Questions: *Social media, digital technology and the counselling professions* (Content Ed. Dunn, K.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2016, updated 2020) GPiA 046 Commonly Asked Questions: *Working with children and young people* (Content Ed. Lanyon-Hogg, J.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2023, updated 2023) GPiA 047 Fact Sheet: *Working online* (Content Ed. Dunn, K.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2016, updated 2022) GPiA 052 Legal Resource: *Understanding child protection in Scotland* (Content Ed. Driscoll, M.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2017, updated 2020) GPiA 065 Clinical Reflections for Practice: *Confidentiality and record keeping within the counselling professions* (Content Ed. Stainsby, K.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2018, updated 2020) GPiA 066 Research Overview: *Equality, Diversity and Inclusion in the counselling professions* (Content Ed. Ruby, M.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2016, updated 2020) GPiA 068 Fact Sheet: *Record keeping within organisational settings within the counselling professions* (Content Ed. Gentry, J.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2018, updated 2022) GPiA 069 Legal Resource: *Sharing records with clients, legal professionals and the courts in the context of the counselling professions* (Content Ed. Mitchels, B.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2018, updated 2022) GPiA 071 Legal Resource: *Ownership and storage of client notes and records in the context of the counselling professions* (Content Ed. Mitchel, B.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2016, updated 2023) GPiA 073 Fact Sheet: *Accountability and candour within the counselling professions* (Content Ed. Stainsby, K.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2020, updated 2021) GPiA 104 Fact Sheet: *Clinical wills and digital legacies in the counselling professions* (Content Ed. Williams, C.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2018, updated 2023) GPiA 0105 Legal Resource: *The United Kingdom General Data Protection Regulation (UK-GDPR) legal principles and practice notes for the counselling professions* (Content Ed. Mitchels, B.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2020, updated 2022) GPiA 113 Clinical Reflections for Practice: *Accountability and candour within the counselling professions* (Content Ed. Warman, E.). Lutterworth: BACP (accessed 9 October 2023).

BACP (2020, updated 2021) GPiA 124 Clinical Reflections for Practice: *Social media, digital technology and the counselling professions* (Content Ed. Dunn, K.). Lutterworth: BACP (accessed 9 October 2023).