



Cumann Síceolaithe Éireann

The Psychological Society
of Ireland
**Guidelines for
Confidentiality and
Record Keeping in
Practice**

Updated July
2022

PSI Guidelines for Confidentiality and Record Keeping in Practice

Approved by PSI Council September 2022

Reviewed 2022

Next Review Date 2025



Introduction

It is recognised that psychologists work in a variety of settings with different client groups and perform a variety of roles, such as researchers, trainers, therapists, consultants, clinicians, supervisors, members of teams, including Multi-Disciplinary Teams (MDTs), etc. These Guidelines are intended to encompass the work of psychologists in these varying roles and settings. Principles of confidentiality apply equally to psychologists and the practice of psychology regardless of the setting individual or group. It is further acknowledged that psychologists often have multiple responsibilities (e.g., when acting as supervisors or trainers or when working with children) and have a duty to remain aware of particular considerations, such as power differentials and competing obligations that may be encountered.

Careful consideration and deliberation with respect to confidentiality and record keeping are inherent to all of the above roles and responsibilities. In all roles, due consideration is given to the importance of protecting the public and promoting good practice. This may be even more important when working with trainees/supervisees with respect to confidentiality and record keeping.

The first section of these Guidelines will address confidentiality and the second will address record keeping. There is an overlap between these two areas and good practice in both requires prioritising the best interests and well-being of the recipient or participant in psychological practice(s).

As in all professional activities, the PSI Code of Professional Ethics should form the basis for decision-making with respect to confidentiality and record keeping.

Fundamental Assumptions

The PSI recognises that psychologists are guided in their work by the PSI Code of Professional Ethics, which is based on four overarching principles:

- Respect for rights and dignity of the person
- Competence
- Responsibility
- Integrity

In addition to these four fundamental principles, it is assumed that psychologists work in accordance with the following set of key principles:

- Confidentiality is fundamental to the work of psychologists and their relationships with their clients/ research participants;
- Psychologists protect and promote client confidentiality within the ethical and legal limitations that exist;
- Clients' and research participants' rights to privacy are respected and remain paramount at all times;
- Psychologists maintain a respect for their clients' autonomy and balance this with the duty of care that is central to a professional relationship;
- Psychologists are cognisant of the privileged relationships they hold with the people with whom they work;
- Psychologists expect diversity among clients and research participants and are sensitive to the unique needs and contexts of people's lives;
- In all professional activities, psychologists strive to ensure the safety and well-being of those with whom they work.

Contents

Introduction	2
1 Purpose and Scope of the Guidelines	6
1.1 Who are these Guidelines for?	6
2 Confidentiality and Consent	7
2.1 Obtaining Consent	7
2.2 Consent with Children and Young People	7
2.3 Consent with Vulnerable Persons	8
2.4 Consent and Research	9
2.5 Ensuring Confidentiality	9
2.6 Confidentiality, Information Sharing and Disclosure	10
3 Record Keeping	12
3.1 General Guidelines on the Management of Records	12
3.2 Electronic and Multimedia Records	13
3.3 Storage and Security	14
3.4 Retention, Disposal, Access and Release of Records	14
3.5 Records and Breaches of Confidentiality	15
3.6 Access	15
3.7 Shared Files and Multiple Records	16
4 Applying These Guidelines	17
References	18
Appendix I Acknowledgements	20
Appendix II Background and Development of the Guidelines	21
Appendix III Additional Resources	24
Appendix IV Ethical Practice Model	29

1 Purpose and Scope of the Guidelines

These Guidelines should be read in conjunction with the PSI Code of Professional Ethics (2019), relevant legal documents, and other policy statements. The Guidelines are intended to provide broad guidance for psychologists working in a range of settings who encounter issues related to confidentiality and record keeping as well as potential conflicts between professional guidelines, ethical standards, legal and regulatory requirements, and the policies/procedures of any organisation in which psychologists work. These Guidelines may be used in the process of resolving ethical dilemmas in conjunction with the ethical decision-making model contained within the PSI Code of Professional Ethics (2019).

These Guidelines are not intended to replace sound professional judgement in line with professional standards, nor are they intended to be used as a substitute for ethical approval, supervisory consultation, or legal advice. This document may be used to complement consultation with peers and supervisors regarding confidentiality issues.

These Guidelines are intended to facilitate a high level of professional conduct. As guidelines rather than standards, they are not intended to be compulsory or exhaustive.

The purpose of this document is to:

- Guide psychologists in their practice;
- Facilitate decision-making when faced with potentially conflicting interests;
- Empower psychologists to make sound ethical decisions.

1.1 Who are these Guidelines for?

These Guidelines apply to all psychologists who are members of the PSI and who work in the areas of public and private service provision (including assessment and intervention), education, training, supervision, research, consultation, and all other professional areas in which psychologists work.

2 Confidentiality and Consent

Confidentiality: *the word confidentiality has its origins in Latin with 'fidere' referring to trust or 'put ones' faith in', thus confidentiality can be taken to mean 'to strongly trust someone' (Bond and Mitchels 2009). In a professional relationship, this is taken to mean that information that would have a cost in terms of impacting another's privacy is protected.*

Freely given, informed consent is the cornerstone of working with people whether they are clients, service users, research participants, or other recipients of psychological services. In order to provide consent, an individual must have the capacity to understand and make a choice. Psychologists have a responsibility to ensure consent is specific, informed, valid, and freely given.

Psychologists understand informed consent to be an evolving process that begins at first contact and is revisited as necessary with due consideration to developmental processes.

2.1. Obtaining Consent

It is recommended that psychologists:

- 2.1.1.** Obtain written consent from the client (or the client's legal representative) prior to disclosing client information to associated parties related to the service, unless disclosure is required by law;
- 2.1.2.** Seek appropriate witnesses for verbal consent when written consent is not possible and ensure that witnesses are aware of the boundaries of confidentiality; the process and the names of witnesses should be documented;
- 2.1.3.** Before a psychological service commences it is good practice to:
 - Obtain explicit informed consent from the direct recipient(s) of the service, or where necessary their parent/guardian or legal representative;
 - clarify who owns and has responsibility for client records which may include special category data (SCD);
 - state how the information will be used and stored and for how long;
 - explain who has or can have access to the client record;
 - clarify how information in the client record is made available (e.g., in writing, verbal feedback);
 - explain what information may be shared (e.g., all or sections of the client record)
 - document the above process.
- 2.1.4.** In circumstances where a third party has requested and/or is paying for the provision of a psychological service and the client has provided consent for the disclosure of their personal information to that third party, psychologists should establish that the client understands what information they have consented to be released and to whom. Psychologists should also establish that the consent provided was contemporaneous with the third-party request for client information;
- 2.1.5.** Psychologists providing psychological services within entities such as organisations, businesses, schools, hospitals, or employee assistance programs inform clients from the outset about how their personal information may be used and disclosed to others. Where psychologists' conditions of employment require disclosure of client information, this should be explained to the client at the outset. For example, in the context of forensic settings, issues of safety and security may require the disclosure of client information within the organisation. In the context of hospitals and healthcare settings, it is common to have a team approach to

client care which may require psychologists to share relevant client information

- 2.1.6.** Ensure, in the process of obtaining explicit informed consent, that at least the following points are understood: purpose and nature of the activity; mutual responsibilities; likely benefits and risks; alternatives; the likely consequences of non-action; the option to refuse or withdraw at any time without prejudice; the time period during which the consent applies; and how to rescind consent if desired (PSI, 2019, p. 7);
- 2.1.7.** When working in forensic settings, understand that the degree and limits of confidentiality will vary and must be clarified and negotiated for the task at hand (European Federation of Psychologists Associations, 2001);
- 2.1.8.** When discussing disclosure of information with clients, ensure clients are fully informed about what information may be disclosed, to whom, for what purpose, and identify if or how a client may act to stop the disclosure when it is known that information is going to be shared with a third party, for example, health insurers, courts, etc;
- 2.1.9.** Are cognisant of both trainee and client rights with respect to confidentiality when involved in the training of psychologists;
- 2.1.10.** Remain cognisant that their responsibility to maintain confidentiality should continue after the death of a client;
- 2.1.11.** When engaged in delivering online/digital psychological services, strive to obtain and document informed consent that specifically addresses the unique concerns related to online/digital service provision service they provide. In doing so they should be cognisant of the risks inherent in both the process and the equipment.

2.2. Consent with Children and Young People

- 2.2.1.** Whenever possible, obtain informed consent/assent when working with children and young people and ensure children and young people's rights to participate in their own healthcare, to therapy, confidentiality, and dignity are protected (Helseth & Aschild, 2004);
- 2.2.2.** Obtain the written consent of both parents of a child or young person when appropriate and possible; however, a child's well-being is of paramount importance in instances when one or both parents do not consent (Guardianship of Infants Act 1964);
- 2.2.3.** Carefully document all attempts to communicate with and obtain consent from a parent or parents.

2.3. Consent with Vulnerable Persons

- 2.3.1.** Psychologists have a duty of care to assess their clients' abilities to understand information and to make decisions in their own best interests. When clients present with a temporary or permanent impairment of the ability to give informed consent and another person has been nominated to act on their behalf, psychologists consider, among other ethical and policy statements, organisational expectations in the management of confidentiality and seek to obtain consent from the relevant nominated person;
- 2.3.2.** Psychologists working with vulnerable persons in practice and research settings have a responsibility to ensure that the rights of those persons are protected and that informed consent results from developmentally appropriate conversations with clients, participants, and carers;
- 2.3.3.** When there is a question about the capacity of an individual to give informed consent, obtain the consent of people with legal authority to act on behalf of the client, and attempt to obtain the client's consent as far as practically possible. To do so, consider using a 'goodness-of-fit' model of the informed consent process (Fisher 2002; Fisher, Cea, Davidson, & Fried 2006), which involves designing the informed consent process to fit each client's cognitive strengths, vulnerabilities, decision making capacities and styles;

- 2.3.4. Carefully apply the ethical decision-making model contained in the PSI Code of Professional Ethics (2019) when proceeding with service provision in the absence of consent from both parents.

2.4. Consent and Research

It is also recommended that when conducting research, psychologists:

- 2.4.1. Obtain consent as a rule; however, anonymised existing data may be used in some situations after careful consideration of ethical issues, without obtaining consent (Data Protection Commissioner, 2007);
- 2.4.2. Consider the ethical principles related to consent and confidentiality throughout the research process in addition to considering confidentiality and consent when seeking ethical approval;
- 2.4.3. Ensure confidentiality or anonymity of research participants at all stages of the therapeutic or research process;
- 2.4.4. Ensure that identities are carefully disguised and obtain appropriate consent when publishing research or case studies concerning clients;
- 2.4.5. Ensure that dissemination of findings does not result in the identification of participants with careful consideration given to small-scale research projects and/or qualitative projects with small participant pools where identification of participants may be a particular issue;
- 2.4.6. Consider offering a seven-day “cooling off” period after obtaining consent and before beginning data collection, especially when doing research with service users and/or involving sensitive topics.

2.5. Ensuring Confidentiality

It is further recommended that psychologists:

- 2.5.1. Agree with clients about their preferred means of being contacted in order to ensure their confidentiality is maintained (e.g., texting, emailing, writing letters, telephoning);
- 2.5.2. Inform clients when engaged in supervision if this will have implications for the confidentiality of the client’s personal information;
- 2.5.3. Consider the appropriateness of continuing contact with a client or participant when contacts outside the professional relationship occur; for example, when you find you have a mutual friend or unexpectedly encounter a client or participant in a social setting;
- 2.5.4. Whenever possible, avoid acting as both treatment provider and assessor, especially for a third party, in order to avoid conflicts with respect to the disclosure of information;
- 2.5.5. Ensure that the setting for sessions or data collection is appropriately private and, when working in private practice, ensure that office and support facilities (e.g., phone, computer, internet) are confidential; others in the setting, e.g. administrative staff should also be aware of the need for confidentiality;
- 2.5.6. In those situations where individual therapy or interpersonal groupwork is a course requirement maintain clear boundaries between those providing these experiences and those delivering the course;
- 2.5.7. Ensure the confidentiality and anonymity of any client or participant used in a case example for education or training purposes;
- 2.5.8. If providing a telepsychology service, inform clients of the increased risks to confidentiality inherent in the use of telecommunication technologies.

2.6. Confidentiality, Information Sharing and Disclosure

2.6.1. Limitations of Confidentiality

2.6.1.1. As stated in the list of key principles, psychologists protect and promote confidentiality; however, there are situations when confidentiality cannot be guaranteed. These include:

- When there is a known or suspected risk to, or potential concern about, a child or children;
- When there is a known or suspected risk of harm to one's client;
- When there is a known or suspected risk of harm to some other individual(s).

2.6.1.2. There are additional situations where psychologists may need to share personal information. These include:

- When a psychologist works as part of a shared care/Multi-Disciplinary Team (MDT);
- When a psychologist receives supervision regarding a client/patient;
- When a transfer or referral has been agreed with the client and with the client's permission;
- When a report is requested by third parties;
- When there is a legal obligation to disclose information.

It is important to have clear and detailed conversations informing clients about the limitations of confidentiality at the outset of the working relationship (See Appendix III). It is important to have clear and detailed conversations informing clients about the limitations of confidentiality at the outset of the working relationship (See Appendix III). The situations described in 2.6.1.1 and 2.6.1.2. call for careful decision-making that involves consideration of the PSI Code of Professional Ethics (2019) and relevant documents, including the guidelines set out below.

2.6.2. Disclosure with Consent

When faced with a dilemma about the release of information, it is recommended that psychologists:

2.6.2.1. Obtain the client's consent for a proposed action; or

2.6.2.2. Inform the client of a planned course of action when a client refuses to consent and the psychologist assesses that a risk exists and disclosure is necessary;

2.6.2.3. Disclose without consent only when an immediate risk or threat of harm is identified, when there is an overriding public interest that justifies such a disclosure or when the protection of a child warrants disclosure, or where there is a legal obligation to disclose. Such disclosures should be necessary and proportionate (McDonald, 2009);

2.6.2.4. Respect the views, well-being, and best interests of clients in making the decision to disclose confidential information.

2.6.3. Disclosure without Consent

As mandated persons under the Children First Act (2015), psychologists are required to report any knowledge, belief, or reasonable suspicion that a child has been harmed is being harmed or is at risk of being harmed. The Act defines harm as assault, ill-treatment, neglect, or sexual abuse, and covers single and multiple instances.

When considering the need to disclose confidential information without consent, it is recommended that psychologists:

- 2.6.3.1.** Seek consultation with peers/supervisors and/or legal advice when faced with an instruction by a court to release information or other circumstance in which disclosure without consent may be necessary;
- 2.6.3.2.** Keep clear and accurate records of their consultations and considerations in the process of their decision making;
- 2.6.3.3.** Document the decision-making process regarding a decision to disclose confidential information when a psychologist determines that it is not possible or not appropriate to inform a client and/or obtain consent prior to the disclosure;
- 2.6.3.4.** Carefully consider the need to take further action to protect the client's welfare or the welfare of an identified person or child;
- 2.6.3.5.** Limit any information that is disclosed, after careful consideration, to those to whom it is essential and to that information which is required;
- 2.6.3.6.** Consider carefully who should be informed about concerns and who can best support the client;
- 2.6.3.7.** If including a support person at a session, obtain client consent prior to doing this;
- 2.6.3.8.** Inform the client(s) of the disclosure and provide copies of relevant correspondence, when appropriate;
- 2.6.3.9.** When disclosing to another professional, be informed as to the confidentiality guidelines of the other professionals involved in the care of the client and be aware of any potential conflicts.

While the sections above highlight some circumstances under which confidentiality is or might be limited, these guidelines are in no way intended to undermine the importance of confidentiality as an ethical principle.

3 Record Keeping

As stated in the Preamble, the following guidelines are intended for psychologists working in a variety of settings and roles. Each guideline is therefore applicable to psychologists who work delivering psychological services, conducting research, providing supervision, and training future psychologists or in other settings.

Psychologists are responsible for keeping accurate and confidential records. Records are maintained for a variety of purposes, including documenting and reviewing the delivery of psychological services. Records include any information that relates to an identifiable person either directly or indirectly or provides information about a client's contact with a psychologist. This includes contact details, email addresses and phone numbers, but also details and results of assessments, or notes of therapy sessions. Records may be held in written, electronic, or other multimedia formats. All records, in whatever format, are subject to data protection legislation, and much of the information psychologists hold on clients is sensitive and would be regarded as a special category under the General Data Protection Regulations (GDPR)

The guidelines which follow are intended to apply to all forms of record keeping, whether paper-based, electronic, or a combination of both.

3.1. General Guidelines on the Management of Records

Appropriate record keeping involves informing clients about record-keeping practices as well as the creation, storage, security, and retention of records. Psychologists keep up to date with current legal and ethical requirements as well as organisational obligations with respect to record keeping. Psychologists should also ensure that their practice is in line with current data protection legislation. Psychologists are reminded that there are limitations to the confidentiality of records and that all records may be subject to disclosure, for example, in the event of a court order or subpoena. It is recommended that psychologists make every effort to maintain accurate, current and complete records of psychological services that contain sufficient detail to permit:

- Delivery of psychological services;
- Clinical audit, data analysis or other research;
- Continuity in the routine delivery of psychological services;
- Continuity of care in the event that another psychologist takes over that responsibility due to death, disability, resignation or retirement.

It is further recommended that psychologists:

- 3.1.1.** Develop a written privacy policy detailing how records are kept and processed;
- 3.1.2.** Inform clients about requirements to maintain records;
- 3.1.3.** Discuss the necessity of record keeping with clients, and when clients do not wish records to be kept, explain the reasons for record keeping and obtain consent for a mutually acceptable form of record keeping;
- 3.1.4.** Ensure that clients are fully informed about the policies governing the management of records, including how to access their records;
- 3.1.5.** Consider at the outset of a professional relationship the provision of a written statement

outlining the limitations of confidentiality of records;

- 3.1.6.** Ensure that appropriate information is provided to children and young people about access to their records, including the information that records may be accessed by parents/carers;
- 3.1.7.** Keep records in accordance with the requirements of GDPR and other legislation, and in a manner that ensures respect for clients' autonomy and dignity; in particular follow the GDPR principles of purpose limitation, data minimisation, data accuracy, storage limitation, and data security and confidentiality.
- 3.1.8.** Protect the confidentiality of records and take reasonable steps to establish and maintain the confidentiality of information arising from the delivery of psychological services, or the services provided by others working under their direct supervision, including trainees;
- 3.1.9.** Make reasonable efforts to protect against the misuse of records;
- 3.1.10.** Maintain the confidentiality of client details, case notes, reports, and any other records after the death of a client.

When creating records, it is recommended that psychologists:

- 3.1.11.** Use organisational protocols regarding the structure, content, and format of records;
- 3.1.12.** Consider developing a record-keeping protocol if one is not in place;
- 3.1.13.** Maintain records in a legible and intelligible format and use only commonly accepted abbreviations;
- 3.1.14.** Write client notes or data summaries from the perspective that they may be read by the client or research participant, or another party;
- 3.1.15.** Ensure information is concise, relevant and objective and ensure that records are dated and signed;
- 3.1.16.** Clearly identify when recording hypotheses, professional opinions or conclusions;
- 3.1.17.** Ensure that records are completed contemporaneously and that any subsequent changes to the record are signed and dated.
- 3.1.18.** Psychologists may maintain separate files or records for sensitive information such as raw test data and materials, third-party information, clients' written work, and psychotherapy process notes, when appropriate. However, psychologists are aware that all of these can be subpoenaed as part of the record.

3.2. Electronic and Multimedia Records

It is acknowledged that records may be maintained in a variety of media, so long as their utility, confidentiality security, and durability can be ensured. The use of electronic records follows the same guiding principles as those for written/paper records [see 3.1].

In addition, it is recommended that psychologists:

- 3.2.1.** Inform themselves of the issues associated with the use of electronic methods and media and seek appropriate training, consultation and support when required;
- 3.2.2.** Create a built-in audit trail to enable tracking of access to electronic databases, as well as electronic records;
- 3.2.3.** Ensure that no identifying information is revealed when using online test administration and scoring systems, and consider the use of a coding or case identification system;
- 3.2.4.** Obtain prior written informed consent and clarify issues related to confidentiality, ownership, copying, security and destruction at the outset when making video or audio recordings of sessions or observations (BPS DCoP, 2022);
- 3.2.5.** Ensure that audio/video recordings that form part of the clinical record are maintained and destroyed appropriately, in line with these Guidelines;

- 3.2.6. Ensure that audio and video recordings of sessions and supervision sessions are erased as soon as they have served their purpose and, at the latest, at discharge, unless the client has given consent for materials to be used for research or training purposes at a later date.

3.3. Storage and Security

- 3.3.1. Take appropriate measures to ensure that records are kept in a secure location and protected from damage;
- 3.3.2. Ensure that access to records is managed appropriately;
- 3.3.3. Comply with organisational record keeping policies and procedures and inform the appropriate person in the organisation when security or confidentiality of records is a concern;
- 3.3.4. Ensure electronic records are maintained securely, and that appropriate safeguards are in place to stop such records from being amended retrospectively or accessed inappropriately;
- 3.3.5. Save each version of record/report with the date of creation if modifying records/reports electronically;
- 3.3.6. Avoid sending sensitive or confidential client information by electronic means as it may not be a confidential means of sending information. (When it is deemed necessary to send confidential information by email, it is recommended that psychologists encrypt or password protect the information, limit it to the minimal amount necessary and document the decision-making that resulted in this action);
- 3.3.7. Ensure adequate mechanisms (i.e., password and encryption) are in place to preserve the security of electronic records;
- 3.3.8. Take adequate measures to ensure records are not lost or stolen, for example, during removal or transfer of records.

3.4. Retention, Disposal, Access and Release of Records

It is recommended that psychologists:

- 3.4.1. Maintain records resulting from contact with clients, trainees, or research participants in a confidential manner only for as long as required;
- 3.4.2. Retain records in line with relevant legislation and guidance issued by their employing organisation and professional insurance obligations;
- 3.4.3. Understand that varying periods for retention of records are recommended depending on the nature of the records held and/or age of client;
- 3.4.4. Retain adult client records or research data for a period of seven years in the absence of any other guidance, unless it is likely that the records could be needed for litigation purposes;
- 3.4.5. Retain records in perpetuity in cases involving child protection concerns or otherwise falling under the Child Care Acts 1991-2015;
- 3.4.6. Retain records of work with children for a minimum of seven years post majority unless there are reasons to retain the record for longer;
- 3.4.7. Have in place written policies and procedures to ensure the confidential and appropriate destruction and disposal of records once the retention period expires;
- 3.4.8. Ensure clients are informed regarding policy on retention of records, time periods for keeping records and processes relating to destruction and disposal of records when retention periods expire;
- 3.4.9. Make provision for the appropriate storage, retention and disposal of records in the event that the psychologist becomes incapacitated or dies;

- 3.4.10.** Destroy records that have been retained for the required period in a secure and confidential manner.

3.5. Records and Breaches of Confidentiality

A personal data breach means a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data.

It is recommended that psychologists:

- 3.5.1.** Ensure that there is a system in place for investigating and reporting breaches of personal data;
- 3.5.2.** Consider the possible impact on affected clients and respond appropriately to clients' needs when the confidentiality of their personal data has been compromised;
- 3.5.3.** Follow procedures as outlined by their organisation/employer and the Data Protection Commission (2019) if records are lost, stolen, or destroyed in a manner that compromises security, including notifying the Data Protection Commission if required and, where relevant, the person(s) whose records have been lost or stolen;
- 3.5.4.** Notify An Garda Síochána if appropriate;
- 3.5.5.** Carefully document actions and decisions taken in the event of breaches of the security of confidential information.

3.6. Access

It is recommended that psychologists:

- 3.6.1.** Facilitate access to records when clients request this in line with data protection legislation; Under GDPR, Subject Access Requests usually need to be responded to within one calendar month.;
- 3.6.2.** Provide information to third parties when requested by clients. Written consent should be obtained and the implications discussed with the client;
- 3.6.3.** Are aware of potential conflicts between employer procedures regarding access to records and clients' rights;
- 3.6.4.** Develop a policy governing access to records that ensures clients are adequately supported when accessing their records;
- 3.6.5.** Note any client requests for alterations or corrections to their records and amend records as appropriate;
- 3.6.6.** Note, sign and date any inaccuracies that clients find in their records;
- 3.6.7.** When professional judgement indicates that it would be inappropriate to amend the record, and the client remains dissatisfied with this, inform the client that he or she may follow the guidelines as set by the Data Protection Commission;
- 3.6.8.** Ensure that research participants have access to data maintained about them and to results/findings of assessment and research.

3.7. Shared Files and Multiple Records

Psychologists who work in settings where files are shared or reports are co-authored among members of multi-disciplinary, or other types of teams, may have special responsibilities to maintain sensitive confidential information.

It is recommended that psychologists:

- 3.7.1.** Inform clients of the limitations on the confidentiality of the record when files are shared;
- 3.7.2.** Consider recording limited information in shared files and keeping separate (secure and confidential) files where more complete information is recorded, such as raw test data or session notes;
- 3.7.3.** Clearly note in the main file that another separate file is maintained, providing details of how this file may be accessed;
- 3.7.4.** Offer clients choices, when possible, as to whether their psychology records are held on the shared file or in a separate psychology file;
- 3.7.5.** Carefully consider clients' requests that confidential information about their treatment not be entered into a shared file;
- 3.7.6.** Consider keeping separate records for children's/young persons' individual work and for sessions with parent(s)/carer(s), family sessions or groupwork in order to protect confidentiality and allow ease of access to records;
- 3.7.7.** Are aware that, when keeping separate records on a client (i.e., process vs. case notes), all notes identifiably belonging to a client are part of the record;
- 3.7.8.** Ensure financial records of the psychologist are accurate, up to date and anonymised to protect client confidentiality in the event of audit;
- 3.7.9.** Consider holding written fee policies and agreements as part of financial record.

4 Applying These Guidelines

These Guidelines are intended to support ethical practice with respect to record keeping and also to further promote the rights of clients, research participants, and others with whom psychologists work. It is important for psychologists to consider the Guidelines in light of the particular context(s) in which they work. The application of the Guidelines may vary from one setting to another. It is the responsibility of each psychologist to determine how to integrate the Guidelines into existing practice. It is recommended that psychologists develop their own locally specific protocols, where appropriate, to address record keeping and confidentiality. These Guidelines will be reviewed and updated periodically but this does not override the ethical responsibility of every psychologist to maintain professional competence.

References

- American Psychological Association. (2002). Criteria for practice guideline development and evaluation. *American Psychologist*, 57, 1048–1051.
- American Psychological Association. (2007) Record keeping guidelines. *American Psychologist*, 62, 993 - 1004. Australian Psychological Society. (2004). *Guidelines on record keeping*. Melbourne, Australia: Author.
- Bond, T. & Mitchels, B. (2008). *Confidentiality and record keeping in counselling and psychotherapy*. London: Sage.
- British Psychological Society, Division of Counseling Psychology. (2002). *Guidelines on Confidentiality and Record Keeping*. Leicester: Author.
- British Psychological Society, Division of Clinical Psychology (2008). *Good Practice-guide: Service user and carer involvement within clinical psychology training*. Leicester: Author.
- Government of Ireland (1964). *Guardianship of Infants Act, 7/1964*. Dublin: Houses of the Oireachtas.
- Government of Ireland (1991). *Child Care Act, 17/1991*. Dublin: Houses of the Oireachtas.
- Data Protection Commissioner. (2007). Data protection guidelines on research in the health sector. Retrieved from: http://www.dataprotection.ie/documents/guidance/Health_research.pdf.
- Department of Health (2018) Guidance on Information Principles for informed consent for the processing of personal data for health research. Dublin: Author
- Data Protection Commission (2019) A Quick Guide to GDPR Breach Notifications Retrieved from: <https://www.dataprotection.ie/sites/default/files/uploads/2019-08/190812%20GDPR%20Breach%20Notification%20Quick%20Guide.pdf>
- Donnelly, M. (2002). *Consent: Bridging the gap between doctor and patient*. Cork: Cork University Press.
- European Federation of Psychologists' Associations. (2001). *The European psychologist in forensic work and as expert witness: Recommendations for an ethical practice*. Brussels: Author.
- Fisher, C.B. (2002). A goodness-of-fit ethic for informed consent. *Fordham Urban Law Journal*, 30, 159-171.
- Fisher, C. B., Cea, C. D., Davidson, P. W. & Fried A. L. (2006). Capacity of persons with mental retardation to consent to participate in randomized clinical trials. *American Journal of Psychiatry*, 163, 1813-1820.
- Helseth, S., & Aschild, S. (2004). Research involving children: Some ethical issues. *Nursing Ethics*, 11 (3), 298 – 308.

McDonald, B. (2009). *Information sharing and mental health: Guidance to support information sharing by mental health services*. United Kingdom Department of Health and Central Office of Information: London.

Pomerantz, A. M. (2005). Increasingly informed consent: Discussing distinct aspects of psychotherapy at different points in time. *Ethics & Behavior*, 15 (4), 351–360.

Psychological Society of Ireland. (2008). *Code of Professional Ethics*. Dublin: Author. Psychological Society of Ireland. (2010). *Strategic Plan 2010-2013*. Dublin: Author.

Appendices

Appendix I

Acknowledgements

As Chair of the Working Group on Confidentiality and Record Keeping, I wish to express my sincere appreciation to the Group members for their time, energy, and ideas which were so essential to the development of these Guidelines. In particular, I would like to acknowledge Dr Katie Baird who was instrumental in establishing the Working Group and ensuring that its work was completed.

I would also like to thank all the PSI members, other individuals, and groups who made submissions to the Working Group during the consultation process. These contributions formed an important part of the development of the Guidelines.

Confidentiality is fundamental to the work of psychologists, and record keeping issues impact most psychologists in practice. It is the hope of the Working Group that these Guidelines will serve to support, guide, and enhance the work of psychologists in Ireland.

Fiona Ward

Chair, Working Group Confidentiality and Record Keeping, 2011

Appendix II

Background and Development of the Guidelines

A Working Group on Confidentiality and Record Keeping in Practice was formed in December 2009 following requests from PSI members for assistance and information in relation to questions regarding confidentiality and record keeping; recognition of the need for guidelines and standards to promote good practice, particularly when psychologists are faced with the possibility of a subpoena or another form of legal discovery/disclosure order; and to support psychological practice.

The terms of reference for the Working Group were to:

1. Develop guidelines for practitioners and recommend a policy on confidentiality and record keeping to PSI Council;
2. Consult with members and relevant others as appropriate to facilitate the development of same;
3. Refer to relevant literature and statutes in order to provide an evidence base for the development of the guidelines and policy;
4. Disseminate information regarding guidelines and policy in written and/or verbal format to PSI members

Membership of the Working Group

Membership of the Working Group included psychologists working in both private and public sectors, from a variety of backgrounds as well as external experts.

- Ms Fiona Ward, Chair, Director of Counselling, HSE Dublin North East
- Dr. Katie Baird, Director of Professional Development, PSI
- Ms. Anne Marie Regan, Psychologist in Private Practice
- Dr. Mary Creaner, External Member
- Dr. Ursula Kilkelly, External Member
- Dr. Juliana Macleod, Representative from HPSI
- Ms. Maeve Lewis, External Member

Consultation Process with Members and Interested Stakeholders

The Working Group undertook a comprehensive consultation process with key stakeholders which included:

- Seeking the views of PSI members through an invitation issued in the Irish Psychologist (March 2010);
- Inviting key stakeholders to make submissions;
- Consultation with PSI Divisions and Special Interest Groups;
- Workshop at 2010 PSI Annual Conference.

Details of the consultation process and submissions received are outlined in Appendix I

Literature Review

As part of its terms of reference, the Working Group was requested to refer to relevant literature and statutes in order to provide an evidence base for the Guidelines. This work included a review of all major English language guidelines on confidentiality and record keeping (APA, 2007; APS, 2004; BPS DCP, 2008; BPS DCoP, 2002; CPA, 2001). In addition, a targeted literature review by each member of the Working Group on the key area(s) of special interest was undertaken, including children and young people; research; supervision; psychotherapy with adults; training; working in rural settings. The Working Group identified three key messages arising from the literature review:

- Consent as an evolving concept (Pomerantz, 2005);
- “Goodness of fit” model of consent (Fisher, 2002);
- Importance of contracting with clients/participants.

The Working Group further noted that in some key areas there remains in the literature a lack of consensus. Appendix II details additional resources identified by the Working Group which were referred to in the course of the development of the Guidelines and which may be of benefit to members.

Update of Guidelines

In 2020, a new Working Group was established with terms of reference to revise the Guidelines in the light of changes in legislation, technology and evolving understanding of confidentiality issues. The members of the Working Group were:

- Nicola Elmer (Chair)
- Aine Kennedy
- Eamon O’Brian
- Trevor James

External Consultation

Twenty-nine external agencies were invited to make submissions to the PSI. Invitation letters specified why the particular agency had been approached and asked that submissions focus on issues relevant to confidentiality and record keeping in order to assist the PSI in the development of a policy statement and guidelines.

Submissions were received from:

- Acquired Brain Injury Ireland (ABI);
- Barnardos;
- Children’s Rights Alliance;
- Health Research Board;
- Irish Association of Counselling and Psychotherapy;
- Mental Health Commission;
- National Counselling Service (Maire Magennis);
- Shine.



Internal Consultation

An advert was printed in the March 2010 Irish Psychologist inviting members of the PSI to make submissions to the Working Group. The aims of the Group were described. A submission was received from Saoirse Kenny.

All the PSI Divisions and Special Interest Groups were invited to comment on a draft of the Guidelines. The Working Group received comments from:

- Division of Educational Psychology;
- Division of Forensic Psychology;
- Division of Health Psychology;
- Autistic Spectrum Disorder Special Interest Group;
- Death, Dying and Bereavement Special Interest Group;
- Sexual Diversity and Gender Issues Special Interest Group;

In addition, a workshop was delivered at the 2010 PSI Annual Conference. Attendees of the workshop had the opportunity to use the draft Guidelines to respond to vignettes. Members of the Working Group received verbal feedback from workshop attendees and several attendees gave written comments to the Working Group.

A copy of the draft Guidelines was circulated to the PSI Council and several Council Members gave feedback using a structured feedback form.

The Working Group would like to thank all the PSI members and external stakeholders who provided submissions and / or feedback. Your involvement was an important part of the development of the PSI Guidelines on Confidentiality and Record Keeping.



Appendix III

Additional Resources

General Resources

- American Psychological Association. (2002). Criteria for practice guideline development and evaluation. *American Psychologist*, 57, 1048-1051.
- American Psychological Association. (2007) Record keeping guidelines. *American Psychologist*, 62, 993-1004. Australian Psychological Society. (2004). *Guidelines on record keeping*. Melbourne, Australia: Author.
- Bersoff, D.N. (Ed.). (2008). *Ethical conflicts in psychology (4th ed.)*. Washington DC: American Psychological Association.
- British Psychological Society, Division of Counseling Psychology. (2002). *Guidelines on Confidentiality and Record Keeping*. Leicester: Author.
- British Psychological Society, Division of Clinical Psychology (2008). *Good practice-guide: Service user and carer involvement within clinical psychology training*. Leicester: Author.
- Canadian Psychological Association. (2001). *Practice guidelines for providers of psychological services*. Ottawa: Author.
- Council of Europe (1966). The European Convention on Human Rights. Retrieved from: <http://www.hri.org/docs/ECHR50.html>
- Helbok. C. M. (2003). The practice of psychology in rural communities: Potential ethical dilemmas. *Ethics and Behaviour*, 94, 367-384.
- Irish College of General Practitioners and the National General Practice Information Technology Group. (2003). *Managing and protecting the privacy of personal health information in Irish general practice: An information guide to the data protection acts for general practitioners*. Retrieved from: http://www.icgp.ie/go/in_the_practice/information_technology/publications_reports
- Kitchener, K. S. (2000). *Foundations of ethical practice, research, and teaching in psychology*. Mahwah, NJ: Erlbaum.
- Knauss, L.K. (2006) *Ethical Issues in record keeping in group psychotherapy*. *International Journal of Group Psychotherapy*, 56, 415-429.
- Psychological Society of Ireland. (2008). *Code of Professional Ethics*. Dublin: Author.
- Reeves, A. (2004). *Suicide risk assessment and the ethical framework*. *Counselling & Psychotherapy Journal*, 15(4), 25-8.
- Tribe, R. & Morrissey, J. (Eds.). *The handbook of professional and ethical practice for psychologists, counsellors and psychotherapists*. London: Routledge.

Ethico-Legal Resources

- Campbell, L., Kilcommins, S. & O'Sullivan, C. (2010). *Criminal law in Ireland: Cases and commentary*. Dublin: Clarus Press.
- Department of Health and Children, Government of Ireland. (1999). *Children First: National Guidelines for the Protection and Welfare of Children*. Dublin: Stationery Office.
Retrieved from: http://www.omc.gov.ie/documents/publications/Children_First_A4.pdf
- DPP v. Cagney & McGrath. (2007). IESC 46.
- Fitzpatrick v White. (2007). IESC 51.
- Government of Ireland. (2006). Criminal Justice Act. Retrieved from:
<http://www.irishstatutebook.ie/2006/en/act/pub/0026/index.html>
- Jenkins, P. (2007). Consent, confidentiality and duty of care: why counsellors need to know the law. *Healthcare Counselling and Psychotherapy Journal*, 7 (3), 18-21.
- Kampf, A., McSherry, B., Thomas, S. & Abrahams, H. (2008). Psychologists' perceptions of legal and ethical requirements for breaching confidentiality. *Australian Psychologist*, 43 (3), 194-204.
- McK v Information Commissioner [2006] 2 IESC. [2006] 1 IR 260; [2006] 1 ILRM 504 Retrieved from
<http://www.courts.ie/Judgements.nsf/bce24a8184816f1580256ef30048ca50/a7b01958f768ecc480257100004b6d2a?OpenDocument>
- Magenis, M. (2010) *The ethical and professional dilemmas raised by court ordered disclosure of confidential records*.
- In P. Butler, M. MacBean, T. McGrath, T. Ryan and F. Ward (Eds.). *To a life that shines: NCS 10 years transforming the shadows* (pp. 164-173). Dublin: National Counselling Service and Health Service Executive.
- Mental Health Commission. (2005). Reference guide, Mental Health Act, Part one: Adults. Dublin: Author.
Retrieved from:
<http://www.mhcirl.ie/documents/publications/Reference%20Guide%20Mental%20Health%20Act%202001%20Part%20One%20Adults.pdf>
- Mental Health Commission. (2005). Reference guide, Mental Health Act, Part two: Children. Dublin: Author.
Retrieved from:
<http://www.mhcirl.ie/documents/publications/Reference%20Guide%20Mental%20Health%20Act%202001%20Part%20Two%20Children.pdf>
- Office of the Minister for Children and Department of Health and Children. (2010). *Children First: National Guidelines for the Protection and Welfare of Children (Revised)*. Dublin: Author.
Retrieved from: http://www.omc.gov.ie/documents/child_welfare_protection/Children_First_July_2010.pdf
- Richards, M. M. (2009). Electronic medical records: Confidentiality issues in the time of HIPPA. *Professional Psychology: Research and Practice*, 40, 550-556.
- Sheikh, A.A. (2008). *The Data Protection Acts 1988 and 2003: Some implications for public health and medical research*. Dublin: Health Research Board.
- Walsh v Family Planning Services. (1992) 1 IR 496.

Resources on Confidentiality

- Blau, I. (1996). Ethical issues in the reporting of child sexual abuse disclosed by adult survivors attending a counselling service. *The Irish Journal of Psychology, 17* (2), 126-143.
- Burke, C. (1995). Until death do us part: An exploration into confidentiality following the death of a client. *Professional Psychology: Research and Practice, 26*, 278-280.
- Donner, M.B., Vandecreek, L., Gonsiorek, J. C., & Fisher, C.B. (2008). Balancing confidentiality: Protecting privacy and protecting the public. *Professional Psychology: Research and Practice, 39*, 369-372.
- Fisher, C. & Oransky, M. (2008). Informed Consent to Psychotherapy: Protecting the dignity and respecting the autonomy of patients. *Journal of Clinical Psychology: In Session, 64* (5), 576-588.
- Fisher, M.A. (2008). Protecting confidentiality rights: The need for an ethical practice model. *American Psychologist, 63*, 1-13.
- Fisher, M.A. (2008). Protecting confidentiality rights: An ethical practice model. Retrieved from: <http://www.centerforethicalpractice.org/articles/models-mary-alice-fisher-phd/confidentiality-practice-model/>
- Hudson-Allez, G., (2004). Threats to psychotherapeutic confidentiality: Can psychotherapists in the UK really offer a confidentiality ethic to their clients? *Psychodynamic Practice, 10* (3), 317-331.
- Jackman Cram, S. & Dobson, K. (1993) Confidentiality: Ethical and legal aspects for Canadian psychologists. *Canadian Psychology, 34* (3), 347-363.
- Norris, M.P. (2002). Psychologists' multiple roles in long-term care: Untangling confidentiality quandaries. In M.P. Norris, V. Molinari, and S. Oglan-Hand (Eds.). *Emerging trends in psychological practice in long-term care* (pp. 261-275). Binghamton, NY: The Haworth Press.
- Younggren, J. & Harris, E. (2008) Can you keep a secret? Confidentiality in psychotherapy. *Journal of Clinical Psychology: In Session, 64* (5), 589-600.

Resources Specific to Working with Children

- American Professional Agency (1999). Insight: *The hazards of working with children and adolescents*. Broadway, NY: Author.
- Behnke, S.H., & Warner, E. (2002). Ethics rounds: Confidentiality in the treatment of adolescents. *APA Monitor on Psychology, 33* (3), 44-45.
- British Psychological Society Division of Clinical Psychology, Faculty for Children and Young People. (2003). *Briefing paper: Child Clinical Psychologists working with children with medical conditions*. Leicester: Author.
- Duncan, R. E., Drew, S. E., Hodgson, J., & Sawyer, S.M. (2009). Is my mum going to hear this? Methodological and ethical challenges in qualitative health research with young people. *Social Science and Medicine, 69*, 1691-1699.
- Ellis, E. (2009). Should a psychotherapist be compelled to release an adolescent's treatment records to a parent in a contested custody case? *Professional Psychology: Research & Practice, 40*, 557 – 563.
- Fisher, M.A. (2009). Replacing "who is the client" with a different ethical question. *Professional Psychology: Research & Practice, 40*, 1-7.
- Koocher, G. (2008). Ethical challenges in mental health services to children and families. *Journal of Clinical Psychology: In Session, 64* (5), 601-612.
- Kraft, S. (2005). Sample adolescent consent form. Retrieved from: <http://www.centerforethicalpractice.org/Form-AdolescentConsent.htm>

Nicolai, K.M. & Scott, N.A. (1994). Provision of confidentiality information and its relation to child abuse reporting. *Professional Psychology: Research and Practice*, 25, 154 – 160.

Rae, W.A., Sullivan, J.R., Razo, N.P., George, C.A., & Ramirez, E. (2002). Adolescent health risk behavior: When do pediatric psychologists break confidentiality. *Journal of Pediatric Psychology*, 27, 541 – 549.

Sullivan, J.R., Ramirez, E., Rae, W.A., Razo, N. P., & George, C. A. (2002). Factors contributing to breaking confidentiality with adolescent clients. *Professional Psychology: Research & Practice*, 23, 396 – 401

Resources Specific to Training and Supervision

Bradley, L.J., Kottler, J.A., & Lehrman-Waterman, D. (2001). Ethical issues in supervision. In L.J. Bradley & N. Ladany (Eds.). *Counselor Supervision* (3rd ed.) (pp. 342–360). Philadelphia: Brunner-Routledge.

Dunkley, C. & Henderson, P. (2006). Supervising in cases of suicide risk. *Therapy Today*, 17 (1), 31-33.

Falvey, J. E. (2002). *Managing clinical supervision: Ethical practice and legal risk management*. Pacific Grove, CA: Brooks/Cole.

Handelsman, M. M., Gottlieb, M. C., & Knapp, S. (2005). Training ethical psychologists: An acculturation model. *Professional Psychology: Research and Practice*, 36, 59–65.

Harrar, W.R., VandeCreek, L., & Knapp, S. (1990). Ethical and legal aspects of clinical supervision. *Professional Psychology: Research and Practice*, 21, 37– 41.

Milne, D. (2009). *Evidence-based clinical supervision: Principles and practice*. Chichester: British Psychological Society and Blackwell.

Prieto, L. R., & Schell. K. R. (2002). Using case documentation to strengthen counsellor trainees' case conceptualisation skills. *Journal of Counseling & Development*, 80, 11-21.

Sutter, E., McPherson, R. H., & Geeseman, R. (2002). Contracting for supervision. *Professional Psychology: Research and Practice*, 33, 495–498.

Thomas, J. (2007). Informed consent through contracting for supervision: minimizing risks, enhancing benefits. *Professional Psychology: Research and Practice*, 38, 221–231.

Resources Specific to Record Keeping

Cameron, S. (2002) Learning to write case notes using the SOAP format. *Journal of Counselling and Development*, 80, 286-292

Data Protection Commission (2019) A Quick Guide to GDPR Breach Notifications
<https://www.dataprotection.ie/sites/default/files/uploads/2019-08/190812%20GDPR%20Breach%20Notification%20Quick%20Guide.pdf>

Harris, S., Brown, A., Dakin, S., Riley, L. & Bulham, R. (2009). Are clinical records really that important? The dearth of research and practice guidelines in MFT. *American Journal of Family Therapy*, 37, 373 - 387.

The National FOI Liaison Group for Health Boards. (1999). *Policy for Health Boards on Record Retention Periods*. Retrieved from: <http://www.lenus.ie/hse/bitstream/10147/45859/1/717.pdf>

Health Service Executive. (2009). Electronic communications policy. Retrieved from: http://hsenet.hse.ie/HSE_Central/Commercial_and_Support_Services/ICT/Policies_and_Procedures/Policies/

Peate, I. & Culpin, C. (2009). A guide to record keeping for health care assistants. *British Journal of Healthcare Assistants*, 3 (8),397-400.

United Kingdom Department of Health Digital Information Policy. (2006). *Records management, NHS code of practice, Part 1*. London: Author.

United Kingdom Department of Health Digital Information Policy. (2009). *Records management, NHS code of practice, Part 2*. London: Author.

Resources Specific to The Views of Service Users

MacBean, M. (2010) Client perspectives of confidentiality: An ethical exploration. *In To a Life that Shines: NCS 10 years Transforming the Shadows*. In P. Butler, M. MacBean, T. McGrath, T. Ryan and F. Ward (Eds.).

To a life that shines: NCS 10 years transforming the shadows (pp. 142 - 151). Dublin: National Counselling Service and Health Service Executive.

Martindale, S.J., Chambers, E. and Thompson, A.R. (2009). Clinical psychology service users experiences of confidentiality and informed consent: A qualitative analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 82, 355-368.

Resources Specific to Conducting Research

Baez, B. (2002). Confidentiality in qualitative research: Reflections on secrets, power and agency. *Qualitative Research*, 2, 35-58.

Data Protection Commissioner. (2007). *Data protection guidelines on research in the health sector*. Retrieved from: http://www.dataprotection.ie/documents/guidance/Health_research.pdf

Fisher, C.B. & Goodman, S.J. (2009). Goodness-of-fit ethics for non-intervention research involving dangerous and illegal behaviors. In D. Buchanan, C. B. Fisher, & L. Gable (Eds.), *Research with high-risk populations: Balancing science, ethics, and law* (pp. 25–46). Washington, DC: APA.

Haverkamp, B. E. (2005). Ethical perspectives on qualitative research in applied psychology. *Journal of Counseling Psychology*, 52 (2), 146-155.

Kaiser, K. (2009). Protecting respondent confidentiality in qualitative research. *Qualitative Health Research*, 19, 1632 – 1641.

Trinity College Dublin. (2009). *Policy on good research practice*. Dublin: Author.

University College Dublin Human Research Ethics Committee. (2008). *Code of good practice in research*. Dublin: Author.

Whittaker, E. (2005) Adjudicating entitlements: The emerging discourses of research ethics boards. *Health*, 9, 513 – 535.

World Medical Association. (2008). *Declaration of Helsinki: Ethical principles for medical research involving human subjects*. Retrieved from: <http://www.wma.net/en/30publications/10policies/b3/index.html> on 12th April 2010.

European University Institute (2019). *Good Data Protection Practice in Research*. EUI. <https://www.eui.eu/documents/servicesadmin/deanofstudies/researchethics/guide-data-protection-research.pdf>

Appendix IV

Best Practice Approach to Undertaking Research Projects using Personal Data (Data Protection Commissioner, 2007)*



*This chart was reproduced with permission from the Office of the Data Protection Commissioner.