

# Professional Practice of Psychology

in Aotearoa New Zealand  
3rd edition

Edited by  
**Waikaremoana W. Waitoki, Jacqueline S. Feather,  
Neville R. Robertson & Julia J. Rucklidge**

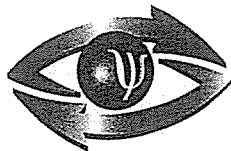


The New Zealand Psychological Society  
*Te Ropu Matai Hinengaro o Aotearoa*

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# **PROFESSIONAL PRACTICE OF PSYCHOLOGY IN AOTEAROA NEW ZEALAND**

**3RD EDITION**



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*Tē Rōpū Mātai Hinengaro o Aotearoa*

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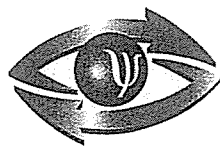
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The New Zealand Psychological Society

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## CONFIDENTIALITY AND PRIVACY

Joanne E. Taylor  
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*Confidentiality is a primary obligation of psychologists . . . There is nothing more fundamental to a therapeutic relationship than confidentiality. It is what breeds trust between the psychologist and the client, and what makes the professional relationship work. (Swenson, 2006, pp. 63–64)*

*Yet there is probably no ethical duty more misunderstood or honored by its breach rather than by its fulfilment. (Bersoff, 2008, p. 159)*

### Introduction

Assessment, treatment, and research activities of psychologists rest on the premise that clients and participants are willing to disclose personal information and that such disclosure is made in confidence, with the individual having a degree of autonomous control over information concerning them. However, translating confidentiality principles into everyday practice can present challenges to the practitioner given the diverse contexts in which psychologists work (e.g., a range of types of practice, as well as research, teaching, and supervision), the range of clients with whom they work, various types of workplaces and contractual arrangements, the variety of legal connotations to confidentiality, and the complications presented by modern telecommunication and computer technology (Jenkins, 2005; Koocher & Keith-Spiegel, 2008; Nagy, 2012; Shapiro & Smith, 2012). Internationally, surveys of psychologists have highlighted issues of confidentiality as being among the most frequent ethical dilemmas faced (Davis, Seymour, & Read, 1997; Kämpf, McSherry, Thomas, & Abrahams, 2008; Lindsay & Colley, 1995; Pope & Vetter, 1992; Wierzbicki, Siderits, & Kuchan, 2012). Difficulties described by registered psychologists in Aotearoa New Zealand included decisions related to breaking confidentiality, storage of records, sharing information, confidentiality in working with children and young people, and third party requests for client information (Davis et al., 1997; Fitzgerald & Myers, 2016). Decisions about confidentiality are rarely clear-cut and are often guided by professional judgement that is informed by ethical and legal considerations, client competence, cultural concerns, as well as developmental considerations, particularly when working with children and young people (Corey, Corey, & Callanan, 2010; Duncan, Williams, & Knowles, 2012; Koocher, 2008; Youngren & Harris, 2008). Despite this, a recent survey of psychologists in Aotearoa New Zealand found that decisions about confidentiality tended to be considered in more absolute terms than is often appropriate (Fitzgerald & Myers, 2016), which is consistent with surveys of Australian psychologists (Kämpf et al., 2008).

This chapter covers privacy, privilege, and confidentiality as these concepts relate to the work of psychologists in Aotearoa New Zealand. The concepts are clarified, followed by an overview of the limits to confidentiality, in terms of general issues as well as application of the concepts when working with children and young people, and other specific contexts. Guidelines applying to particular contexts are provided, including electronic communication, record-keeping, and disclosure of information to third parties. The final section provides general recommendations for best practice.

The chapter draws on national and international literature where work that has originated outside Aotearoa New Zealand is relevant to working as a psychologist in Aotearoa New Zealand. An important caveat is that the chapter in no way replaces the responsibilities of psychologists to familiarise themselves with the relevant legislation regarding confidentiality and privacy, and the *Code of Ethics for Psychologists Working in Aotearoa New Zealand* (Code of Ethics Review Group, 2002). Instead, the aim is to leave the reader with a broad understanding of confidentiality and privacy issues as applied to the practice of psychology in Aotearoa New

Zealand. Seymour, Blackwell, and Thorburn's (2011) *Psychology and the Law in Aotearoa New Zealand* is a companion volume that provides detailed information about relevant legislation as it applies to psychologists working in Aotearoa New Zealand.

When reading this chapter, the reader should not only be mindful of the scientific literature regarding the developmental stage of the client and their ability to provide informed consent on matters regarding assessment, therapy, and disclosure of information to others, but they should also consider cultural implications. Implicit in these guidelines, rules, and regulations, with their emphasis on European values, is that the individual is a separate entity from the family or whānau and that, when a Māori client enters into a therapeutic relationship, they are often explicitly required to step into a world of separate individuals (Nairn, 1999). Nairn highlights the Pākehā prioritisation of individuality and notes that this individualistic view may not concur with the values and customs of Māori clients. Under the Treaty of Waitangi and the Code of Ethics, Māori clients should be able to access services grounded in Māori reality (Article 2) or services offered to any citizen (Article 3) (Nairn, 1997). In other words, some Māori clients will view the "individual" as encompassing the whānau, thereby granting the whānau all the rights granted to the individual. However, it may not be obvious how any given Māori client, of any age, would perceive their "individuality". Consultation with Māori colleagues and supervisors should be an integral part of making decisions in such cases, particularly when a Māori person refuses to have whānau involved, in which case, elaborating the reasons for excluding the whānau may highlight the best course of action for that person. However, given the extent to which Western culture pervades codes of practice and the law, the presence of an ethical and cultural dilemma may not always be evident. Persons of any collective culture, including Māori, Asian, Arabic, and Polynesian peoples, need consideration of collective as well as of individual values.

## Concepts and Principles

Privacy, privilege, confidentiality, and informed consent are related concepts that together contribute to safe and ethical practice by psychologists. In Aotearoa New Zealand, these concepts are included in Principle 1 of the Code of Ethics, *Respect for the Dignity of Persons and Peoples*. In addition to a sound working knowledge of the Code of Ethics, psychologists must be aware of, and be guided by, principles included in the Privacy Act 1993, the Privacy Amendment Act 2000 and 2013, the Health Information Privacy Code 1994, and the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. Although the concepts of privacy, privilege, and confidentiality work together, it is useful to note their distinguishing characteristics. Privacy is generally understood as a constitutional right of individuals to have some control over the sharing of their personal information with others. It is therefore often governed by legislation, as is the case in Aotearoa New Zealand. Privilege, in its legal sense, sits comfortably under the umbrella of privacy in situations where disclosure of information would be prejudicial to the individual, and where there is no risk to the public from non-disclosure. Confidentiality, although a closely related concept that protects an individual's personal information, is more often conceptualised as an ethical issue covered by professional ethics codes; it is also subject to the legislative demands of privacy and, in some situations, is protected by legal privilege (Fisher, 2012; Jefferson, 2011).

## Privacy

Privacy of personal information is the right of each individual. When clients enter into a therapeutic relationship, they should know it is their right for their information to be kept private to the context in which it is divulged. Without confidence in this right to privacy, it would be difficult for clients to feel safe to disclose information that is essential to progress in therapy that they would not be prepared to reveal in other settings. Privacy is the overarching principle under which confidentiality, informed consent, and legal privilege sit.

Principle 1.6 of the Code of Ethics states that "Psychologists recognise and promote persons' and peoples' rights to privacy." In Aotearoa New Zealand, the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations (1996) states in Right 1.2 that "Every consumer has the right to have his or her privacy respected." The Privacy Act (1993), Privacy Amendment Acts (2000, 2013), the Health Information Privacy Code (2008, HIPC), and the Privacy Commissioner (1997) provide guidelines related to the ethical collection of personal information in the Information Privacy Principles (Part II, Principles 1–5). Table 1 lists the important principles for psychologists to note. The rules in the HIPC "have the force of legislation" (Bell & Brookbanks, 2005, p. 363) and should be carefully adhered to. They are intended to ensure

that people retain a degree of autonomy when other people are handling their health information. Although individuals have the right to access their personal information, there are situations in which the safety of the client, the psychologist, or another person may be compromised if particular information is provided. These situations are described later in this chapter.

**Table 1 Information Privacy Principles from the Privacy Act 1993**

Principles 1-5	Information should be collected for a lawful and necessary purpose and from the individual concerned (where possible).  The individual should be fully informed of: <ul style="list-style-type: none"> <li>• the purpose for which the information is sought</li> <li>• any intended recipients of the information</li> <li>• whether the provision of information is voluntary or mandatory</li> <li>• any consequences of not supplying the information</li> </ul> Storage and security of information should be safeguarded.
Principle 6	An individual is entitled to have access to personal information (with limitations outlined in Parts 4 and 5 of the Privacy Act 1993).
Principle 7	An individual is entitled to insist that any incorrect information is corrected to their satisfaction.
Principle 10	There are limits on the use of personal information, including the limitation that information collected from an individual for one purpose cannot be used for another without the informed consent of that person.
Principle 11	Outlines limits on the disclosure of personal information, including the exception where “. . . disclosure of the information is necessary to prevent or lessen a serious and imminent threat to (i) public health or public safety; or (ii) the life or health of the individual concerned or another individual.”

The Privacy Act 1993 does not apply in some areas of the work of psychologists. For example, Family Court assessments by psychologists that are conducted under the Care of Children Act 2004 or Children Young Persons, and Their Families Act 1989 are exempt from the Privacy Act 1993, including the report and any notes or materials used by a specialist report writer in preparing their report (see the revised Practice Note by Judge Tony Walsh, 2014). This means that any third party requests for information in this context should not be complied with and the person should be referred to direct their enquiry to the Family Court (Seymour & Blackwell, 2011). The same applies to reports prepared for Child, Youth and Family (CYF). The report is owned by the referring agency, and Family Court case law “has determined the report is the property of the court and the extent of its circulation is governed by the exercise of the court’s discretion” (Seymour & Blackwell, 2011, p. 76). In most cases, however, the court and CYF will allow each of the lawyers to have access to the psychologist’s report and for it to be read by the parties. Requests to withhold all or parts of a report are always at the discretion of the presiding Family Court judge (Seymour & Blackwell, 2011).

### Privilege

Privilege is a much narrower concept than confidentiality and privacy. It applies only to the right to refuse to answer questions in judicial, quasi-judicial, or statutory enquiries (Tribbensee & Claiborn, 2003). The legislation guiding legal privilege in Aotearoa New Zealand is the Evidence Act 2006. Under section 59 of this legislation, privilege applies to information obtained by medical practitioners and clinical psychologists during assessment or treatment “for drug dependency or any other condition or behaviour that may manifest itself in criminal conduct” (p. 47). Privilege is held by the client, regardless of their age, with the purpose of protecting the client

(not the practitioner) from disclosure of private information in the context of a court or other judicial process. Therefore, only the client can make a decision to waive their right to legal privilege and no competing interests such as the public interest or a parent's viewpoint can be used to challenge it (although a judge has overriding discretion as to confidential information; see section 69 of the Evidence Act 2006, and as noted below). For the communication to be deemed privileged, the client must believe that the communication is necessary to enable the clinical psychologist to "examine, treat, or care for" them (Evidence Act 2006, section 59(2) and (3)). When assessment or therapy is mandated by the court (e.g., for the purposes of determining an individual's fitness to plead or their current psychological state), no privilege exists.

Privilege for the client is more likely to be granted if the following conditions (Wigmore Principles) are met:

- The communication must originate in a setting where it was revealed in confidence and the client assumed that it will not be disclosed.
- This element of confidentiality must be essential to the full and satisfactory maintenance of the relationship between parties.
- The relationship must be one which, in the opinion of the community, must be fostered, such as the professional standing of psychologists.
- The injury that would occur to the relationship by disclosure must be greater than the benefit that would be granted from the correct disclosure under litigation (Wigmore, 1961).

Psychologists should be mindful that clients may either intentionally or inadvertently waive privilege (see section 65). When clients request information from a psychologist to use in their defence or to strengthen a case to be heard by the court (e.g., Family Court, criminal proceedings), it is important for them to understand that their private information can then be accessed and used by opposing counsel. They need to be advised to carefully consider whether it is in their best interests to use information gathered in the context of the therapeutic relationship in court proceedings, as once it is in the legal arena they have waived legal privilege and may have little or no control over how the information is used (Jenkins, 2005). This is also the case where an individual cites a mental health issue as a defence or partial defence during court proceedings (Knapp & VandeCreek, 2012). Section 69 of the Evidence Act 2006 covers situations where a judge has overriding discretion as to confidential information and makes a direction to disclose after weighing up the public good arising from disclosure versus the potential harm from breaching confidentiality.

Legal privilege exists in very specific circumstances for children and young people (or their families) in need of protection who have been mandated to undergo counselling by the Courts (section 74 of the Children, Young Persons, and their Families Act 1989). Under such circumstances, section 77 of the Act explicitly states that any person acting as a counsellor for a child or young person (pursuant to section 74 of the Act) is legally prevented from disclosing information about their client to any court or other judicial enquiry, "except to the extent that it is necessary for a counsellor to do so in the proper discharge of that person's functions". This section identifies information gained through counselling as privileged.

Although privilege most often applies to client information, it also applies for psychologists in the context of quality assurance activities undertaken under the Health Practitioners Competence Assurance (HPCA) Act 2003. Sections 54–63 protect the confidentiality of information that becomes known and documents produced solely for the purpose of competence and disciplinary activities, and gives immunity from civil liability where these activities are engaged in in good faith. Psychologists should seek independent legal advice if there is any doubt about whether legal privilege applies (New Zealand Psychologists Board, November 2011).

## **Confidentiality**

Information provided to a healthcare professional is protected in Aotearoa New Zealand under the Privacy Act 1993, HIPC 1994, Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, and Health and Disability Commissioner Act 1994, and Principle 1 of the Code of Ethics outlines the expectations for confidentiality. Psychologists should be knowledgeable about the Code of Ethics and any legislation that guides or dictates their professional practice because this knowledge provides a sound basis on which to make ethical decisions. However, clinical judgement, based on a careful analysis of the specific circumstances, is also an important guide in making ethical decisions (Corey et al., 2010). An important part of this judgement is consultation with a supervisor or experienced colleague to ensure nothing important

has been missed in the decision-making process (see also the chapter, on supervision by Howard et al., in this volume).

Given that confidentiality of client information cannot be guaranteed to be absolute (Jenkins, 2005), a clear and overt statement of the limits to confidentiality should be provided before psychological services begin. Any questions or concerns should be dealt with at this juncture, and if the limitations are not acceptable to the client, services should not proceed. It is at this point that the concept of confidentiality is inextricably related to that of informed consent (Tribbensee & Claiborn, 2003). Clients cannot give informed consent unless they are aware of the limitations to confidentiality that exist in their specific situation. The protection of private and sensitive information is essential to a good outcome in therapy, and clients need to feel confident that their information is respected and protected, and have knowledge of circumstances that could lead to confidentiality being breached. These issues are covered in more detail below (see also the chapter, on informed consent by Cargo et al., in this volume and the Psychologists Board guidelines on informed consent).

The Code of Ethics provides guidelines on how confidentiality should be dealt with in therapeutic situations. Some of the Practice Implications listed under Principle 1.6 of the Code recommend that:

- 1.6.2 Psychologists explain clearly the measures they will take to protect confidentiality when engaged in services to, or research with, individuals, families, groups, or organisations. Furthermore, psychologists convey to family, hapū/iwi organisations, and community members the responsibilities on them for the protection of each other's confidentiality.
- 1.6.3 Psychologists discuss with persons and organisations with whom they establish a research or professional relationship (a) the limits of confidentiality. . . and (b) the foreseeable uses of the information generated through their services/activities.
- 1.6.4 Psychologists seek to collect only that information which is germane to the purpose(s) for which informed consent has been obtained.
- 1.6.5 Psychologists record only that information necessary for the provision of continuous, coordinated service to a client, or for validating or identifying conclusions in a report, or for the goals of the particular research study being conducted, or which is required by law.
- 1.6.6 Psychologists store, handle, transfer, and dispose of all records, both written and unwritten (e.g., computer files, video tapes) in a way that attends to needs for privacy and security.
- 1.6.9 Psychologists do not disclose personal information obtained from an individual, family, whānau or community group, or colleague without the informed consent of those who provided the information (subject to any limits to confidentiality).

### **Limitations and Exceptions to Non-Disclosure**

Breaches of confidentiality are considered when the public good or an imminent threat to safety (e.g., suicide, homicide, or abuse) outweighs client confidentiality. The Tarasoff decision, a 1974 California court ruling that described circumstances in which a therapist not only may but must breach confidentiality, stated that "The public policy favouring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to divert danger to others. The protective privilege ends where the public peril begins" (Tarasoff v. Regents of the University of California, 1974, p. 561). Internationally, it is accepted that, in certain circumstances, information confidential to a therapeutic relationship should be disclosed, and particularly in the United States, there is a duty to disclose to protect identifiable victims of danger.

Aotearoa New Zealand has not formally adopted the recommendations of the Tarasoff decision (Bell & Brookbanks, 2005), but ethical guidelines and rules on confidentiality have been provided for psychologists in Aotearoa New Zealand for nearly 30 years. Practice Implication 1.6.10 of the Code of Ethics states that "Psychologists recognise that there are certain exceptions and/or limitations to non-disclosure of personal information, and particular circumstances where there is a duty to disclose." These circumstances are outlined in the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and Health and Disability Commissioner Act 1994, and are clearly articulated in Practice Implications 1.6.10a-e in the Code of Ethics as follows:

- *Diminished capacity*, where the person to whom the information belongs is not capable of giving informed consent (see chapter on informed consent by Cargo et al., in this volume). In this situation, every effort should be made to ensure that, as far as possible, the individual is consulted and advised, and consent may be sought from a legal guardian.
- *Children and young persons* may need to be protected when a disclosure is necessary to ensure their safety. The child's or young person's wishes should be taken into consideration to the extent warranted by their level of emotional maturity and cognitive skills.
- *Urgent need* may apply when it is impossible or impractical to gain consent to disclosure in time to prevent harm or injury.
- *Legal requirements* apply when the psychologist is required by law to disclose information given by a client. For example, psychologists working as expert witnesses cannot guarantee confidentiality for any party because their role is to give evidence to the court (Blackwell, 2011; Modes of Evidence Working Party, 2010).
- *Client or public safety* is relevant when non-disclosure might endanger a client or other person but permission for disclosure is denied.

The HPCA Act 2003 also notes that health practitioners may be required to make records available. Section 42 states that:

An authority that is reviewing the competence of a health practitioner or that has set a competence programme or recertification programme for a health practitioner may, for the purposes of the review or programme, inspect all or any of the clinical records of the health practitioner, and that health practitioner must make those records available for those purposes to any person duly authorised by the authority. (p. 45)

Section 44 provides for extension of the confidentiality of the information by those examining such records and delimits exceptions to that confidentiality (i.e., for the purposes of making a report in relation to the programme, of any criminal investigation against the health practitioner, or of making the information available to whom it relates if directed by the authority or requested by the person themselves).

When confidential information is disclosed, professional ethics and relevant legislation dictate that only information that is "accurate and relevant to the situation" is disclosed (Code of Ethics Practice Implication 1.6.11, p. 10). Furthermore, the information must be conveyed only to appropriate persons who require it to ensure the safety, wellbeing, and coordinated care of those affected. If a breach of confidentiality occurs for reasons of safety, the public interest duty overrides the confidentiality contract. If the information is disclosed to an appropriate authority "to prevent or lessen a serious threat to public health or public safety or the life or health of the individual concerned or another individual" (Rule 11 of the Privacy Act 1993 and HIPC 1994), then such a breach can occur without risk of prosecution. (A threat is considered serious in relation to the likelihood of it being realised, the severity of the consequences if it is realised, and the time at which it may be realised.) Since it also conforms to the Code of Ethics, the practitioner would be protected from a professional complaint in this circumstance. Regardless of the ultimate decision the psychologist makes in such situations of discretionary disclosure, good documentation outlining the factors that were considered in reaching a decision, as well as seeking supervision, is essential.

It is important to note that case law can cast a different light on how ethical practice might be interpreted. In their review of legal cases brought in Aotearoa New Zealand, Bell and Brookbanks (2005) describe relevant case law examples and note that:

It is no longer clear that inability to identify a named victim will necessarily be fatal in an action based on failure to warn or protect. ...where the alleged victim was neither identifiable nor foreseeable the duty would not arise. An unknowable victim does not constitute the sort of relevant "public peril" necessary to invoke the exception to the protective privilege. (p. 374)

### **Limitations and Exceptions to Disclosure**

Where there are good reasons, access to personal information can be denied. Under the Privacy Act 1993, the

reasons most pertinent to the practice of psychologists are:

- where disclosure would “prejudice the maintenance of the law, including the prevention, investigation, and detection of offences, and the right to a fair trial”, or “endanger the safety of any individual” [sections 27(c) and (d)],
- where disclosure would compromise the privacy or safety of a third party [sections 29(1)(a) and (b)],
- where the information supplied “would be likely to prejudice the physical or mental health” of the individual making the request [section 29(1)(c)],
- where disclosure to a third party about an individual aged under 16 years “would be contrary to that individual’s interests” [section 29(1)(d)],
- where disclosure may prejudice the safe custody or rehabilitation of an individual who has been convicted of an offence or has been detained in custody [section 29(1)(e)],
- where disclosure would breach legal professional privilege [section 29(1)(f)], and
- where disclosure can be denied if the request is considered “frivolous or vexatious, or the information requested is trivial” [section 29(1)(j)].

In situations where there is good reason not to provide the entire document that contains the requested information, parts of the document deemed inappropriate to disclose can be blanked out and a photocopy taken providing the specific information requested, as per section 43(1) of the Privacy Act 1993. Where disclosure of personal information is denied, it is required that the reasons for non-disclosure be provided to the individual making the request. The issues raised here apply regularly to the work of psychologists. For example, if a client with a history of severe sexual, physical, and mental abuse and intermittent suicidality requests her case notes to help her “work through the content” as she often has little memory of what has occurred in sessions, it may not be safe to release the case notes to the client. In the situation where a client who has been doing well over the past six months is moving to another area and requests their file to give to their next psychologist, once one is located, various options might be considered. The most obvious option would be to suggest the client sign a consent form requesting the release of their file to the new psychologist. If the client requests their notes, the psychologist may consider (1) discussing with the client the possibility that their personal information may not be safe and could be read by others without their permission, and (2) if the client is still insistent, inviting them to review the case notes with the psychologist first. This can provide an opportunity to observe the client’s reaction to the material, clarify any misconceptions, prepare the client for the possible detrimental effect of reading case notes, and again address the risk to the safety of their personal information. Ultimately, in most cases, a client does have the right to their notes if requested, unless there is a safety reason for not releasing them or it is inappropriate for the client to have a copy.

### **Illegal Behaviour**

Generally, psychologists are not required to act as agents of the police and inform of illegal behaviours such as illicit drug use, prostitution, theft, vandalism, trafficking, or speeding. However, some situations raise ethical issues, such as how to deal with knowledge about sex with a minor, a 14-year-old female client reporting a sexual relationship with a 16-year-old, drinking while driving, driving without a licence, selling drugs known to have a potential risk of death by overdose, or a young person having unprotected sex while infected with a serious sexually transmitted infection. In certain cases, psychologists should report such behaviour, especially if it falls under section 14 (care and protection) of the Children, Young Persons, and Their Families Act 1989 or when there is risk of serious harm to self or others. Even if a psychologist feels ethically obliged to breach confidentiality, who they should inform may not be obvious. In other cases, reporting may not be necessary, but best practice may be to discuss with the client the importance of taking responsibility for their actions and encouraging them to involve appropriate others. Often these ethical issues need consultation with a supervisor or professional body (for a discussion on supervision see the chapter, on this topic by Howard et al., in this volume). Having no specific guidelines does not mean that an ethical dilemma is not present. Action may be required and flexible interpretation of existing guidelines could be necessary. Openness, sensitivity, and knowledge of the potential risks of these and other behaviours need careful consideration. In these situations, psychologists must consider how the risky behaviour may fit into the broader psychosocial context – the dangerousness and risk of harm to the person – alongside the desire to maintain the therapeutic relationship (Duncan et al., 2012).

## **Working with Children and Young People**

The ethical and legal status of children has changed over time. In the past, when children or young people of any age were regarded as being totally under the authority and control of their parents or guardians, issues of confidentiality or control of their information were addressed directly to the adult, if at all. Current codes of ethics and laws relating to confidentiality of information reflect the present view that, to varying degrees, children and young people can and should be allowed to have a say in what will happen to their personal information that is obtained by health professionals. However, despite the progress made in identifying the importance of considering the rights of children and young people within health care settings (Paediatric Society of New Zealand, 2002), making decisions and providing guidelines about how to manage ethical and legal issues with this age group is complicated by the variability in developmental competencies of children and young people as well as the impact that certain developmental disabilities may have on perceived or real competencies. Therefore, clinicians should make decisions and develop practices that take into consideration the individual development of the client concerned (including the scientific literature on development) and relevant cultural factors.

A psychologist working with young children needs to be especially aware of the language used in the process of obtaining a child's wishes on handling their information. Not only must the language used be appropriate to the child's ability to understand but psychologists also need to be aware that some words may have acquired significant meaning for children. As part of the effort to avoid or reduce the risk of abuse, children are often taught not to keep secrets. A psychologist who offers to keep that child's information "secret" may confuse them, particularly younger children who may, from other contexts such as school or home, have been encouraged not to keep secrets. An operational description of confidentiality may be a means to communicate the options in a way that is less confusing for the child.

### **Consent when Working with Children**

Various factors should be considered when determining a child or young person's ability to consent to assessment, therapy, and/or disclosure of information. A child or young person is legally presumed competent to make an informed choice, give consent to treatment, and separately decide how their information is handled (see Cargo et al., this volume, for guidelines on assessment of children's competence). Obtaining a child's consent to treatment does not imply consent to access of information. These are separate issues that require separate decisions. The clinician should check what (if anything) the child or young person wants their parents, or significant others, to know. This is consistent with the Care of Children Act 2004, which requires that children should be consulted regarding decisions affecting them. As with any client, the psychologist should keep a record of the consent process with children or young people.

The HIPC makes it clear that a competent child can consent to treatment without their parents' consent or knowledge, and that any competent child or young person participating in treatment can choose whether or not to tell their parents, or have their parents told, about their participation or any other aspect of their treatment. The child or young person's identity and health information must be protected in all situations where they have engaged in the therapeutic process without their parents' participation. This protection applies equally to a competent child under 16 years of age (see section 29(1)(d) of the Privacy Act 1993). The child's or young person's health information can only be disclosed by a psychologist where there is a legal reason for disclosure. Most older adolescents have the cognitive capacity to consent on matters of confidentiality encountered by psychologists. The adolescent striving for maturity and independence may need to weigh up, in discussion with the psychologist, what is in their best interests in terms of who is informed and to what extent. The therapist and client should have a discussion at the outset to negotiate a mutual understanding about what information can be confidential and what information may require disclosure (Koocher, 2008). This negotiated process is in keeping with Aotearoa New Zealand's privacy legislation and the Code of Ethics Practice Implication 1.6.10(b) which states that "The level of a child's/young person's emotional maturity and cognitive skills should determine the weight given to their requests and consent to disclose personal information".

If information from other professionals or healthcare providers is required, the HIPC makes it clear that information can be sought from other agencies such as the referrer, teachers, or a general practitioner. Whether or not that agency discloses information depends on the purpose for which it has been obtained and whether or not the child or young person has consented to the disclosure of the information to the agency or professional requesting it. Although not legally required, it is best practice for a psychologist to discuss the rationale for

requesting further information with the (suitably competent) child or young person, and to explain that the other practitioner is authorised to pass on the required information. For example, if a request for information is made to another health practitioner involved in the treatment of an individual, they must provide it in accordance with section 22F of the Health Act 1956, unless they have grounds to believe that the client does not want that information disclosed to the requesting practitioner. Written authorisation should then be sought from the child or young person. When a child or young person's information is provided to another health practitioner, the commentary for Code of Ethics Practice Implication 1.6.10(b) states that "In the situation that a psychologist intends to convey information to a third party, the child/young person should be informed if possible, and the matter should be discussed to a level that is age appropriate".

It is common practice after receiving consent to release information and, on completing an assessment, to send the report to the referring agent as well as others (e.g., GP, school counsellor, other mental health professional). However, many schools, health agencies, and other services in Aotearoa New Zealand have interpreted HIPC Rule 11 to imply that consent to release information to others must be obtained in writing from the parent or legal guardian (the "representative") in the case of a child under 16 and not from the child, regardless of assessed levels of competency. This procedure represents an agency policy and should be followed by psychologists in their employ, but it does not accurately reflect the law, which is most ambiguous when it comes to strict adherence to age cut-offs. With very young children, involving parents in granting release of information would be the best practice; however, with older children, particularly those who are competent and independent, requiring the parent to sign a release for a child's information may not be respectful to the individuation of the child or young person, should that be culturally appropriate. Such agency practice also could be viewed as inconsistent with privacy laws if a competent young person has requested that their health information not be shared with parents but the same parent grants authorisation to release information that they do not have a right to access.

In circumstances where the clinician has assessed the child or adolescent as not competent to consent to a particular action, that individual should, if reasonable, be told who will receive information about them. Section 22F of the Health Act 1956 states that information can be disclosed to a child's representative on request. In this section, "representative" in relation to a child under 16 is defined as that child's parent or guardian. A "representative" is recognised when the client is not regarded as competent, such as a young child or an older child with a developmental delay. The child deemed incompetent should be advised that, in the process of gaining consent from a representative for their assessment and/or treatment, a certain amount of information may need to be disclosed in order for the representative to have sufficient information to grant informed consent on the child's behalf (Kerkin, 1998). However, this section also allows for refusal to disclose, should the person who holds the information believe that the individual about whom the information is held does not want the information disclosed. This refusal would also be in accordance with section 29(d) of the Privacy Act 1993. In consequence, if a young person under 16 has requested that health information not be disclosed, and the information does not fall within the limits of confidentiality (see below), then the professional should not disclose it.

Only under circumstances where the child needs a representative (usually for reasons of limitations of competence) can someone else exercise the child's right to access their information or to consent to information being provided to others. When they do so, they are acting on the child's behalf and in that child's best interest. However, should the child's information include information about identifiable others, such as other family members, the information on others must be deleted prior to its release unless permission for its release has specifically been obtained from the affected parties. If the information has been requested and it is appropriate to disclose, then the information must be provided within 20 working days (HIPC Rule 6). The HIPC also delineates when information about any client, regardless of age, can be withheld. Whether the person making the request is a child or young person, or when it is someone representing them, they are entitled to access the information, but the rule does not determine ownership of documents.

### **Disclosure of Information to Parents**

Although the laws and codes of ethics now grant greater autonomy to children and young people regarding who can be involved in their care and who can have access to health information, it is usually best practice to involve parents in the treatment of children and young people, and most agency policies require this. Many empirically supported treatments used by clinical and educational psychologists with children (e.g., Parent Management Training, Problem-solving Communication Training, Functional Family Therapy, and Multi-

systemic Therapy) include the family, schools, and wider community as part of the treatment protocol. Consequently, if a young person refuses to have the family involved, the clinician must weigh the importance of keeping practice in line with Practice Implication 2.2.4 of the Code of Ethics, which outlines the need to rely on scientifically derived information, and Practice Implication 1.6.9 that outlines the right of the individual to keep the therapy confidential. Ultimately, in order to ensure the best possible success when treating this population, it is appropriate, and indeed in keeping with published guidelines (Hershell, McNeil, & McNeil, 2004), to encourage a child or young person to discuss matters with their parents and to include the parents in at least part of the assessment and therapy. Although a child may not want their parents to know about certain aspects of their lives, an open discussion early on can often address the majority of the child's concerns. Such a discussion can include the necessity of some disclosures as well as the rationale for having dialogues with parents, thereby facilitating a mutual agreement between the psychologist and the child as to how to handle information and how ultimately some disclosures may be of benefit to the child and actually be in their best interests (and in so doing, be in keeping with the Code of Ethics).

This recommended practice may be more problematic in individual work with an adolescent and, if the child or young person refuses such consent to inform, under the HIPC, services cannot be withheld for that reason. It may then be the case that the psychologist has the role of encouraging the parents to accept the value of their child's autonomy and ability to form independent relationships. Therapy should then be adopted to suit the circumstances as far as possible. As well as preserving confidentiality, such negotiation may enhance the relationship between the maturing adolescent and their parents.

Payment for the service by a parent does not grant them rights to the child's health information. Given that contracts with minors (aged under 20) are not always enforceable (Johnson & Perry, 2004; Minors' Contracts Act 1969), it is not in the psychologist's best interests to engage in a contract for payment with a minor who does not have an income of their own. Regardless of who pays, confidentiality continues to apply and information cannot be given if a competent child requests that it not be provided (Johnson & Perry, 2004). The best way to proceed regarding any work with children and youth is to make the limits of confidentiality clear to all parties at the outset.

### **Discretion to Disclose when Working with Children**

*Child abuse.* Sometimes the law permits a psychologist discretion to disclose confidential information about a client. This is identified by the use of the word "may" rather than the mandatory "shall" or "must" as it relates to disclosure in relevant Acts. However, section 66 of the Children, Young Persons, and Their Families Act (CYPF) 1989 provides that a government department, which includes a psychologist working for such a department, may be required to supply information if it is considered relevant in investigating a report made under section 14 of the Act, indicating that a child may be in need of care and protection. Information obtained in this way can only be used for this specific purpose and cannot be used for investigating an offence.

In cases of suspected child abuse, Aotearoa New Zealand law gives discretion to disclose, with some recent notable exceptions based on revisions to the Crimes Act 1961. The CYPF Act 1989 allows for the reporting of any suspicion of abuse of a child (under 14 years) or young person (over 14 years but under 17 years as long as the young person is not married) to CYF or the police, should it be deemed that the child is in imminent danger. This is supported by the Code of Ethics (Practice Implications 1.6.10c and e). Although the reporting is not mandatory, policies at various schools and health agencies may require mandatory reporting by their staff. Whether to inform the child or their family of the reporting is determined on a case-by-case basis. There are some risks involved in informing the family, especially if it places the child at further risk. Knowledge of the clinical literature on assessing risk of violence may assist in determining whether the threshold for immediate harm has been reached (Ministry of Health, 2002). However, it can be a relief for a parent or parents to know the child is going to be protected. Through the process of informing parents of the need for reporting, alternative solutions might be identified that would not otherwise have been considered. Having an open and honest discussion before therapy starts can minimise the possibility that such a breach will have a lasting negative impact on the young person and their family (Duncan et al., 2012).

However, deciding when to report child abuse is by no means an easy decision, although changes to sections 59 and 195A of the Crimes Act 1961 may make reporting decisions easier. The revision to section 59 no longer allows parents to use force for the purposes of correction, so there is no ambiguity about whether the presence of force was for the purpose of discipline and whether it is child abuse. Psychologists working with children

need to be aware of the changes to section 195A of the Crimes Act that came into effect in March 2012, and the implications these changes have on the duty to inform when a clinician suspects child abuse. Section 195A creates potential criminal liability for a failure to protect a vulnerable person from the potential actions of others, so provides for a crime of omission, rather than the more usual crime of commission. The Act now explicitly states that a person who is a staff member of any hospital, institution, or residence where the victim resides must take adequate steps to protect a child or vulnerable adult. If such a child or vulnerable adult is known by the staff member to be at risk of death, grievous bodily harm, or sexual assault as the result of an unlawful act by another person or omission by another person to discharge or perform a legal duty, then the staff member will be liable to a maximum penalty of 10 years' imprisonment.

The Vulnerable Children's Act 2014 is a further attempt to ensure the safety of children and protect them from abuse and neglect. The implications for psychologists (along with all people employed or engaged in work that involves regular contact with children) are that all psychologists must be safety checked in order to work with children. It also has implications for confidentiality by legislating that district health boards (DHBs) and other child services develop a child protection policy that will result in greater sharing of information amongst agencies in order to improve the identification and reporting of child abuse and neglect. This has led to the development of "Approved Information Sharing Agreements" under the Privacy Act 1993 that provide a framework for the secure and confidential sharing of information in order to identify vulnerable children (Information Sharing Agreement for Improving Public Services for Vulnerable Children, 2015). This process for identifying vulnerable children is currently in the early stages of development.

*Past abuse.* Another complex issue for clinicians is that of past abuse. There is no ethical or legal duty to report historical abuse and it is likely that most clinical and educational psychologists would not do so given the complexities involved in making such a report. The law and the Code of Ethics only offer clear direction concerning future harm. To report past abuse could lead to a complaint of an unjustified breach of confidentiality. However, if past abuse of one individual may be indicative of current or potential abuse of another, particularly a child, reporting should be seriously considered. For example, if a client reports being sexually abused by a family member until three years ago but there is another child still in the home with the alleged perpetrator, the psychologist may need to consider disclosing that information to ensure that the other child is safe. Should there be suspicions that this child is not safe, a report to a CYF's social worker or the police, using the appropriate sections of the Children, Young Persons, and Their Families Act, may be warranted.

## Other Specific Contexts

In addition to the various limits to confidentiality, there are also particular contexts in which psychologists work that give rise to other confidentiality issues. This section briefly discusses some of these additional considerations, although is not intended to be exhaustive.

## Working in Specific Settings

Psychologists work in a variety of settings, some of which can present challenges to confidentiality and privacy. This is particularly so where the nature and demands of the agency compete with the needs of the client, such as the military, government agencies, schools and universities, prisons, or when the "client" is an agency such as a company employing an industrial/organisational psychologist. Koocher and Keith-Spiegel (2008) talk of "juggling porcupines" at times in such agencies (p. 340), and others consider psychologists in some settings, such as the military, to be "in service of two masters" (Jeffrey, Rankin, & Jeffrey, 1992, p. 91) because of their dual roles as psychologists and military officers. In Aotearoa New Zealand, defence psychologists must adhere to the regulations of the Ministry of Defence as well as the Code of Ethics. Military regulations can sometimes conflict with professional ethical codes regarding confidentiality, such as when a psychological evaluation has implications for fitness for duty, or where there are issues of ownership and access to records (Jacques & Folen, 1998). These issues are also relevant for psychologists working in the Department of Corrections, forensic, educational, and industrial/organisational settings (Sharkin, 1995; Weinberger & Sreenivasan, 2003). In these contexts, psychologists need to properly manage the dual demands of the Code of Ethics and regulations of the specific workplace. It is important to discuss potential problem areas with colleagues, supervisors, and relevant others when starting work in a new setting, and to discuss with clients the limits of confidentiality relevant to the agency (Koocher & Keith-Spiegel, 2008). There may still be situations where the psychologist questions the appropriateness of certain institutional rules, in which case practice should prioritise ethical principles and legal

requirements.

Psychologists who reside and work in rural areas or small communities face additional challenges to confidentiality, especially with regard to dual relationships, given the increased likelihood of overlapping social, business, professional, and personal relationships inherent in such a community (Hargrove, 1986; Schank & Skovholt, 1997; Werth, Hastings, & Riding-Malon, 2010). Both psychologist and client should maintain appropriate roles with clear expectations and boundaries to avoid misunderstandings, given that contact outside the professional relationship cannot be closely controlled. Schank and Skovholt (1997) suggest obtaining informed consent, keeping to time limits, protecting confidentiality, documenting any overlapping relationships, and declining social invitations that compromise professional boundaries. Training for administrative staff on maintaining confidentiality in rural settings is critical (Allott & Lloyd, 2009; Werth et al., 2010).

### **Working for Third Party Funders**

Psychologists face particular challenges to confidentiality and privacy when working for third party payers such as the Accident Compensation Corporation (ACC) and private insurance companies. Although the information belongs to the client, it has been collected for the funder, which can raise issues about the funder's access to information as well as who is the client. Briefly, only that information directly relevant to the referral question should be provided, and decisions about releasing information should be in the client's best interests and with the client's consent, where the client is the person referred for psychological services. The Board's guidelines on record-keeping note that the information and report is the property of the third party contractor and must not be released to the client without the contractor's permission (New Zealand Psychologists Board, 2011). In cases where people additional to the contractor may have access to the client's information, the psychologist needs to explain the purpose for which the information is being gathered, the associated impact on confidentiality, and the circumstances regarding storage of and access to records (New Zealand Psychologists Board, 2011).

### **Working in a Multidisciplinary Team**

Many psychologists in Aotearoa New Zealand work in multidisciplinary teams, especially within DHB services. Maintaining confidentiality and client privacy can be difficult in a multidisciplinary medical or mental health setting because professionals from other disciplines work with the same clients and may have legitimate reasons to ask psychologists for client information. It can often be difficult to balance the provision of information within the team with a client's desire to retain information provided to one team member as confidential (Tan, Passerini, & Stewart, 2007). In the majority of cases, sharing information freely with other team members is generally acceptable to a client if the reason for it is discussed openly from the outset. Many workplaces have established policies regarding withholding or sharing of information within a team. According to Right 4(5) of the Code of Health and Disability Services Consumers' Rights 2004, all health providers are obliged to work as a team and ensure proper communication and co-operation. Practice Implication 2.1.12 of the Code of Ethics notes that psychologists provide services that are coordinated and avoid duplication, and communicate with other providers within the bounds of confidentiality and informed consent. However, there may be cases where the development of the therapeutic relationship can be ruptured if the client is aware that particular items of their information are being supplied to others, even if those others are also involved in aspects of their care. In situations such as these, it is essential to discuss and negotiate such issues with the client and the team. Being open with all involved should address any concerns that withholding of certain information is not in the best interest of the client or the team. In situations where not sharing information could result in ineffective overall care, some information will have to be shared with the clinical team, regardless of the client's wishes.

### **Court Summons or Subpoenas**

Psychologists may be issued with a subpoena or summons to appear in court when specific information about a client is required in court proceedings. Although the psychologist is generally aware of the potential for receipt of a court summons in their dealings with current clients where there are matters before the court, it is possible for this to occur unexpectedly, either from opposing legal counsel, or in respect of a former client (Knapp & VandeCreek, 2012). For example, a search warrant can be issued to uplift a physical file. It is an offence to impede a valid search under a search warrant and it is an offence not to answer a court summons. On receiving a court summons, it is essential that the psychologist contact the client (or former client) to determine the client's wishes. If the client wants their records entered into court, the psychologist should advise them (and perhaps

also their lawyer) what information is likely to be disclosed. Written consent to proceed should be obtained once the client has a clear understanding that, if they allow any part of their private information to be entered into court, they may not be able to selectively enter only some of the content of their records. The judge may agree to withhold some parts of records that are clearly not relevant to the matters before the court, but this is by no means certain (Knapp & VandeCreek, 2012).

Psychologists should be aware that receiving a court summons does not automatically compel them to supply the requested information to the court. If they do so without the informed consent of their client, they are in breach of their professional ethics. Instead, they should acknowledge the summons and advise the court as to the reasons for any non-compliance, citing legal privilege (Knapp & VandeCreek, 2012).

### **Court Orders**

Although psychologists may not be compelled to supply client records to the court when requested by summons, a court order requires provision of requested information, and can be more likely in situations where the original assessment or treatment was court ordered. A court order is a document signed by a judge who has determined that the requested information is germane to the court proceedings and not protected by legal privilege. Failing to comply with a court order puts the psychologist in contempt of court, possibly leading to financial or other penalties as determined by the judge (Knapp & VandeCreek, 2012). However, if the psychologist believes that complying with the court order violates the client's legal privilege, they may present a case to the judge requesting reconsideration of the situation. The psychologist would need to convince the judge that, on balance, disclosure of the privileged communication would do more harm than good (Knapp & VandeCreek, 2012). It may also be prudent to clarify the information being requested. That is, there may be an obligation to release some information to answer a particular question being addressed by the court but this may not imply the psychologist has the obligation to release *all* information they have about the client.

### **Assessment and Test Data**

The confidentiality of test data gathered by psychologists in the process of assessment presents special issues, especially when there is a request for records by the client or a third party. In addition to copyright laws, Practice Implication 2.1.4a of the Code of Ethics states that "Uninterpreted data from assessments is not normally released to persons who are not specifically trained in the use and interpretation of the instruments concerned". Information Privacy Principle 8 of the Privacy Act 1993 notes that an individual's personal information should not be used without ensuring that the information is "accurate, up to date, complete, relevant, and not misleading" (p. 23). When requests from third parties are received, psychologists need to decide whether information should be released and to whom. If information release is appropriate, psychologists should have clients give written consent to release specific test information, and be careful to release only the information necessary to satisfy the inquiry (Miller & Evans, 2004). Raw scores and copies of protocol forms can only be released to other psychologists or other appropriately trained professionals. Untrained persons who have consent to access the results should only be provided with clear interpretations of the results.

Clients may ask to see test results, and the appropriate response to such a request depends on many factors, including the particular circumstances of the client, the assessment, and the tests used. An important part of any assessment is providing feedback to the client. If appropriate and useful, test materials and profile forms may be shown to the client in the process of providing feedback. Clients should not be given copies to take away, but a brief written summary of the results may be helpful (Knapp & VandeCreek, 2012).

Security of test materials is another issue related to confidentiality, especially considering that, despite copyright protections, information about test materials sometimes finds its way into the public domain, including being posted on the Internet (Knapp & VandeCreek, 2012). For example, Ruiz and colleagues (2002) found that 2–5% of websites identified by three psychology graduate students and two non-psychologists posed a direct threat to the security of psychological tests. One psychologist had posted the test stimuli for many popular neuropsychological tests, such as the Mattis Dementia Rating Scale, on a website. Another website contained accurate facsimiles of the Rorschach Inkblot Test cards and detailed information on their interpretation, and a set of Rorschach plates were for sale on a popular auction site. Psychologists should take responsibility for ensuring that only qualified people have access to secure test materials held within their workplace (Tribbensee & Claiborn, 2003).

## **Internet Therapy, Email Communication, and Use of Social Media Networking**

Although the rapid advancement in computer technology has distinct advantages, there are also important limitations to the confidentiality of electronic communications using email or the Internet. Koocher and Keith-Spiegel (2008) refer to problems with “cyber confidentiality” (p. 133) and the many ways in which the use of technology such as email, texting, video clips, messaging, chatrooms, online message boards, online phone systems, Skype services, facsimile, and laptop computers can present challenges to confidentiality and privacy, in often very subtle ways. The use of telephones, answering machines, voicemail, and pagers are also relevant here. Psychologists should do as much as possible to ensure the confidentiality of information transmitted by electronic means. It is the sender’s responsibility to make sure that a message is delivered in a way that it can be kept confidential, perhaps by calling to check that the appropriate person can retrieve the information (Corey et al., 2010). It may be safer to assume, when talking to a client by cell phone, that the client is not in a private place and that the conversation may be intercepted by an unauthorised person (Corey et al., 2010).

Communicating via email and the Internet has many pitfalls in terms of possible confidentiality violations, many of which may be beyond the psychologist’s control. It may not be possible to clearly establish that the recipient of the information is the one intended, messages can be mistakenly sent to the wrong person, and communications made outside of a secure network can be intercepted (Anthony & Goss, 2003; Shapiro & Schulman, 1996). A useful preventative measure is to discuss with clients how best to communicate between appointments and how to leave messages for them (Corey et al., 2010), as well as to remind clients who use email that no such communications are private or confidential (Nagy, 2005; Shapiro & Schulman, 1996). Other authors have outlined the additional problems of confidentiality when psychologists conduct therapy online or in discussion groups, chat rooms, and sites where individuals can ask questions of an expert (Evans, 2014; Hill, 2003; Humphreys, Winzelberg, & Klaw, 2000). Although this appears to apply predominantly to countries other than Aotearoa New Zealand, there is likely to be increasing use of online technologies in Aotearoa New Zealand, and many psychologists already use email or text message to make appointments or send brief messages. The Psychologists Board guidelines (2012, December) on the practice of telepsychology provide detailed consideration of the issues associated with using online and other technologies in psychological practice.

Use of social media has rapidly expanded in recent years and presents both opportunities and challenges for psychologists. Psychologists who choose to participate in social media should be aware of the potential risks in doing so, whether the use is for professional or personal reasons (Kaslow, Patterson, & Gottlieb, 2011). The recent Board guidelines (August 2013) on maintaining professionalism when using social media networking are an excellent resource for psychologists, and cover issues of the professional uses and risks of social media, confidentiality, defamation, boundary violations, knowledge about the psychologist, client privacy, responsibility when there is a known risk of harm, privacy settings, employer checks, and cyber-bullying.

## **Group, Couple, and Family/Whānau Work**

Maintaining confidentiality can become particularly complicated when undertaking work that involves more than one person. Although effective group work is dependent on client confidence being respected, clients are not formally obliged to maintain the confidentiality of other clients (Aveline, 2003; Glass, 1998). As facilitators of group work, psychologists can discuss the importance and limits of confidentiality with clients at various points throughout the group process (Corey et al., 2010) and develop a mutual confidentiality agreement, however such an agreement is in no way enforceable. As noted by Glass (1998), there is a need to explain “the complexities inherent in their shared responsibility for maintaining group confidences” (p. 114).

Work with couples and families/whānau presents unique issues of confidentiality given that the participants have established relationships outside of the sessions with the psychologist. Issues arise when one person wants to disclose information to the psychologist in the absence of the partner or other family/whānau members, and expects the information to remain in confidence. This might include information about past relationships, abuse, substance use, extra-relational affairs, or HIV/AIDS status (Thorp & Fruzzetti, 2003). In these situations, the psychologist’s responsibility is to the couple or family/whānau as a whole. Individual disclosures can create an imbalance in the therapist’s alliances and could be seen as collusion.

Many psychologists arrange for information to be disclosed only in couple or family/whānau sessions, except when adults need to discuss issues that are inappropriate to review in the presence of children (Tribbensee &

Claiborn, 2003). Psychologists should discuss confidentiality and its limits at the start of contact with the couple or family/whānau and provide reminders as appropriate during the course of the contact. It is also important to recognise that clients may have different understandings of confidentiality that relate to their culture and value systems (Hill, 2003). For example, provided informed consent has been given, the family/whānau may direct particular practices that are appropriate for the tikanga (customs/traditions) of the group, such as Māori. Requests to disclose information privately need to be handled with the best interests of the couple or family/whānau in mind. Burnham, Cerfontyne, and Wynn (2003) suggest that, for between-session contact (such as telephone calls), the person is asked if they can delay giving the information until they have been asked questions such as: *Do the other people know that you have called? How will they learn of it? How would it be if you talked about this in the next session? How will it help for me to listen to this information?* Psychologists working in the area are encouraged to familiarise themselves with issues of confidentiality in work with couples and families/whānau (e.g., Weeks, Odell, & Methven, 2005).

### **People with Intellectual Disabilities**

The issues of confidentiality relevant to working with people with intellectual disabilities overlap with those of other vulnerable populations. (For a detailed explanation of confidentiality when working with this population, see the chapter by Skirrow and Mathieson in this volume).

### **Record-Keeping**

Regardless of the setting or specific client group that makes up the work of psychologists, there is an ethical and legal requirement to keep records of that work, which raises additional issues of confidentiality and privacy. Psychologists working in Aotearoa New Zealand should be familiar with the guidelines on keeping records of psychological services that were adopted by the New Zealand Psychologists Board in November 2011.

### **Purpose and Content of Records**

Psychologists maintain records of their work with clients for various purposes, including service planning, implementation, and documentation, self-monitoring by the psychologist and/or other agency, financial, and legal reasons (American Psychological Association, 1993). Koocher and Keith-Spiegel (2008) state that: “. . . in a legal sense, if it was not written down, it did not happen” (p. 138). The APA considers records to include “. . . any information (including information stored in a computer) that may be used to document the nature, delivery, progress, or results of psychological services” (1993, p. 985). The APA guidelines on record-keeping outline the minimum information to be included in records of psychological services as identifying data, dates of services, types of services, fees, any assessment, intervention plan, consultation, reports, appropriate supporting data, and any release of information obtained. In Aotearoa New Zealand, the Standard for Health Records (Standards New Zealand, 2002), which applies to all health records kept by health and disability service providers, emphasises the provider’s responsibility in maintaining client privacy and encourages organisations to develop policies for health records that address the issues outlined in the Standard, such as minimum record requirements and retention of records.

All client-related contacts should be recorded, including telephone calls and electronic communication. Records should clearly indicate the source of information, especially where people other than the client have provided information. Soisson, VandeCreek, and Knapp (1987) describe the “documentation of significant decisions and events” including the goal of the decision/event, rationale, risks and justification, alternatives that were considered and rationale for their rejection, and steps taken to improve the effectiveness of the chosen treatment (p. 500). They also note the importance of deciding what not to document, in that “. . . records should exclude emotional statements and other personal opinions. Information about illegal behavior, sexual practices, or other sensitive information that may embarrass or harm the client or others is rarely appropriate for the record” (p. 500), unless it is directly relevant to the client’s presenting concerns. The Code of Ethics states that:

Psychologists record only that information necessary for the provision of continuous, coordinated service to a client, or for validating or identifying conclusions in a report, or for the goals of the particular research study being conducted, or which is required by law. (Practice Implication 1.6.5.)

Records should be kept in sufficient detail to enable another psychologist to take over service provision, as well as to inform any regulatory or administrative review. Psychologists are responsible for the organisation, legibility, and timeliness of records. When adding to the client's record, psychologists should always bear in mind the purpose of the information and who will (or could) have access to it. Client access to records may be denied if this could be harmful to the client, however, "...psychologists should generally assume that one's clients will eventually review their records" (Soisson et al., 1987, p. 501). Specific agencies may also have particular record-keeping practices of which psychologists need to be aware.

In addition to informing the client about general issues of confidentiality, it may also be appropriate to discuss confidentiality of client records and relevant limitations at the client's request, if the need arises, or as part of a general discussion of confidentiality and its limits. As noted by Tribbensee and Claiborn (2003), clients may not be fully aware of the complete contents of their records or of the potential consequences of releasing records to third parties. In the event that a client requests that their record be sent to others or they are considering a request from a third party to release their records, psychologists should assist the client to anticipate and understand the possible consequences of such a release.

Practice Implication 1.6.6 of the Code of Ethics notes that psychologists need to take steps to maintain the security and confidentiality of client records, regardless of whether they are written, typed, computerised, or stored in any other medium, such as audiotape or videotape. Nagy (2005) encourages psychologists to "... be vigilant about confidentiality when creating, storing, accessing, transferring, moving, or interacting with your records in any way" (p. 154). Storing records on computers requires additional security considerations to those that are more obvious with paper filing systems, and can be aided by using firewalls, antivirus software, password protection, and backing up files on an external hard drive (Nagy, 2005). Such strategies help to reduce the chances that a computer crash or related event will corrupt files. Practices relating to where records should be kept vary throughout Aotearoa New Zealand and within specific settings. For example, some psychologists working in hospital-based mental health settings keep separate files for psychological material, particularly test protocols and raw data.

## **Retention of Records**

Practice Implication 1.6.7 of the Code of Ethics stipulates that "Psychologists retain information as defined in current legislation or ethical guidelines (for research data)", and Practice Implication 1.6.8 states:

Psychologists take all reasonable steps to ensure that information over which they have control remain [sic] retrievable as long as is necessary to serve the interests of those to whom they refer and/or the purpose for which they are collected, or as required by law.

The Health (Retention of Health Information) Regulations 1996 enforced on 1 January 1997 require providers of health services to retain client information for at least ten years, starting from the day after the most recent treatment. This requirement applies whether or not (1) the provider holding the information has been the most recent provider, (2) the information came into existence before the regulations were initiated, or (3) the information includes material that came into existence before the beginning of the ten-year period. The obligation also transfers if records are transferred to another provider or organisation. Records should be retained for longer periods where there is good reason to do so, and this often includes mental health services, obstetrics, and services to children (New Zealand Psychologists Board, 2011). Psychologists should also make themselves familiar with the record-keeping policies and practices of their workplace. Psychologists in private practice need to make provision for retention and safe storage of records before retirement (New Zealand Psychologists Board, 2011). Client welfare is another relevant factor when considering retention of records, including the client's need, the benefit to the client of the records, and any risks of records, such as when they contain obsolete or potentially harmful information.

The Regulations do not specify the form in which records must be retained. As noted in the New Zealand Psychologists Board (2011) guidelines on record-keeping:

If the medium in which they are held is likely to deteriorate to an extent that it places in doubt that the records will be able to be read or retrieved over the time period, it is sufficient to keep an accurate summary or interpretation of the original records (p. 5).

A section on storage of records on cloud computing services was added to the Board's (2011) guidelines in March 2014, which reiterates the responsibility of the owner of the records to ensure the ongoing safety and security of the records, in accordance with the Privacy Act 1993. The guidelines provide useful information pertaining to issues associated with the process of moving client records to such a storage facility and to another storage provider.

### **Best Practice Recommendations**

When considering the concepts of confidentiality and privacy, their limitations, and their application in different work settings, various generally appropriate recommendations can be made.

1. Psychologists can minimise ethical conflicts by discussing the limits of confidentiality with the client at the start of the professional relationship. The specific nature of this discussion depends on factors, such as the age of the client, although the basic information to be communicated (ideally in writing as well) should include:
  - the confidential nature of the discussion,
  - informed consent and determinations of competence,
  - limits to confidentiality related to the safety of the client and others, including the process of how information will be released when necessary for reasons of safety,
  - the role of clinical supervision,
  - the sharing of information if the psychologist works in a multidisciplinary team,
  - information about how records will be maintained in the agency (including how they are protected),
  - information about any reports that will be provided to third party payers, and final ownership of records in this case, and
  - limits to confidentiality when the psychologist is employed by an agency that has some degree of authority over the client such as military, occupational, and prison psychologists.
2. Information should be restricted unless the client consents or unless their competence to do so is limited by developmental or other factors. If competence is reduced, the client should still be informed of who will be given what information. A psychologist working with children should assess, and periodically reassess, a child's competence to consent to how information will be handled, taking into consideration both the child's wishes, assessed level of competence, and what practice would ultimately be in that child's best interests.
3. Consent to treatment or consent to participate in research, and consent to disclose information are separate decisions, whether made by an adult or a child.
4. When responding to safety issues, psychologists are encouraged to work as much as possible within the parameters of informed consent in the first instance. When this does not resolve the issue, consultation with a supervisor and/or colleagues is recommended. When disclosing information for safety reasons, disclose only that information necessary to ensure the safety of the client or third party, and only to those directly involved in the safety of the person at risk.
5. The safety needs of children are paramount, and psychologists have a duty to protect these vulnerable clients. Disclosure should only be made to those who can make the child safe. A history of abuse or other risk would be grounds to disclose without consent if it indicated that another person, such as another child in a family, is still at risk of harm.
6. When writing reports or letters, only include information relevant to the purpose of the communication, so as to minimise intrusions on privacy.
7. Psychologists need to protect their client's privacy in response to enquiries from third parties by communicating that professional ethics dictate the inability to confirm or deny whether the individual named is a client or to discuss clients with others.
8. Except in emergencies or in response to a court order, psychologists should obtain written consent from

clients before disclosing or releasing information.

9. The location in which a psychologist works should ensure privacy and confidentiality by being soundproof, private, and designed to avoid inadvertent disclosure of a client relationship such as use of agency vehicles that feature company logos when visiting clients in the community, use of letterhead stationery (especially envelopes) in sending mail to clients, and respecting privacy when leaving answerphone messages. It is the responsibility of psychologists to ensure that their supervisees, office staff, and other professionals are aware of their responsibility to maintain confidentiality and security of records (Knapp & VandeCreek, 2012). Knapp and VandeCreek suggest that establishing a “culture of safety” in the workplace is the most effective way to prevent breaches of confidentiality (p. 117).
10. When there is a possibility of meeting a client in a situation outside of the professional context, such as in a small community, rural mental health, and some education settings (e.g., a university student counselling service), psychologists should discuss this with the client at the first session and ask whether they would like to be greeted should there be an incidental encounter. Psychologists can advise the client that they will respond with a brief greeting if the client initiates the contact, but will not initiate contact themselves (Swenson, 2006). The psychologist’s behaviour should prioritise the client’s treatment, not the personal relationship (Swenson, 2006).
11. When psychologists use client information for teaching purposes, any identifying details must be changed. It is not sufficient to change the name of the client when other information may pose the risk that they will be recognised by specific details (Nagy, 2005). In some cases, a composite or fictitious case may be the best approach.
12. The obligation to preserve confidentiality continues after the end of the psychologist’s professional contact with the client. Removal of client status does not absolve the psychologist from ethical responsibilities, including maintenance of confidentiality.
13. Client records, in whatever form, need to be protected from casual disclosure or deliberate intrusion through the use of locks, passwords, and other forms of secured access. When a psychologist retires or an agency is closed or merged with another, the psychologist must arrange for ongoing safe storage of records while preserving access for the client and any legitimate authorities (e.g., Health and Disability Commissioner in the event of an inquiry).

## Conclusion

In this chapter, we set out to highlight the major ethical and legal concerns for psychologists working in Aotearoa New Zealand specifically as they pertain to issues of confidentiality and privacy. The current climate in which psychologists work raises ethical issues of confidentiality that can sometimes be complex and not easily resolved. The issues are further complicated by the understanding that confidentiality is not a unitary concept but perhaps better considered as a continuum, from absolute confidentiality at one end, followed by absolute confidentiality for limited types of information, confidentiality except for exceptional circumstances, confidence revealed only to other professionals, through to no specific confidentiality at the other extreme (Fisher, 2008, 2012; Francis & Cameron, 1997). Further complicating matters is the fact that confidentiality is “heavily constrained by contextual factors” (Jenkins, 2005, p. 63), such as the setting in which the psychologist works and the type of client.

Laying out the legal and ethical complexity and ambiguity involved is unlikely to make an individual practitioner’s decisions any easier. It is tempting to follow the increasing set of rules and laws in order to reduce risk to oneself rather than to focus on the client and the risks to them (Donner et al., 2008). The aims of this chapter are to clarify the related concepts of privacy, confidentiality, and privilege, outline the aspects of the Code of Ethics and relevant legislation that pertain to confidentiality and privacy, and suggest practices that minimise the possibility of confidentiality issues arising, as well as ways of avoiding breaches of confidentiality in one’s practice. In so doing, we also hope to increase psychologists’ sense of competence in dealing with matters of confidentiality and privacy.

Additional issues highlighted relate to the variety of work done by psychologists in different contexts and with different client groups, and there will no doubt be other issues not covered here. Regardless of the range of work done by psychologists in Aotearoa New Zealand, psychologists are encouraged to (1) create a safe environment

through the quality of the relationship and the sensitivity that they show to disclosures from the client, (2) be meticulous about keeping client information confidential, and (3) preserve trust by taking care to inform clients of the limits of confidentiality at the outset and about the ways that information will be handled in grey areas where therapeutic discretion is required (Knapp & VandeCreek, 2012). The unique nature of each client and the potential conflict between ethical codes, agency policy, and relevant legislation mean that professional judgement always plays an important role in resolving ethical conflicts regarding confidentiality.

When making suggestions about ethical decision-making, it is easy to appear to be offering simplistic solutions to what are, by definition, complex, ambiguous, and value-laden situations that contain a significant potential for harm. We have made no attempt to unravel or over-simplify either the legal and ethical issues involved or the actual decision-making process. We cannot remove the frightening aloneness and sense of responsibility that can sometimes be experienced by a psychologist facing a difficult ethical dilemma, especially one involving vulnerable clients such as children. However, greater awareness of the issues involved and of the values an individual psychologist brings to the decision-making process can add to the continual process of refining ethical decision-making. There are rarely best answers in ethical and legal decision-making, and a good enough decision, whether as the result of good implicit habit or careful deliberation, is the only reasonable aim. In ethical decision-making, an aim to achieve “the best” (i.e., perfect or ideal) is often the “enemy of the good” (Simon, 1991). Only consistently reflecting on our daily practice can we become more explicitly aware of the powerful influence that personal views and Western culture have on the practice of psychology.

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## **PROFESSIONAL PRACTICE OF PSYCHOLOGY IN AOTEAROA NEW ZEALAND**

**Edited by: Waikaremoana W. Waitoki, Jacqueline S. Feather, Neville R. Robertson & Julia J. Rucklidge**

This book is a major revision of the previous edition of the New Zealand Psychological Society's professional practice handbook. It represents the continuing evolution of psychology in Aotearoa New Zealand which has been shaped by the interaction of international theory and practice, te ao Māori and the cultural realities of newer peoples.

The 34 chapters cover a vast range of psychology topics and contexts all of which promote safe and ethical practice of psychology in Aotearoa New Zealand with reference to Te Tiriti o Waitangi/the Treaty of Waitangi and the *Code of Ethics for Psychologists Working in Aotearoa New Zealand/ Te Tikanga Matatika, Mā ngā Kaimātai Hinengaro e mahi ana i Aotearoa/New Zealand*.

The editors and authors have cast their vision beyond the self to reflect on the diverse historical, structural, cultural and environmental factors that have an impact on health and wellbeing and on the practice of psychology in Aotearoa New Zealand. At the same time this is a handbook which provides insights into issues that are at the heart of the day to day practice of psychology.

This new edition of *Professional Practice of Psychology in Aotearoa New Zealand* will interest anyone who wishes to know more about the rich, unique and diverse practice of psychology in Aotearoa New Zealand.



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