Hot Topics in Ethics and Risk Management in Psychological Practice

The Trust 6 Hours CE Credit

Registration
Introduction to Ethical and Legal Decision Making

Risk Management Hot Topics:
• Who owns the kid?
• Who owns the records?

Break
Risk Management Hot Topics:
• My patient committed suicide.
• Help! I’ve been yelped.
• I have to testify in court.

Lunch
Risk Management Hot Topics:
• We are not getting along.
• I’ve got a secret.
• My patient is leaving town.

Break
Risk Management Hot Topics:
• I lost my computer.
• Who is my boss?

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The Trust Risk Management Program

- Workshops
- Advocate consultation service
- Case Review Process
- Assessing & Managing Risk in Psychological Practice
- Website resources
- Policy enhancements
  - Deposition representation
  - Regulatory coverage including Medicare & Medicaid audits

Ethical and Legal Decision Making
Ethical Fundamentals, Beauchamp and Childress, 2008

- Beneficence
- Nonmaleficence
- Autonomy
- Justice
- Rules for Professional-Patient Relations
  - Fidelity
  - Veracity
  - Confidentiality
  - Privacy

ASSESSING AND MANAGING RISK IN PSYCHOLOGICAL PRACTICE:
An Individualized Approach
Bloom's Taxonomy

- Knowledge
- Comprehension
- Application
- Analysis
- Synthesis
- Evaluation

The Trust Risk Assessment Model

- Patient Risk Characteristics
  - Nature of problem
  - History
  - Diagnosis and level of function
  - Expectations
  - Therapeutic readiness
  - Financial Resources including insurance coverage
  - Litigiousness/court involvement
  - Social support network

- Situation or Contextual Risk
- Therapist's "Personal Toolbox" Characteristics
- Potential Disciplinary Consequences
The Trust
Risk Assessment Model

Situation or Context
• Nature of relationship
• Real world consequences
• Setting (rural v. urban, solo practice v. institutional practice)
• Type of service requested
• (CBT, Family therapy, Forensic Evaluation)

Therapist “Tool Box”
• Psychological makeup/personal issues
• Personal & professional stress levels
• Training background/qualifications
• Experience
• Resources (e.g., consultation, access to other providers, involvement with professionals and professional groups)
• Computer & internet savvy

Risk Management Skills/Discipline
• Risk assessment skills
• Documentation skills and implementation
• Willingness to seek and follow good advice
• Knowledge of Ethics Code and ability to analyze situations from an ethical perspective
• Limit setting abilities
The Trust Risk Assessment Model

Potential Disciplinary Consequences
- Dependence on third party reimbursement
- Risk of specific conduct (sexual intimacies, dual relationships, business relationships)
- Legal restrictions (civil, criminal, administrative)
- Previous complaints/lawsuits
- Licensing board characteristics

Elements of Risk Management

Know the legal and ethical standards governing practice
Provide comprehensive informed consent
Conduct a conservative evaluation of your competence to perform
  - Intellectual competence
  - Technical competence
  - Emotional competence

Identify high-risk patients and high-risk situations
Be nice
Develop good recordkeeping practices and strategies
Seek appropriate consultation
Take all complaints and dissatisfactions seriously
Notify the insurance carrier and consult with a knowledgeable attorney if a suit or disciplinary complaint is filed against you
Who Owns the Kid?

> Dr. Ramos is an early career psychologist who began seeing Bobby Marcum, age 6, at the request of his parents. Mr. and Mrs. Marcum were having significant marital problems and reportedly wanted Bobby to have a “safe place” away from their difficulties. They chose Dr. Ramos because of her reputation as a person who worked well with children whose parents were in conflict.

Who Owns the Kid?

> Dr. Ramos has the Marcum family complete all of the necessary informed consent documents.
> Dr. Ramos has a policy of meeting with the parents individually and jointly throughout therapy to discuss Bobby and how to help him.
Who Owns the Kid?
> Dr. Ramos sees that while the parents report that they want therapy to be a “safe place”, they consistently ask questions about Bobby with which Dr. Ramos feels uncomfortable. She consistently feels that both parents are giving Bobby information which subtly pressures him to take sides in their dispute.
> The parents’ conflict continues and they choose to divorce.

Who Owns the Kid?
> Mrs. Marcum calls Dr. Ramos and tells her that she thinks that Bobby was abused by his father.
> Dr. Ramos receives a request from Mrs. Marcum for Bobby’s treatment records.
> Dr. Ramos receives a subpoena with an authorization from Mrs. Marcum’s attorney who plans to use the information about Bobby’s therapy in the parents’ dispute over his custody.

Who Owns the Kid?
> Mrs. Marcum calls Dr. Ramos and tells her that she no longer has her permission to treat Bobby.
> Dr. Ramos believes that Mrs. Marcum is a bully and she feels sorry for a somewhat passive Mr. Marcum.
> Dr. Ramos receives a call from Dr. Adversarial, a GAL appointed by the court, asking for her records and wanting to talk to her.
Areas of Concern
- Access to Records
- Informed Consent
- Role in Legal Proceedings
  - Types of testimony
- Sharing Information with Parents
  - Child rights to control/access
- Adversarial Parent/Conflict with Parents
- Preservation of Records
- Therapy Strategies
- Child Abuse Reporting

Legal Issues
- Access to Records
  - HIPAA: Defers to state law for parental access exceptions, unless state law is silent, in which case, the following provision applies:
    - Psychologist may elect to not treat parent as a legal representative if they have reasonable belief that:
      - Child may be/has been subject to abuse or...
      - Doing so would endanger child and...
      - Psychologist decides, through exercise of professional judgment, it is not in child’s best interest to do so.

- Informed Consent
  - The Trust Child Therapy Contract
    - The agreement represents a contract between the parents and psychologist limiting access rights
    - HIPAA supports this contract as binding
    - Court may not honor depending on state law
    - Stipulated agreement
Terms of the Confidentiality Contract

> “When a family is confronted by parental separation or divorce, it is very hard on everyone. It is particularly hard on children. When the parental relationship is unsafe, it is even more important that therapy presents a safe environment. That safety is particularly endangered when a child has to worry that what he says in therapy will be revealed in court and used against one of his parents.

Terms of the Confidentiality Contract

> In order to protect that safety, I want us all to agree that the therapist will not be called as a witness by either party. Everyone needs to understand that a judge may decide not to honor this agreement and that I may be required to be a witness, although I will try to prevent that from happening.”

Terms of the Confidentiality Contract

> “You should be aware that once we start treatment, it is unethical of me to give any opinion about custody or visitation arrangements, even if I am compelled to be a witness.”

> “I want your permission to provide information to anyone who the court appoints to perform a custody evaluation or to represent the legal interests of your children. I will not make any recommendation about the final decision.”
Legal Issues

> Role in Legal Proceedings
  • Fact witness
  • Expert witness
  • Treating expert

Legal Issues

> Adversarial Parents/Conflict with Parent
  • Clinical risk management with divorcing parents
  • Involve both parents
  • The elusive goal of neutrality
  • Limit setting
  • Dealing with GALs
  • Licensing board perspective
Ethical Issues

> Is release of records in Bobby’s best interest?
> What can Dr. Ramos do to mitigate any negative impacts of her involvement in the court proceeding?
> Should Dr. Ramos fight to continue to see Bobby?
> Provider’s role clarity:
  > Ethic’s Code: 10.02 Therapy Involving Couples or Families

Who Owns the Record?

Dr. Aware has been a successful private practitioner for 20 years. Six years ago, his private practice was so successful that he felt that he could move to an entirely self-pay practice. He had always been primarily a psychodynamic practitioner, but had been able to get authorizations by providing sufficient “behavioral narratives” to insurance company reviewers in required reports.
He is also aware of the need to document extensively with high risk clients as a good friend of his was reprimanded by the board partially because of poor documentation.

With the passage of time, he had to start taking more direct insurance reimbursement cases. Currently, his referral base is aging and he is feeling pressure to sign up for Medicare. He knows about the aggressive audits which go along with being a Medicare provider, but he thinks that providers will be required to be Medicare providers in order to get specialty referrals.

He has been hearing a lot about the changes that health care reform is likely to cause, particularly changes to reimbursement and oversight.
Who Owns the Record?

Dr. Aware is also worried about the new CPT codes and what they will mean to his practice. In addition, he has read a lot on the state psychological association list serve about how insurance companies are dropping reimbursement rates and aggressively auditing providers. He has also been confused about HIPAA and Psychotherapy Notes along with the Minimum Necessary Disclosure Rules.

Who Owns the Record?

Dr. Aware has a number of clients who requested records. He successfully avoided responding to these requests by managing to talk clients into taking summaries of their records. However, recently a client insisted on the complete record and he had to disclose it. It caused him considerable anxiety since this was a litigious client with borderline features. He, also, recently had his records subpoenaed. This seems an impossible task so he calls you.

Issues of Concern

Recordkeeping Perspectives
- Insurance company
- Client
- Therapist
- Licensing board
Issues of Concern

> Recordkeeping Requirements
  • State law
  • APA
  • HIPAA
    • Clinical record
    • Psychotherapy note

Issues of Concern

> Record Access
  • Jaffe v. Redmond
  • State requirements:
    • Client consent
    • Workers compensation records
    • Forensic records
    • Deceased patient
    • Legal actions

Issues of Concern

> Record Access
> HIPAA Requirements
  • Clinical records and psychotherapy notes
  • Minimum necessary disclosure rule
  • What about secondary source records?
  • Raw test data
Sources of Guidance

What impact does health care reform have on documentation requirements?

- Outcomes not inputs
- Increasing pressure on fee for service practice
- CPT codes
- Physician Quality Reporting System (PQRS)
- Increased audits
- Increased recoupment requests

Preparing and dealing with audits (APAPO)

- Identify your major sources of third party payment
- Know the payer’s definition of medical necessity
- Know what needs to be preauthorized
- Identify practice patterns that are likely to be audit targets
- Understand recordkeeping requirements or expectations

Trust Model Record

- Biopsychosocial treatment plan
- Data supported diagnosis
- Symptoms
- Patient’s behavioral goals and objectives
- Minimization of unnecessary information
- Dynamics of recordkeeping
- Consistent documentation of progress toward goals
Dr. Deborah Feeling has been in practice for 15 years. She trained in an inpatient setting and has experience with more seriously diagnosed patients. Dr. Feeling was recently informed by her patient’s mother, Lillian, that her only daughter, Sarah, 24, committed suicide by hanging herself at her home in a city two hours away from her therapist’s office. Mother is hysterical but thanks Dr. Feeling for her good work with the daughter and asks for a meeting. Father and mother were divorced when patient was 15.

Sarah had been Dr. Feeling’s patient for a year. She reported estrangement from her father whom she felt was overly protective and emotionally abusive of her. He refused involvement in her treatment although he paid for it. Sarah had been in mental health treatment since she was sixteen when she made her only suicide attempt by taking a large volume of Tylenol and then texting her closest friend about it. Sarah had the same psychiatrist since that time who was prescribing Zoloft for her.
In college Sarah had a difficult time. She graduated, although she had to take a semester off after a breakup with a boyfriend. She had symptoms of Major Depression, but Dr. Feeling diagnosed her with Dysthmic Disorder because Sarah had not evidenced any major depressive episodes for more than two years. Dr. Feeling talked to the psychiatrist two months ago. She also talked extensively to a former therapist at the outset of treatment. However, Dr. Feeling only has sketchy notes of these consultations.

Sarah started treatment with Dr. Feeling when she moved after 18 months of living at home following her graduation from college. She was very excited to be on her own. Sarah canceled her last two sessions: the first with adequate notice; the second as a "no show." Dr. Feeling made two phone calls to Sarah and got her voice mail. Later Sarah called back and left a message that she was very busy and would talk about what was "going on" at her next appointment. Dr. Feeling did not notice anything remarkable about the call.

Sarah's father doesn't believe in therapy and believed her problems were signs of weakness. He blamed the mothers over protectiveness for her problem. The parents still remain in active conflict about money and support and each others parenting styles. Dr. Feeling called you for a consult. She just received a records request from Sarah's father.
My Patient Committed Suicide

Dr. Feeling thinks that she should be more upset than she is, because she felt close to this patient. That said, she is actually quite numb and finds it difficult to connect with her current patients. Dr. Feeling is divorced. She finds herself worrying excessively about her own daughter who is Sarah's age. She has a strong impulse to discuss what happened with her former husband. In addition, Dr. Feeling is in a longstanding therapy consultation group which is very supportive. They have been pushing her to share what happened with them so that they can support her.

Thomas Joiner, Myths About Suicide, 2011

"Psychiatrists and psychologists—highly trained doctoral level mental health professionals—sometimes whisper about or panic about or skirt around the issue of suicide, an aversion that has always puzzled me and strikes me as similar to a surgeon being afraid of blood."

Areas of Concern

- What is the standard of practice in a suicide?
- Is there a risk of legal action?
- Should Dr. Feeling retain a lawyer?
- What about confidentiality or who can Dr. Feeling talk to and what should she say?
  - Insurers and other reviewers
  - Police & medical examiners
- What can Dr. Feeling discuss with her support group?
- Should Dr. Feeling inform The Trust?
Suicide and Malpractice Suits

> In suicide cases, expert testimony regarding adherence to the standard of care is often confounded by poor documentation and inscrutable handwriting. Inadequate documentation of suicide risk assessment is endemic... Adequate documentation is rarely found in outpatient and inpatient records or quality assurance reviews. (Simon & Shuman, 2006)

Suicide and Malpractice Suits

> Malpractice suits are the exception
> Psychologist competence v. jury’s emotional response
> Good documentation crucial
> Never alter the record
> Trust your lawyer and your insurer but verify with your own consultants

Basic Information about Suicide and Malpractice

> Standard of Care
  * The provider is not expected to predict suicide and prevent it
  * The provider is expected to identify clinical factors that are associated with a high risk of suicide
  * The provider is expected to take reasonable professional steps to reduce the risk and protect the patient where elevated risk is identified
  * Greater control over the patient creates greater responsibility to protect patient
Basic Information about Suicide and Malpractice Suits

> Standard of Care
- Customary practice v. prudent practice standards
- Standard of care in malpractice case is established by the testimony of “experts”
- There is no agreement in the profession or in the literature about what clinical factors are statistically significant predictors
- Various suicide risk assessment models are available, and there is some overlap between them, but no risk assessment model has been empirically tested for reliability and validity
- “Expert testimony that a standard model of suicide risk assessment exists is not credible” (Simon and Shuman, 2006)

In a study of over 200 clinicians (S. K. Litman, 1965) found the experience of losing a patient to suicide to have an almost nightmarish quality. Clinicians frequently experience feelings of grief, loss and depression.

> They also had feelings associated with their professional role as psychotherapist: guilt; inadequacy; self blame; fears of being sued, investigated or vilified in the media; (Pope & Vasquez, 2011).
**Post Suicide Issues**

**Self Care**
- 25% of psychologists lose a patient
- Losing a patient is often the biggest professional trauma they will experience
- Suicide is rarely the therapist's fault
- Avoid obsessing over the possibility of a lawsuit
- Immediate consultation is very important
- Patient suicide is a loss that must be grieved
- Therapy is the safest place to do grieving
- Do your self recriminations in a safe place
  - You can share your feelings of loss and sadness with colleagues and close relatives

**Interaction with the Family**
- Be aware of your state law
- Personal representative usually has access
- It is ok to meet with the family
- It is possible to talk about the treatment while protecting important personal information
- Consult about how to structure the meeting
- Demonstrate care and empathy, if you have it
- Be a human being

**HELP! I Have Been Yelped!**
HELP! I Have Been Yelped!
> Dr. Saul Anxious has been in a private and successful practice for 20 years. Eight years prior to that, he worked in a community mental health center. He deals with the difficulties that are common among all psychologists. These difficulties include problems with insurance carriers, managed care companies, and the overall operation of a successful small business and career. Dr. Anxious is very concerned about the reorganization of health care delivery and reimbursement.

HELP! I Have Been Yelped!
> A client comes into his office and reports that he was looking for a restaurant review on Yelp.com., and came across a review of Dr. Anxious that was posted by “Still Depressed” who reported getting more depressed after working with Dr. Anxious for almost a year. She reported that when she stated her dissatisfaction with the treatment, Dr. Anxious was “abusive and insensitive.”

HELP! I Have Been Yelped!
> The review further stated that throughout the treatment, she always felt uncomfortable with the way Dr. Anxious seemed to be focused on her breasts. She posts her review as a warning to other women. Dr. Anxious thinks he knows the identity of this client, a borderline patient whom he had to terminate because of her outrageous demands for more contact and her noncompliance with treatment. After a difficult termination, she said that she would get even with Dr. Anxious.
HELP! I Have Been Yelped!

- The same day, a colleague calls and suggests that Dr. Anxious check out the review. He is embarrassed and somewhat angry as he senses his colleague is engaging in schadenfreude. When Dr. Anxious Googles himself, the first thing that is referenced is the review. Dr. Anxious is flabbergasted, furious and scared. He calls you and asks what he can do about this. He wants to sue Yelp and the client.

HELP! I Have Been Yelped!

- The growth of online health care rating sites and the change in the way clients seek services
  - More than 30 sites and numbers continue to grow
  - It's the stars that count
  - Different sites/different strategies
  - Data show that when asked to review health care professionals, most patients give very positive reviews
HELP! I Have Been Yelped!

Response Strategies

- Monitor the web
- Google yourself regularly
- Know what’s out there
- Hire a lawyer and demand that they be taken down by the website or you will sue for libel and slander
- Prevent them through contractual provisions that provide heavy penalties for breach of contract
- The Strange Story of Medical Justice Inc.

Response Strategies

- Hire a reputation protection company
  - ReputationDefender.com
- Google alerts
- Solicit your colleagues to post positive reviews
- Create positive reviews yourself and post them
- Ignore them and hope that they will not influence consumers, at least, consumers that you want to see

Response Strategies

- Respond to them on the site
  - What about client confidentiality?
- How to respond
  - Positive information, positive tone
  - Remind people that there are two sides to every story
  - Don’t mention the patient or any specific statements about the treatment
HELP! I Have Been Yelped!

> Understand that the internet has radically changed the nature of the way in which people search for services and the services that they want

> Marketing consultants believe that the only effective way to deal with negative internet reviews is to have a positive strategy for branding oneself which will produce positive information about you that will either bury or contextualize the negative reviews
  - Survival is based on positive marketing

If You Can't Lick Them...

> Develop an Active/Positive Branding Program
  - Do things that get picked up by Google in a positive way
  - Have a professional website
  - Blogging
  - Testimonials
  - Information resources
  - Customer satisfaction surveys
  - Alternative services
    - Coaching or consulting services
  - Importance of marketing research
  - Use of a marketing consultant

If You Can't Lick Them...

> Risk Management Issues
  - Don’t damage your professional reputation. The most successful practices will still need good word of mouth and a referral network of professionals
  - All of the branding strategies have potential risks, particularly for those who are not internet competent
  - Use the small test
  - Consult with colleagues
  - Don’t make promises you can’t keep
  - Remember, the internet is forever
Dr. Sam is a clinical neuropsychologist who specializes in the evaluation of traumatic brain injuries. She receives a telephone call from Mr. Jones, who says that he recently had a car accident and was told by his primary care physician and a neurologist that he needs a neuropsychological evaluation because he is having memory problems.

The evaluation consists of an interview, a review of records and the administration of a battery of psychological tests. Dr. Sam concludes that Mr. Jones is currently exhibiting some cognitive deficits, which mostly consist of the impaired retrieval of information from short-term memory, difficulty sustaining concentration and impaired executive-functioning skills. Dr. Sam also concludes that Mr. Jones is suffering from moderate depression and anxiety.
Dr. Sam writes a comprehensive neuropsychological report and schedules Mr. Jones for a feedback session. Mr. Jones expresses a desire to have such a session, but also requests that his attorney be allowed to accompany him at the session so that he can gather information for Mr. Jones' impending lawsuit against the repair shop that worked on Mr. Jones' car just before the accident. This is the first time Mr. Jones has mentioned a lawsuit.

After the feedback session, Dr. Sam provides a copy of her neuropsychological report to Mr. Jones and to his treating physicians. A few weeks later, Dr. Sam receives a telephone request from Mr. Jones' attorney, Mr. Chavez, to provide him with a complete copy of Mr. Jones' file, including the raw psychological test data.

After reviewing Mr. Jones' evaluation, Mr. Chavez telephones Dr. Sam. Mr. Chavez indicates that he would like to talk about the pending lawsuit and perhaps retain Dr. Sam to testify as an expert in the matter. He tells Dr. Sam that he will expect her testimony and will issue a subpoena for her deposition. Mr. Chavez indicates that he wants Dr. Sam to primarily talk about how Mr. Jones has exhibited impaired cognitive and emotional functioning since the occurrence of the car accident.
I Have To Testify in Court

Dr. Sam is concerned about what role she can play in the legal case; how she will get paid; what assistance she will need in preparing; and what risks she will incur from her participation.

Areas of Concern

- Different roles of psychologists in court cases
- Role of someone who does an assessment as opposed to therapist
- Confidentiality/privilege
- Fees
- Structure your initial contract to include this possibility

Areas of Concern

- What is the value of a “no testimony” contract?
- How to deal with pressure from attorneys?
- What is a deposition?
  - Do you have actual deposition experience?
  - Deposition decorum
  - Do you need your own attorney?
  - Deposition risk
Areas of Concern
> Confidentiality v. Privilege
> Can you release psychological testing raw data or test materials?
  • APA ethics v. Pearson position
  • “HIPAA protective agreements”

Sources of Guidance
> References
  • Ethical Principles of Psychologists and Code of Conduct (2010).
  • Specialty Guidelines for Forensic Psychology (APA, 2011).

Sources of Guidance
> Specialty Guidelines, 4.02.02 Expert Testimony by Practitioners Providing Therapeutic Services
> Providing expert testimony about a patient who is a participant in a legal matter does not necessarily involve the practice of forensic psychology even when that testimony is relevant to a psycholegal issue before the decision maker. In contrast, rendering opinions and providing testimony about a person on psycholegal issues (e.g., criminal responsibility, legal causation…) would ordinarily be considered the practice of forensic psychology.
Sources of Guidance

- Specialty Guidelines for Forensic Psychology, Conflicts with Legal Authority
  - When their responsibilities conflict with law, regulations, or other governing legal authority, forensic practitioners make known their commitment to the EPPCC, and take steps to resolve the conflict. In situations in which the EPPCC or Guidelines are in conflict with the law, attempts to resolve the conflict are made in accordance with the EPPCC (EPPCC, 1.02).

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<tr>
<th>Description</th>
<th>Source of Guidance</th>
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<td>Knowledge of current guidelines.</td>
<td>Confidential.</td>
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<tr>
<td>Knowledge of current laws and regulations.</td>
<td>Confidential.</td>
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<tr>
<td>Knowledge of current ethical considerations.</td>
<td>Confidential.</td>
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<tr>
<td>Knowledge of current professional standards.</td>
<td>Confidential.</td>
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We Are Not Getting Along
Dr. Kandil is an outpatient psychologist, who has a practice that focuses on adults. He was referred a 42-year-old female, who had life-long difficulties with depression. The patient, Mary Flamer, was referred to Dr. Kandil by her primary care provider since Dr. Kandil specializes in cognitive-behavioral therapy, an approach that Ms. Flamer had not tried.

At the first therapy session, the patient completed Dr. Kandil’s informed consent form which outlined his policies. This included his fee structure, his billing policies which required payment for services at the end of the treatment session. Ms. Flamer agreed and signed the form. Ms. Flamer has insurance with a 20% copay.

At the end of one of their sessions together, Ms. Flamer told Dr. Kandil that she had forgotten her checkbook and would pay him the copay at the next session. Dr. Kandil agreed, but at the next session she told him that, once again, she had forgotten the checkbook and was extremely apologetic. She said she would mail him a check before the next session, something that never happened. She, however, did pay him part of her bill at the next session but stopped paying him after that.
Dr. Kandil also requested a release to speak to Ms. Flamer’s former therapist which Ms. Flamer refused saying she needed to get to know Dr. Kandil better before she would feel safe with the contact. After fifteen sessions of therapy, which produced no progress, Dr. Kandil found himself increasingly in conflict with Ms. Flamer who refused to complete her homework and increasingly argued with him about where treatment should be going.

In addition, when she became frustrated and highly agitated, she would immediately threaten to commit suicide. When Dr. Kandil addressed the lack of progress with Ms. Flamer, she said she “just knew he was going to reject her like everyone else.” Dr. Kandil became increasingly aware that Ms. Flamer met the diagnostic criteria for a borderline personality disorder. Frustrated, Dr. Kandil told Ms. Flamer that he thought therapy should be ended.

Upon hearing this she became very upset and told him that she thought he was unprofessional and incompetent. She said that she was going to sue him and file a complaint with the state board. Following this, she abruptly stomped out of the office slamming the office door behind her.
Areas of Concern

- Therapist duty v. patient responsibility
- Importance of a thorough evaluation
- Informed Consent deviations
- Termination Policy (J. Younggren, et. al, 2012)
  - Adequate Notice
  - Appropriate Resources
- What to do when termination is resisted
- Autonomy

Areas of Concern

- Treatment Compliance
  - Therapy strategies
  - Informed consent
  - The importance of setting and enforcing limits
  - Pay attention to early warning signs
  - Patient threats
  - Boundary issues
  - Adjunctive therapy like DBT skills groups

Ethical Issues

- APA EPPCC, 10.10 Terminating Therapy
  - (a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.
  - (b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.
  - (c) Except where precluded by the actions of clients/patients or third party payers, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.
Dr. Lee begins individual psychotherapy with Ms. Fisher. One of Ms. Fisher’s issues is that she is engaging in an extra-marital affair and is very ambivalent about what to do regarding her marriage and this affair. During the individual therapy, Ms. Fisher requests that her husband come to some of her individual sessions, which does occur, although she is continuing with the affair during this period. After a few joint sessions, Ms. Fisher requests that she and her husband commence marital therapy with Dr. Lee, but she demands that Dr. Lee not reveal any information to her husband about her affair.

Dr. Lee decides to begin marital therapy with the Fishers, and this therapy commences. During this period, Dr. Lee meets with the Fishers together, and he also has periodic individual meetings with each of the spouses. In an individual meeting, Ms. Fisher informs him that she continues to have periodic sexual contact with her extra-marital partner, but she again directs Dr. Lee to keep this secret from her husband. Dr. Lee notices that the inability to address Ms. Fisher’s past affair and her ongoing periodic contact with her paramour in the joint sessions is interfering with the marital therapy.
I've Got a Secret

The marital therapy terminates after five sessions, and Dr. Lee does not continue to treat either of the Fishers. Shortly thereafter, the couple separate, and they commence a bitter dispute over the custody of their two children. Five months later, Dr. Lee receives a subpoena from the husband’s attorney demanding a complete copy of Dr. Lee’s file on both of the Fishers. The subpoena is accompanied by an authorization to release information signed by the husband. Dr. Lee contacts Ms. Fisher, who states that she does not want Dr. Lee to release any information about her.

Areas of Concern

Definition of patient
Informed Consent
Conflicts of Interest
Multiple Relationship Conflicts
Privilege
Recordkeeping

Ethical Issues

Informed Consent, American Psychological Association (2010)

10.02(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist’s role and the probable uses of the services provided or the information obtained.
Ethical Issues

> Conflict of Interest (American Psychological Association, 2010)

• 3.06 Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

Legal Issues

> Recordkeeping Issues

• One record or two?
• Redacting the record?
• "Licensees who release confidential records relating to a patient or client that also contain confidential information relating to a second patient or client that the licensee obtained through the provision of services to that second individual, and who lack consent or other legal authority to disclose the second individual’s identity and/or records, must remove all identifying and confidential information relating to the second individual before releasing the records. [Texas State Board of Examiners of Psychologists, 2006, §465.12(f)]"

Legal Issues

> Privilege Issues

• Confidentiality versus privilege
• Does privilege exist when there is more than one person in the room?

> Subpoena for Records/Testimony

• No authorization from anybody
• Authorization from one person
• Authorization from all persons
Dr. Innovate is a mid-career clinical psychologist whose primary work consists of individual psychotherapy with adults, with a sub-specialty in the treatment of women and couples, who are going through infertility treatments. Dr. Innovate is on many insurance panels, and most of his patients pay for their psychotherapy with their insurance. Dr. Innovate’s office is in the state of Utopia but borders closely on two other states, Erewhon and Mordor.

Dr. Innovate’s business has been flagging, so he decides that he would like to expand his services. He has two additional services that he would like to offer: remote psychotherapy using Skype, and short term psychoeducational consultation to clients considering or going through fertility treatments.
Dr. Innovate has redesigned his website to promote these new services and wants to place an ad on Google and in Psychology Today to recruit new patients who want to use this service. He also puts flyers in his waiting room announcing these services and encouraging his clients to spread the word.

Dr. Innovate’s first taker of his new service turns out to be an existing client, who is moving out-of-state, but who wants to continue her individual psychotherapy with Dr. Innovate. This client, Ms. Timber, has been in treatment with Dr. Innovate for about six months. She has been working hard with Dr. Innovate and she is quite attached to him. She has a history of one suicide attempt and of severe substance abuse; but she has been relatively stable and drug free for five years. However, she continues to exhibit a number of Axis II features; she takes both an anti-depressant and a mood-stabilizing medication.

Ms. Timber has a relatively good job and has been offered a promotion if she moves to another state. Ms. Timber intends to use her insurance to pay for the remote therapy as she cannot afford self pay. Utopia has recently passed a law mandating insurance reimbursement for telemedical services. Dr. Innovate has some misgivings about doing teletherapy with Ms. Timber, but decides to give it a try. Before proceeding, however, he decides to consult with you, one of his psychology colleagues, and get some advice about this venture.
My Patient is Leaving Town

Dr. Innovate receives an email from Madre Noveau, who saw Dr. Innovate’s ad on Psychology Today’s website and who would like to work with Dr. Innovate because she is going through in-vitro fertility treatments. Ms. Noveau lives in a remote area of Erehwon where there are no mental-health professionals who specialize in infertility issues. Ms. Noveau is willing to pay out-of-pocket for the treatment.

Dr. Innovate is unsure about how to proceed and comes to you for a consult.

Areas of Concern

Risk Management Issues
- Professional issues
- Inter-jurisdictional issues

Ethical Issues
- Client suitability
- Clinical benefits v. risk
- Training/competence in the area
- Technological competence
- Clinical competence
- Informed Consent
- Preparation for emergencies

Risk Management Strategies
References

> Draft APA Teletherapy Guidelines
> The Trust template for Social Media and Electronic Communications
(www.APAIT.org)
Dr. Adaptation is a senior neuropsychologist who has a combined clinical and forensic practice. Over the years in an attempt to reduce his paperwork, he converted all of his records into an electronic record format. All electronic records are stored on his laptop computer which has a very large hard drive. He also stores a backup of these files on the cloud and this backup is a mirror of what is on his computer. In addition, he carries his computer with him when he travels and docks it in his office when he returns.

Dr. Adaptation recently left his office to use the restroom and put the computer on its docking station. When he returned, the computer and the docking station were gone. Apparently, a thief entered his office while he was gone and walked off with them. The police have been notified, but they have been unable to locate the computer. The computer was password protected, but the data were not encrypted. Finally, he used a commercial email server for his business emails and stored his emails using Outlook.
I Lost My Computer!

Dr. Adaptation’s landlord reveals that he has security cameras in the building. The police review the tapes and find an individual was leaving the building in a hurry immediately after the theft must have occurred. He is carrying a paper bag that could be holding the computer. They show the pictures to Dr. Adaptation. He recognizes that the individual in the photograph is a relatively new client of his, who is on probation. The police and landlord want to know if he recognizes the individual in the picture. The client is scheduled for an appointment the next day.

Issues

> HIPAA Issues (Privacy/Security)
  - Confidentiality
  - Privacy
  - Enforcement
> State Law
  - Record-keeping requirements
> Ethics

HIPAA Security Rule

> Security Rule Issues
  - Providers required policies and procedures
  - Risk assessment
  - Written data security policy
  - Data backup (off site)
> Breach Notification Requirements
  - Notification of clients
  - Scope of loss (over/under 500)
  - Notification of Health and Human Services
  - Encryption
HIPAA Security Rule

What should Dr. Adaption do about a patient's criminal conduct?
- Ethics
  - privacy/confidentiality
- State Law
  - Inconsistent conduct/reasonable expectation of confidentiality
- HIPAA
  - Providers may generally disclose PHI to law enforcement to alert law enforcement about criminal conduct on the premises of a HIPAA covered entity.

Risk Management

Should Dr. Adaption:
- Tell police?
- Notify landlord?
- Tell the probation officer?

How should he deal with the client?
- What should he tell his current and future clients about the security cameras?
- Is there any HIPAA or confidentiality issues that he should take up with the landlord?

Who Is My Boss?
Who Is My Boss?

Ima Confused, Ph.D., is the head of Student Counseling Services, at Money Pit U. She has a staff of two other licensed psychologists along with two paid interns. Her facility is accredited by the APA and is responsible for providing psychological services to students who fit the needs of their training model. The department also participates in a limited number of research projects conducted in the affiliated Department of Psychology.

Who Is My Boss?

Dr. Confused has been contacted by the Dean of Students regarding how the training center deals with at risk students. The Dean is concerned about the University’s exposure for students who pose a danger to themselves or others and asks Dr. Confused for advice on how she can assist him in protecting the University and its students.

Who Is My Boss?

The Dean suggests to Dr. Confused that she consider creating a process by which at risk students are reported to the administration. In addition, the Dean wants to create a mechanism by which the faculty can refer students to the counseling service for assistance and wants to have the service give feedback to the faculty on the progress these students are making and whether they are compliant.
Who Is My Boss?

> The Dean asks Dr. Confused to participate in regular “crisis response team” meetings with the Head of Student Affairs, the Chief of the University Police, the University Counsel, and the Dean to discuss “students of concern.”

Who Is My Boss?

> The Dean produces a letter for Dr. Confused written by University Counsel that indicates that since the students are being seen in an academic setting, the provisions of the Family Educational Rights and Privacy Act (FERPA) allow for this type of exchange of information with the administration.

Who Is My Boss?

> Areas of Concern
  * Multiple Role Conflicts
  * Privacy vs. safety
  * Job vs. ethics
  * Inconsistent responsibilities
  * Students vs. parents
  * Conflict of interest
  * Informed consent
  * Policy