CAMFT'S 52ND ANNUAL CONFERENCE "THE FUTURE OF MENTAL HEALTH: TOOLS FOR THE THERAPIST'S TOOLBOX"

FRIDAY, MAY 13, 2016

ALL-DAY WORKSHOP (6 CE CREDITS)
8:00 A.M.–4:30 P.M.

HANDOUT 1 OF 2

F4 "Key Legal and Ethical Issues for Mental Health Professionals: What Therapists Should Always Do, Never Do and/or Really Don't Have To Do" presented by Mike Griffin, JD, LCSW, CAMFT Staff Attorney

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May 13, 2016,
Los Angeles, Ca.

"Key Legal & Ethical Issues for Mental Health Professionals: What Therapists Should Always Do, Never Do, and/or Really Don't Have to Do"

I. The "Licensing Laws" What is Unprofessional Conduct?
II. The Big Three: Scope of Practice/Scope of Competence/Standards of Care
III. Setting the Stage: Addressing Key Issues at the Start of Treatment
IV. Legal & Ethical Issues Involving Telehealth
V. Working with Minors: Issues Involving Consent, Confidentiality, Psychotherapist-Patient Privilege and Access to the Treatment Record
VI. Working with Couples and Families: Issues Involving Confidentiality, Psychotherapist-Patient Privilege and Access to the Treatment Record
VII. Issues Involving Rights of Access to the Treatment Record
VIII. Working with Clients Who Are Involved With The Legal System
IX. Handling Requests For Personal Opinions (Letters)
X. Working With Suicidal and/or Dangerous Clients
XI. Clinical Documentation/Maintaining an Appropriate Treatment Record
XII. Avoiding Problems During Termination

Overall Purpose Of The Workshop

This workshop examines various actions, which therapists should *(*generally speaking) *always, or, never do*, when working with clients. We will also examine a variety of activities, such as writing letters, talking to attorneys, etc., that therapists commonly perceive as required or mandatory when working with clients, when in fact they are often subject to the therapist's discretion.

Please note: Although the words "*always*" and "*never*" are used for the sake of discussion, the reader/attendee should understand that actions taken by a therapist may vary, depending upon the relevant facts and circumstances. Information presented in these materials and in the corresponding workshop, is offered for educational purposes only and is not intended to serve as legal advice.

To a significant extent, workshop content is drawn from discussions with members of CAMFT regarding legal and ethical issues that are commonly encountered in clinical practice. The subject matter is also based upon my experience as the CAMFT attorney assigned to the CAMFT Ethics Committee. The primary intent of the workshop is not just to say: "Don't do this...it will get you into trouble." The goal is to provide information that is useful and relevant to clinicians and to illustrate the application of legal and ethical standards to real-life situations. To that end, there will be some opportunity for group discussion during the day. The amount of time that is available for Q and A and related discussion will necessarily vary, depending on the size of the group, and other factors.

No two workshops are identical. The specific workshop content, (including the amount of time devoted to a particular issue) varies from workshop to workshop, depending upon the needs and interests of a particular audience and other factors.

I. THE LICENSING LAWS: WHAT IS UNPROFESSIONAL CONDUCT?

Laws and regulations which are specifically intended to govern the conduct of health care professionals in every state are commonly referred to as "licensing laws." All of the California statutes can be found at: http://leginfo.legislature.ca.gov/faces/codes.xhtml

California statutes and regulations applicable to marriage and family therapists, clinical social workers, and professional clinical counselors are also accessible via the Board of Behavioral Sciences website, at:

http://www.bbs.ca.gov/pdf/publications/lawsregs.pdf

California laws applicable to psychologists are available at: http://www.psychboard.ca.gov

The following sections of the California Business & Professions Code (statutes) and the California Code of Regulations contain the licensing laws:

Marriage and Family Therapists

§§4980-4989 Business & Professions Code
§§1829-1848 Code of Regulations

Clinical Social Workers:

§§4991-4998.5 Business & Professions Code,
§§1870-1881 Code of Regulations

Professional Clinical Counselors

§§4999.10-4999.129 Business & Professions Code
§§1820-1823 Code of Regulations

Practice of Psychology

§§2900-2999 Business & Professions Code
§§1380-1397.71 Code of Regulations

Should Therapists Be Afraid To Practice?

While it is true that any therapist could be the subject of a complaint to a regulatory Board such as the BBS, the commonly expressed belief that therapists are in constant danger of a disciplinary action by the BBS is unwarranted. The incidence of complaints and disciplinary actions against California therapists is extremely low, relative to the total number of practitioners.

California Therapists (as of December, 2015)

Licensed Marriage & Family Therapists	39,223
MFT Interns	19,611
Assoc. Clinical Social Workers	15,338
Licensed Clinical Social Workers	23,395
Licensed Professional Clinical Counselor	1323
Professional Clinical Counselor Interns	1554
	100444

California licensed Psychologists as of 2/12 18023

BBS Disciplinary Actions[1] Fiscal Year July 1, 2012-June 30, 2013

	Qtr.1	Qtr.2	Qtr.3
Complaints received	274	251	228
Citations issued	46	36	18
AG cases initiated	22	29	23
Accusations filed	21	20	15
Statement of Issues filed	9	2	9
Stipulations Adopted	17	14	18
Revoked	8	9	7
Revoked, Stayed Probation	8	10	17
Surrender of License	12	9	3
Public Reprimand	1	0	4

Disciplinary Decisions (By Violation Type) (From 7/1/12-6/30/13
Fraud (1)
Health & Safety, Substance Abuse, Mental/Physical Impairment (1)
Sexual Misconduct (1)
Competence / Negligence (6)
Convictions (32)
Unprofessional Conduct (8)
Disciplined by Another State (1)
Violation of Probation (7)

[1] Business & Professions Code , 4982 defines "Unprofessional Conduct" for marriage and family therapists; 4992.3 applies to clinical social workers; 4999.90 applies to professional clinical counselors and 2960 applies to the practice of psychology

There is a seven-year statute of limitations for the enforcement of a disciplinary action by the Board of Behavioral Sciences (or ten years for an allegation of sexual misconduct involving a client), per Business and Professions Code, 4982.05, 4990.32

statute of limitations

It is worth noting that Section 340.5 of the Code of Civil Procedure provides for a three year statute of limitations for the commencement of a civil action against a therapist for alleged professional negligence (malpractice).

II THE BIG THREE: SCOPE OF PRACTICE/SCOPE OF COMPETENCE/STANDARDS OF CARE

Scope Of Practice

*** Every practitioner has a duty to practice within the scope of practice of his/her profession.**
*** The scope of practice for each of the mental health professions is defined by statute.**

The scope of practice for marriage and family therapists, clinical social workers, professional clinical counselors and psychologists are provided below. There are many similarities in these descriptions, but they are not identical. As you review the scope of practice definition which applies to you, consider: Are all of your professional activities clearly within your scope of practice?

Marriage & Family Therapists[2]

The practice of marriage and family therapy shall mean that service performed with individuals, couples, or groups wherein interpersonal relationships are examined for the purpose of achieving more adequate, satisfying, and productive marriage and family adjustments. This practice includes relationship and pre-marriage counseling. The application of marriage and family therapy principles and methods includes, but is not limited to, the use of applied psychotherapeutic techniques, to enable individuals to mature and grow within marriage and the family, the provision of explanations and interpretations of the psychosexual and psychosocial aspects of relationships, and the use, application, and integration of the coursework and training required by (Business & Prof. Code) Sections 4980.36, 4980.37, and 4980.41, as applicable.

Clinical Social Workers[3]

The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve more adequate, satisfying, and productive social adjustments. The application of social work principles and methods includes, but is not restricted to, counseling and using applied psychotherapy of a nonmedical nature with individuals, families, or groups; providing information and referral services; providing or arranging for the provision of social services; explaining or interpreting the psychosocial aspects in the situations of individuals, families, or groups; helping

[2] Business & Prof. Code, 4980.02
[3] Business& Prof. Code, 4996.9

communities to organize, to provide, or to improve social or health services; or doing research related to social work. Psychotherapy, within the meaning of this chapter, is the use of psychosocial methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions which affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes.

Psychologists[4]

No person may engage in the practice of psychology, or represent himself or herself to be a psychologist, without a license granted under this chapter, except as otherwise provided in this chapter. The practice of psychology is defined as rendering or offering to render for a fee to individuals, groups, organizations or the public any psychological service involving the application of psychological principles, methods, and procedures of understanding, predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counseling, psychotherapy, behavior modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotions, and motivations. The application of these principles and methods includes, but is not restricted to: diagnosis, prevention, treatment, and amelioration of psychological problems and emotional and mental disorders of individuals and groups. Psychotherapy within the meaning of this chapter means the use of psychological methods in a professional relationship to assist a person or persons to acquire greater human effectiveness or to modify feelings, conditions, attitudes and behavior which are emotionally, intellectually, or socially ineffectual or maladjustive.

Professional Clinical Counselors[5]

Means the application of counseling interventions and psychotherapeutic techniques to identify and remediate cognitive, mental, and emotional issues, including personal growth, adjustment to disability, crisis intervention, and psychosocial and environmental problems. "Professional clinical counseling" includes conducting assessments for the purpose of establishing counseling goals and objectives to empower individuals to deal adequately with life situations, reduce stress, experience growth, change behavior, and make well-informed, rational decisions.

"**Professional clinical counseling"** is focused exclusively on the application of counseling interventions and psychotherapeutic techniques for the purposes of improving mental health, and is not intended to capture other, nonclinical forms of counseling for the purposes of licensure. For purposes of this paragraph, "nonclinical" means non-mental health.

[4] Business & Prof. Code, 2903
[5] Business & Prof. Code, 4999.20

A person engages in the practice of professional clinical counseling when he or she performs or offers to perform or holds himself or herself out as able to perform this service for remuneration in any form, including donations.

Professional clinical counseling <u>does not include</u> the assessment or treatment of couples or families unless the professional clinical counselor has completed all of the following training and education:

(A) One of the following:(i) Six semester units or nine, quarter units specifically focused on the theory and application of marriage and family therapy. (ii) A named specialization or emphasis area on the qualifying degree in marriage and family therapy; marital and family therapy; marriage, family, and child counseling; or couple and family therapy.

(B) No less than 500 hours of documented supervised experience working directly with couples, families, or children. (C) A minimum of six hours of continuing education specific to marriage and family therapy, completed in each license renewal cycle.

"**Counseling interventions and psychotherapeutic techniques**" means the application of cognitive, affective, verbal or nonverbal, systemic or holistic counseling strategies that include principles of development, wellness, and maladjustment that reflect a pluralistic society. These interventions and techniques are specifically implemented in the context of a professional clinical counseling relationship and use a variety of counseling theories and approaches.

"**Assessment" means** selecting, administering, scoring, and interpreting tests, instruments, and other tools and methods designed to measure an individual's attitudes, abilities, aptitudes, achievements, interests, personal characteristics, disabilities, and mental, emotional, and behavioral concerns and development and the use of methods and techniques for understanding human behavior in relation to coping with, adapting to, or ameliorating changing life situations, as part of the counseling process. "**Assessment" shall not include the use of projective techniques in the assessment of personality, individually administered intelligence tests, neuropsychological testing, or utilization of a battery of three or more tests to determine the presence of psychosis, dementia, amnesia, cognitive impairment, or criminal behavior.**

<u>Scope Of Competence</u>

Every professional is required to practice within the scope of his or her competence. A practitioner's Scope of competence is based upon his or her <u>education</u>, <u>training</u> and <u>experience</u>.

<u>Code of Regulations</u>, 1881 (Unprofessional Conduct)

The board may suspend or revoke the license of a licensee or may refuse to issue a license to a person who: (g) Performs or holds himself or herself out as able to perform professional services beyond his or her field or fields of competence as established by his or her education, training and/or experience.

Code of Regulations, 1845 (marriage & family therapists) **Unprofessional conduct includes:**

(a) Performing or holding himself or herself out as able to perform professional services beyond his or her field or fields of competence as established by his or her education, training and/or experience.

(b) Permitting a trainee or intern under his or her supervision or control to perform or permitting the trainee or intern to hold himself or herself out as competent to perform professional services beyond the trainee's or intern's level of education, training and/or experience.

Business & Professions Code , 4982 (marriage & family therapists)

A supervisor may not permit his or her trainee or registered intern to hold himself or herself out as competent to perform professional services beyond the trainee's or registered intern's level of education, training or experience.

Business & Professions Code, 4999.90 (professional clinical counselors)

(l) Performing, or holding oneself out as being able to perform, or offering to perform, or permitting any trainee, applicant, or registrant under supervision to perform, any professional services beyond the scope of the license authorized by this chapter (is unprofessional conduct)

Code of Regulations, 1881 (social workers)

A supervisor who "Permits a person under his or her supervision or control to perform or permits such person to hold himself or herself out as competent to perform professional services beyond the level of education, training and/or experience of that person" commits unprofessional conduct.

Code of Regulations, 1396 (psychology)

A psychologist shall not function outside his or her particular field or fields of competence as established by his or her education, training and experience.

CAMFT Code of Ethics

3.9 SCOPE OF COMPETENCE:

Marriage and family therapists take care to provide proper diagnoses of mental and emotional disorders or conditions and do not assess, test, diagnose, treat, or advise on problems beyond the level of their competence as determined by their education, training, and experience. While developing new areas of practice, marriage and family therapists take steps to ensure the competence of their work through education, training, consultation, and/or supervision.

4.2 COMPETENCE OF SUPERVISEES:

Marriage and family therapists do not permit students, employees, or supervisees to perform or to hold themselves out as competent to perform professional services beyond their level of experience, competence, or unlicensed status.

10.8 SPECIALIZATIONS:

Marriage and family therapists may represent themselves as either specializing or having expertise within a limited area of marriage and family therapy, but only if they have the education, training and experience that meets recognized professional standards to practice in that specialty area.

Standards Of Care

In all cases, a therapist is expected to meet the applicable "standard of care." The standard of care that is applicable in a given situation depends on the actual facts and circumstances present in the case

A therapist must exercise the reasonable degree of skill, knowledge and care that is ordinarily exercised by other members of his or her professional community, when practicing under similar circumstances.

Standards of care are relevant to the issue of competency

In a malpractice lawsuit against a health care professional, the primary issue is whether or not the treatment provided was within the applicable standard of care.

The standard of care is fact-driven: It is intended to reflect what is generally expected of a therapist who is treating a particular client, under the circumstances.

California Civil Jury Instruction, Standard of Care for Health Care Professionals[6]

[A/An] [insert type of medical practitioner] is negligent if [he/she]fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful [insert type of medical practitioners] would use in the same or similar circumstances. This level of skill, knowledge, and care is sometimes referred to as "the standard of care."

[You must determine the level of skill, knowledge, and care that other reasonably careful [insert type of medical practitioners] would use in the same or similar circumstances, based only on the testimony of the expert witnesses [including [name of defendant] who have testified in this case.]

Examples to consider

* The depressed client
* The suicidal client
* The client with panic disorder
* The client with OCD
* The client with a history of sexual/physical abuse
* The client with an eating disorder

[6] Civil Jury Instructions, Section 501

HYPOTHETICAL SCENARIO #1

35 year old male patient informs his therapist during the initial intake visit that he worries a lot and can't sleep. Recently, his wife drove him to the emergency room when it looked like he was hyperventilating. She wondered whether he was having a panic attack, like his mom experiences. A few months ago, his family doctor prescribed valium for him to use, but he only uses medicine when he is "desperate," The therapist recommended to the patient that he should avoid using the valium if at all possible. The patient has never been to therapy before. The therapist has some experience working with anxiety disorders, but he has never treated anyone with panic disorder.

The therapist is interested in treating the patient but he is a little worried about his limited experience in treating individuals with significant symptoms of anxiety. When he had a minute in between patients, he asked two other therapists for their opinions. One of them said that he should probably refer the patient, the other one said that he should take the case because it sounded interesting.

1. What should the therapist do in this situation?

2. What are the relevant issues concerning scope of practice?

3. What are the relevant issues concerning scope of competency?

4. What are the relevant issues concerning standard of care?

III. SETTING THE STAGE: ADDRESSING KEY ISSUES AT THE START OF TREATMENT

In my experience at CAMFT as a staff attorney, a significant percentage of the problems that I have discussed with CAMFT members were evident to the therapist during his or her initial phone contact with the client, or during the initial visit.

Things You Should Always Do

Consider Whether You Are You The Right Therapist For The Client.

It is not necessarily evident during the first session, but it is always necessary to consider this question because not every therapist is a good match for every client. Therapists are often reluctant to consider the idea that they may not be able to work with a client.

What does the client *really* want? Does the client actually say what it is, or do you wonder what you are being asked to do after the intake session concludes? You should be able describe the chief complaint/presenting problems in the client record.

Consider whether the client's problem description and his/ her request(s) coincide with what you are able to do, and/or, what you are willing to do? You should be able to discuss these issues (with some specificity) with the client(s) and reflect that in the record.

Is there anything that you cannot or will not do? Where relevant, it is important to discuss the issue with the client and be sure to document the conversation in the client record.

Clarify Who The Client Is (individual/couple/family)

CAMFT Code of Ethics

1.9 FAMILY UNIT/CONFLICTS:

When treating a family unit(s), marriage and family therapists carefully consider the potential conflict that may arise between the family unit(s) and each individual. Marriage and family therapists clarify, at the commencement of treatment**,** which person or persons are clients and the nature of the relationship(s) the therapist will have with each person involved in the treatment.

Required Disclosures

This information can be provided in intake documents/informed consent paperwork/information documents explaining your office policies and procedures.

Marriage and family therapists must disclose the following information to their patients:

(Note: The following disclosure requirements are identical or nearly identical for social workers, professional clinical counselors and psychologists).

Prior to the commencement of treatment, information concerning the fee to be charged for the professional services, or the basis upon which that fee will be computed, must be disclosed to the client or prospective client. [7]

If the therapist is an intern or trainee, he or she must inform each client or patient prior to performing any professional services that he or she is unlicensed and under the supervision of a licensed marriage and family therapist, licensed clinical social worker, licensed psychologist, or a licensed physician and surgeon certified in psychiatry by the American Board of Psychiatry and Neurology. [8]

Any licensed marriage and family therapist who conducts a private practice under a fictitious business name shall not use any name which is false, misleading, or deceptive, and shall inform the patient, prior to the commencement of treatment, of the name and license designation of the owner or owners of the practice. [9] If incorporated, clients must be also be informed that the business is being conducted by a licensed marriage and family therapist corporation. All of this information may be included in the written information that is provided to clients at the time of intake.

The therapist is also required to conspicuously display his or her professional license in his or her primary place of business.[20] This means that you are required to post a copy of your license somewhere where it can be easily seen in your place of business.

[7] Business & Prof. Code, 4982(n)
[8] Business & Prof. Code, 4980.44, 4980.48,
[9] Business & Prof. Code, 4988.45,

Marriage and family therapists have a unique disclosure requirement: California law encourages, (but doesn't require) marriage and family therapists to disclose the following: "…all marriage and family therapists are encouraged to provide to each client, at an appropriate time and within the context of the psychotherapeutic relationship, an accurate and informative statement of the therapist's experience, education, specialties, professional orientation, and any other information deemed appropriate by the licensee.[10]

CAMFT Code of Ethics

1.5 THERAPIST DISCLOSURES:

Marriage and family therapists provide adequate information to patients in clear and understandable language so that patients can make meaningful decisions about their therapy. Marriage and family therapists respect the right of patients to choose whether to enter into or remain in a therapeutic relationship.

1.5.1 DISCLOSURE:

Where a marriage and family therapist's personal values, attitudes, and/or beliefs are a determinative factor in diagnosing or limiting treatment provided to a client, the marriage and family therapist shall disclose such information to the patient.

1.5.3 EMERGENCIES/CONTACT BETWEEN SESSIONS:

Marriage and family therapists inform patients of the extent of their availability for emergencies and for other contacts between sessions. When a marriage and family therapist is not located in the same geographic area as the patient, he/she shall provide the patient with appropriate resources in the patient's locale for contact in case of emergency.

1.5.5 LIMITS OF CONFIDENTIALITY:

Marriage and family therapists are encouraged to inform patients as to certain exceptions to confidentiality such as child abuse reporting, elder and dependent adult abuse reporting, and patients dangerous to themselves or others.

1.5.6 THERAPIST BACKGROUND:

Marriage and family therapists are encouraged to inform patients at an appropriate time and within the context of the psychotherapeutic relationship of their experience, education, specialties, and theoretical and professional orientation, and any other information deemed appropriate by the therapist.

[10] Business & Prof. Code ,4980.55,

9.3 DISCLOSURE OF FEES:

Marriage and family therapists disclose, in advance, their fees and the basis upon which they are computed, including, but not limited to, charges for cancelled or missed appointments and any interest to be charged on unpaid balances, at the beginning of treatment and give reasonable notice of any changes in fees or other charges.

Psychologists Must Disclose The Following Information To Their Patients

All licensees and registrants are required to post the following notice in a conspicuous location in their principal psychological business office: "NOTICE TO CONSUMERS: The Department of Consumer Affair's Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints, you may contact the board on the Internet at www.psychboard.ca.gov, by calling 1-866-503-3221, or by writing to the following address: Board of Psychology 1422 Howe Avenue, Suite 22, Sacramento, California 95825-3236."[11]

Disclosures by "Covered Entities" under HIPAA

All therapists who are covered entities according to HIPAA must provide clients with a copy of their Notice of Privacy Practices. [33] The therapist is not required to obtain the patient's signature on the Notice, but must make a good faith effort to obtain the patient's written acknowledgment of receipt of the Notice." The Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

The privacy practices notice must specifically indicate whether you are a therapist who does, or does not, utilize "psychotherapy notes" ***as they are defined in HIPAA.*** The specific meaning of this term will be further discussed later in the workshop, in the section concerning documentation. (On the CAMFT website, there are examples of different versions of privacy practices).***Note:** **If you are not a HIPAA-covered entity , don't distribute HIPAA privacy practices!**

Optional /Suggested Disclosures

Therapists are not limited to the disclosures mandated by California law. Because therapists have unique backgrounds, training and varied theoretical approaches, no single list will address all of their needs. The following is a list of commonly utilized disclosures. Individual therapists may select those items that are meaningful to him or her, eliminate those that aren't and modify or add content as needed.

* **Information regarding the use of health insurance, charges for missed sessions and any policies concerning the use of collection services for unpaid fees.**

* **Information describing the therapist's policies regarding scheduling and cancellations.**

* **Information regarding therapist availability, including "on-call" availability for after-hours emergencies.**

[11] Business & Prof. Code, 2996

* **The therapist's policies concerning termination of treatment for lack of cooperation (client no-shows, unpaid fees, etc.)**

* **Information regarding the limitations of psychotherapy, including the fact that therapists cannot guarantee a particular outcome.**

* **Information regarding the value of patient cooperation and collaborative participation in the treatment process.**

* **Information about the limits of confidentiality, including the mandated reporting of child abuse, elder abuse, the therapist's "duty to warn / protect"**

HYPOTHETICAL SCENARIO #2

Therapist received a call from the mother of a 15 year old girl, (Ann), who states that he daughter has been extremely defiant, angry, and "needs to talk to someone." During the initial phone conversation with mom, the therapist learns that Ann's problems are long-standing, but appear to have worsened over the past 6 months. There is a history of at least one prior treatment episode which involved both individual therapy and family therapy sessions, but the purpose and the outcome of those sessions is unknown. The initial phone call with mom lasted almost twenty minutes, as mom was understandably concerned about her daughter's well-being. Although mom urged the therapist to see her daughter that same day, the therapist decided to meet with the mom first, to get a better understanding of the issues. During their meeting, mom told the therapist that she was also very concerned about her 17 year old son, (Jason), who stopped going over to his dad's house recently because dad's new wife was constantly trying to tell him what to do, and his dad never sticks up for him.

Ann's parents divorced about 5 years ago and they have joint legal custody of their kids. According to mom, Ann's dad is reportedly in favor of therapy for Ann, because he is convinced that she is bi-polar. When the therapist brought up the issue of fees, mom interrupted her saying, "you need to talk to her father about that, because he has the insurance and he took care of everything the last time we did this."

1. What are the key issues that must be addressed by the therapist in this case in order for him/her to move forward with treatment?

2. What information would you like to have if you were this therapist?

IV. LEGAL & ETHICAL ISSUES INVOLVING TELEHEALTH

California's Telehealth Law

Business and Professions Code, 2290.5

(a)(6) "Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care

management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site."

(b) Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health . The consent shall be documented."

Documentation

Providers must keep a treatment record for telehealth clients, and retain that record in the same manner that would apply if the client were being seen in person. All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

Jurisdictional Issues

Generally speaking, CAMFT does not recommend providing therapy to patients out of state unless you are licensed in the state where the patient is receiving treatment. The question of jurisdiction in this situation is not as simple as it may seem to some. Issues such as "Where does therapy occur?" "Which state's law do you apply in dangerous patient situations?" or "Which law governs legal disputes?" put the provider in a very precarious position. Until the law surrounding issues such as these becomes clearer, CAMFT recommends providing telehealth solely to individuals within California.

A California marriage and family therapist license allows the holder to practice psychotherapy in the state of California. The BBS acknowledges that licensing requirements vary by state and individuals who provide psychotherapy or counseling to persons in California are required to be licensed in California. Thus, a California license does not – in and of itself – allow a therapist to practice in any jurisdiction other than in California. There is no reciprocity between California and any other state which would allow a California LMFT to practice in a different jurisdiction. Every state is responsible for licensing and regulating the profession of marriage and family therapy. As such, each state's licensing or regulatory board determines who may practice marriage and family therapy in that state. So, while the inclination to continue a therapeutic relationship with a patient who is in another state may feel – and be – ethically justifiable, it is important to be mindful of the risks involved in providing services to an individual in another state without being appropriately licensed by that state; or, otherwise authorized by that state's regulatory board acting in accordance with that state's laws and regulations. [12]

Reimbursement Issues

California law mandates that managed health care service plans and insurers cover services that can be provided through telehealth. (Health and Safety Code, §1374.13, Welfare and Institutions Code §14132.72, and Insurance Code §§10123.13 and 10123.85.) The intent of the Telemedicine Act was to "encourage health insurers to establish reimbursement policies for telehealth providers." It required

[12] See, "The Basics of Telehealth," Montgomery, Alain, JD., *The Therapist*, February/March, 2015

every insurer issuing group or individual policies of disability insurance to reimburse claims for those expenses within 30 working days after the receipt of claim unless contested; prohibited health care service disability insurers, non-profit plans, and the Medi-Cal program, from requiring face-to-face contact between patient and physician as a condition of payment for services; and, required service plans to adopt reimbursement policies to compensate telehealth services. In practice however, some providers report that plans may deny payment for telehealth, stating that they do not believe they are required to reimburse for such services, or, the plan may require pre-authorization for telehealth. In other instances, the insurance plan may require the provider to participate in some kind of training program put on by the plan prior to being eligible for reimbursement. Consequently, reimbursement for telehealth has thusfar been inconsistent and problematic. CAMFT has raised such concerns with the insurance plans themselves , have expressed out concerns with the department of insurance, and is attempting to pursue the issue of reimbursement and access to telehealth with California legislators.

CAMFT Code of Ethics

1.4.2 ELECTRONIC THERAPY:

When patients are not physically present (e.g., therapy by telephone or Internet) during the provision of therapy, marriage and family therapists take extra precautions to meet their responsibilities to patients. Prior to utilizing electronic therapy, marriage and family therapists consider the appropriateness and suitability of this therapeutic modality to the patient's needs. When therapy occurs by electronic means, marriage and family therapists inform patients of the potential risks, consequences, and benefits, including but not limited to, issues of confidentiality, clinical limitations, transmission difficulties, and ability to respond to emergencies. Marriage and family therapists ensure that such therapy complies with the informed consent requirements of the California Telemedicine Act.

HIPAA-Related Issues

HIPAA privacy and security rules require individuals, organizations, and agencies who meet the definition of a "covered entity" to comply with the rules' requirements to protect the privacy and security of a patient's health information. A covered entity is a health care provider (an individual or organization) who transmits health information electronically to another covered entity to effectuate administrative and/or financial transactions related to a patient's health care. If a covered entity engages a "business associate" – a third party who provides services to the covered entity who may have access to a patient's protected health information, the covered entity must have a written business associate agreement which assures that the business associate will appropriately safeguard and protect the privacy and security of a patient's health information. [13]When conducting telehealth over the Internet, the process necessarily involves the transmission of private health information as the health care provider interacts with his or her patient. The relevant question therefore is whether it is necessary for a health care provider who is a covered entity under HIPAA to have a business associate agreement with a business entity that provides the videoconferencing technology that is being utilized

[13] For more information regarding the issue of Business Associates under HIPAA, see, "Neither You Nor Your Business Associates Can Afford to be Lax About Complying with HIPAA Requirements," Kashing, Sara, JD. *The Therapist,*

for telehealth. The most cautious answer is that a business associate agreement should be used in this situation

HIPAA-Compliant Video technology Resources

Fortunately, there are an ever-increasing number of companies who offer HIPAA-compliant videoconferencing solutions for telehealth. A recent Internet search on this topic revealed numerous options, including plans which are tailored to the needs of sole practitioners. Several companies offer free product trials, or demonstrations, so a provider can assess whether the technology is user friendly, and compatible with the needs of his or her practice. Products vary, and may include related practice-management services, such as the ability for clients to schedule sessions, send secure messages to clients, and/or, to provide payments on-line for services rendered.[14]

The following is a partial list of Internet technology providers who offer HIPAA compliant platforms for telehealth services, and provide a Business Associate Agreement.

VSee: **http://vsee.com**
Offers a plan for solo practitioners for $45.00 per month.

SecureVideo: https://securevideo.com
Offers plans for single clinicians priced from $25.00 per month.

Thera-link: https://www.thera-link.com
Offers plans for single practitioners for $30.00 per month; $85.00 month for 2-10 providers.

CounSol.com: https://counsol.com
Offers "practice management plus" plan which includes secure email, appointment making, billing, secure record storage, etc., for $59.95 month.

Doxy.me: https:doxy.me
Offers HIPAA compliant audio/video communications, including live chat. Cost is Free.

WeCounsel.com: **http:www.wecounsel.com**
Offers a plan that includes practice management services such as secure messaging, billing, document storage, etc., for $14.99 month.

[14] See, "Selecting the Right Videotechnology for Telehealth: Key Issues for Covered Entities," Griffin, Michael, JD, LCSW, *The Therapist*, Nov/Dec., 2015

V. WORKING WITH MINORS: ISSUES INVOLVING CONSENT, CONFIDENTIALITY, PSYCHOTHERAPIST-PATIENTPRIVILEGE AND ACCESS TO THE TREATMENT RECORD

Consent For The Treatment Of Minors

Where there are both biological parents, still married, either adult may provide consent.

Where The Biological Parents Are Divorced

The therapist must determine whether there is joint legal custody, or sole legal custody of the child. If one parent has sole legal custody, they alone may consent. If both parents share legal custody, their final custody order should be consulted to help clarify their authority to consent to the minor's health care. If the language of the order indicates that both parents must consent to specific health care decisions, the therapist should ask for the consent of both parents. In the absence of specific language in the custody order and there is joint legal custody, either parent may provide consent.

In general, it is best to pursue the consent of both parents.

In circumstances where it is not legally required to have the consent of both parents, it is important to consider that the parent who is not involved is unable to contribute to the minor's treatment. Furthermore, as a general rule, the parent who is not involved by the therapist is likely to become aware of the child's treatment at some point, and may be angry with the therapist for being "left out." In such a circumstance, the parent may be opposed to any continuation of the child's treatment and he or she may make it difficult, or stressful for the minor to continue.

Family Code, 3002 "Joint custody" means joint physical custody and joint legal custody.

Family Code, 3003 "Joint legal custody" means that both parents shall share the right and the responsibility to make the decisions relating to the health, education, and welfare of a child.

Family Code, 3004 "joint physical custody" means that each of the parents shall have significant periods of physical custody. Joint physical custody shall be shared by the parents in such a way so as to assure a child of frequent and continuing contact with both parents, subject to Sections 3011 and 3020.

Family Code, 3006 "Sole legal custody" means that one parent shall have the right and the responsibility to make the decisions relating to the health, education, and welfare of a child.

Family Code, 3007 "Sole physical custody" means that a child shall reside with and be under the supervision of one parent, subject to the power of the court to order visitation.

Family Code, 3083 In making an order of joint legal custody, the court shall specify the circumstances under which the consent of both parents is required to be obtained in order to exercise legal control of the child and the consequences of the failure to obtain mutual consent. In all other circumstances, either parent acting alone may exercise legal control of the child. An order of joint legal custody shall not be construed to permit an action that is inconsistent with the physical custody order unless the action is expressly authorized by the court.

Family Code, 3085 In making an order for custody with respect to both parents, the court may grant joint legal custody without granting joint physical custody.

Family Code, 3087 An order for joint custody may be modified or terminated upon the petition of one or both parents or on the court's own motion if it is shown that the best interest of the child requires modification or termination of the order. If either parent opposes the modification or termination order, the court shall state in its decision the reasons for modification or termination of the joint custody order.

Family Code, 6550.(a), 6552 (Caregiver's Authorization Affidavit) This statute provides a mechanism for "authorized caregivers" to provide consent for the treatment of a minor. Section 6550 describes the requirements and section 6552 is the actual affidavit/declaration that the caregiver would need to review and sign, to provide his or her consent.

Consent For Treatment by a Minor

There are two laws which permit a minor to consent to his or her mental health treatment: Family Code Section 6924 and Health and Safety Code, Section 124260.

Family Code, 6924

(B)(b) **A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if both of the following requirements are satisfied: (1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services. (2) The minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or (B) is the alleged victim of incest or child abuse.**(c) A professional person offering residential shelter services, whether as an individual or as a representative of an entity specified in paragraph (3) of subdivision (a), shall make his or her best efforts to notify the parent or guardian of the provision of services. (d) **The mental health treatment or counseling of a minor authorized by this section shall include involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. The professional person who is treating or counseling the minor shall state in the client record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian. (e) The minor's parents or guardian are not liable for payment for mental health treatment or counseling services provided pursuant to this section unless the parent or guardian participates in the mental health treatment or counseling, and then only for services rendered with the participation of the parent or guardian.** The minor's parents or guardian are not liable for payment for any residential shelter services provided pursuant to this section unless the parent or guardian consented to the provision of those services. (f) This section does not authorize a minor to receive convulsive therapy

or psychosurgery as defined in subdivisions (f) and (g) of Section 5325 of the Welfare and Institutions Code, or psychotropic drugs without the consent of the minor's parent or guardian.

Health and Safety Code, 124260.

(a) As used in this section: (1) "Mental health treatment or counseling services" means the provision of outpatient mental health treatment or counseling by a professional person, as defined in paragraph (2). (2) "Professional person" means any of the following: (A) A person designated as a mental health professional in Sections 622 to 626, inclusive, of Title 9 of the California Code of Regulations. (B) A marriage and family therapist as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code. (C) A licensed educational psychologist as defined in Chapter 13.5 (commencing with Section 4989.10) of Division 2 of the Business and Professions Code. (D) A credentialed school psychologist as described in Section 49424 of the Education Code. (E) A clinical psychologist as defined in Section 1316.5 of the Health and Safety Code. (F) A licensed clinical social worker as defined in Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code. (G) A marriage and family therapist registered intern, as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, while working under the supervision of a licensed professional specified in subdivision (f) of Section 4980.40 of the Business and Professions Code as that subdivision read on January 1, 2003. (H) A board certified, or board eligible, psychiatrist. (b**) Notwithstanding any provision of law to the contrary, a minor who is 12 years of age or older may consent to mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services. (c)Notwithstanding any provision of law to the contrary, the mental health treatment or counseling of a minor authorized by this section shall include involvement of the minor's parent or guardian, unless the professional person who is treating or counseling the minor, after consulting with the minor, determines that the involvement would be inappropriate. The professional person who is treating or counseling the minor shall state in the client record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian. (d) The minor's parent or guardian is not liable for payment for mental health treatment or counseling services provided pursuant to this section unless the parent or guardian participates in the mental health treatment or counseling, and then only for services rendered with the participation of the parent or guardian.** (e) This section does not authorize a minor to receive convulsive therapy or psychosurgery as defined in subdivisions (f) and (g) of Section 5325 of the Welfare and Institutions Code, or psychotropic drugs without the consent of the minor's parent or guardian.

Confidentiality Issues Involving Minors

Minors Are Entitled To Confidentiality.

However, the parameters of confidentiality when working with minors are not identical, in general, to those, which exist when working with adult clients.

Standard Of Care Issues

The general standard of care when working with most minor clients is that the minor's caretaker(s) will be involved in his or her treatment, in some fashion, depending on the circumstances of the case. There are exceptions and variations to this general standard.

The parent or legal guardian can demand to have access to the minor's treatment record. However, California law permits a therapist to decline the parent's request for access to the minor's record according to the provisions of the Health and Safety Code.

Psychotherapist-Patient Privilege Involving Minors

In California, a minor patient is the holder of the psychotherapist-patient privilege.

In re: Daniel C.H., (1990) 220 Cal.App.3d 814 (minor as holder of psychotherapist-patient privilege)

A guardian ad-litem and/or minor's counsel can assert or waiver privilege on behalf of the minor.

Health & Welfare Code, 317(f) (regarding minors in placement)

When a minor is involved in the dependency court, there are special rules related to the psychotherapist-patient privilege. Either the child or the Counsel for the child, with the informed consent of the child if the child is found by the court to be of sufficient age and maturity to so consent, which shall be presumed, subject to rebuttal by clear and convincing evidence, if the child is over 12 years of age, may invoke the psychotherapist-client privilege, physician-patient privilege, and clergyman-penitent privilege; and if the child invokes the privilege, Counsel may not waive it, but if counsel invokes privilege, the child may waive it. Counsel shall be holder of these privileges if the child is found by the court not to be of sufficient age and maturity to so consent.

CAMFT Code of Ethics

8.6 MINORS AND PRIVILEGE:

Marriage and family therapists confirm the holder of the psychotherapist patient privilege on behalf of minor clients prior to releasing information or testifying.

Access To The Minor's Treatment Record

Health & Safety Code, 123115 (Request for a minor's treatment record)

Parents and guardians have the right to inspect their children's records (so long as the records do not pertain to care for which the minor actually provided the consent.) However:

(a) "The representative of a minor shall not be entitled to inspect or obtain copies of the minor's patient records in either of the following circumstances:

(1) With respect to which the minor has a right of inspection under Section 123110.

(2) Where the health care provider determines that access to the patient records requested by the representative would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being. The decision of the health care provider as to whether or not a minor's records are available for inspection or copying under this section shall not attach any liability to the provider, unless the decision is found to be in bad faith.

Releases/Authorizations

A parent or guardian must sign the authorization when the parent or guardian consented for the minor's treatment. The minor must sign the authorization if the minor consented to his or her own treatment.

***Note: HIPAA defers to California law concerning minors' health care records and access to those records.**

HYPOTHETICAL SCENARIO #3

A therapist who is working with an adolescent male patient receives a phone call from the boy's parents who want to know why it is that the therapist (allegedly) told their son that "he is free to do whatever he wants to do at this point, because he is going to be eighteen in less than a year,"

1. Is it possible for the therapist to respond to this question without violating the minor's confidentiality?

2. Alternate Scenario: Suppose that the boy's parents ask the therapist what he or she thinks about the adolescent's "ridiculous" interest in attending some kind of "alternative" high school? Can the therapist express his/her opinion about this question without first asking for the minor's consent to do so? What information would you need to know to answer this question?

VI. WORKING WITH COUPLES AND FAMILIES: ISSUES INVOLVING CONFIDENTIALITY, PSYCHOTHERAPIST-PATIENT PRIVILEGE AND ACCESS TO THE TREATMENT RECORD

Confidentiality Issues When Working With Couples And Families

Clarify the unit of treatment

Confidentiality rights belong to both members of the couple, or, all of the family members, depending on the case. [15] [16] [17]

[15] 2.,CAMFT Code of Ethics **Confidentiality** Marriage and family therapists have unique confidentiality responsibilities because the "patient" in a therapeutic relationship may be more than one person. The overriding principle is that marriage and family therapists respect the confidences of their patients.

[16] 2.2, CAMFT Code of Ethics, **Signed Authorizations-Release of Information** When there is a request for information related to any aspect of psychotherapy or treatment, each member of the unit receiving such therapeutic treatment must sign an authorization before a marriage and family therapist will disclose information received from any member of the treatment unit.

[17] 1.5.4, CAMFT Code of Ethics, Consent for Recording/Observation Marriage and family therapists are encouraged to inform patients as to certain exceptions to confidentiality such as child abuse reporting, elder and dependent adult abuse reporting, and patients dangerous to themselves or others.

The Use Of "No-Secrets" Policies

When a "no secrets" policy is utilized, members of the family/couple agree, at the start of treatment, that the therapist is permitted to share information that he or she learned in an individual session with one of them, with other members of the family/couple, if the therapist believes that the information is relevant to the treatment.

Privilege Involving Couples/Families

Evidence Code, 912 (b)

Where two or more persons are joint holders of a privilege provided by Section 954 (lawyer-client privilege), 994 (physician-patient privilege), 1014 (psychotherapist-patient privilege), 1035.8 (sexual assault counselor-victim privilege), or 1037.5 (domestic violence counselor-victim privilege**), a waiver of the right of a particular joint holder of the privilege to claim the privilege does not affect the right of another joint holder to claim the privilege.** In the case of the privilege provided by Section 980 (privilege for confidential marital communications), **a waiver of the right of one spouse to claim the privilege does not affect the right of the other spouse to claim the privilege.**

Confidentiality Rights Of "Collateral" Participants In Therapy[18]

A person or persons who attends the therapy session of another individual, in furtherance of that other person's therapy is often referred to as a "collateral," who was involved in the patient's treatment. While the collateral attendee may not be considered to be a patient, unless he or she was told that confidentiality did not apply to his or her participation in treatment, he or she would probably have some reasonable expectation of privacy as to his or her communications with the therapist.

Privilege Involving "Collateral" Participants

The communications of "collaterals" in treatment is generally considered to be "privileged," if their involvement was in furtherance of the patient's treatment, but the privilege would be an extension of the patient's privilege.

Access To The Treatment Record: Where the identified "patient" is the couple or family, the record cannot be released unless there is consent from all of the participants. Confidentiality rights are jointly held. Issues here often arise when one member of a couple requests a copy of the marital treatment record.

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[18] See, Kashing, Sara, JD., "Understanding the Role Of Collaterals in Psychotherapy," *The Therapist*, March/April, 2016

CAMFT Code of Ethics

2.2 SIGNED AUTHORIZATIONS-RELEASE OF INFORMATION:

When there is a request for information related to any aspect of psychotherapy or treatment, each member of the unit receiving such therapeutic treatment must sign an authorization before a marriage and family therapist information received from any member of the treatment unit.

VII. ISSUES INVOLVING RIGHTS OF ACCESS TO THE TREATMENT RECORD[19]

Responding to a Patient's Request for Records

Under California law, a therapist has three (3) options to respond to a patient's request to either inspect or receive a copy of his or her record. A provider shall do one of the following:

*** Allow the patient to inspect or receive a copy of his or her record;**

*** Provide the patient with a treatment summary in lieu of providing a copy of the record; or,**

*** Decline the patient's request.**

Health & Safety Code, 123110,(Right of inspection of the record/right to request a copy of the record)

Any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient representative shall be entitled to inspect patient records upon presenting to the health care provider a written request for those records and upon payment of reasonable clerical costs incurred in locating and making the records available. However, a patient who is a minor shall be entitled to inspect patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent. A health care provider shall permit this inspection during business hours within five working days after receipt of the written request. The inspection shall be conducted by the patient or patient's representative requesting the inspection, who may be accompanied by one other person of his or her choosing. (b) Additionally, any patient or patient's representative shall be entitled to copies of all or any portion of the patient records that he or she has a right to inspect, upon presenting a written request to the health care provider specifying the records to be copied, together with a fee to defray the cost of copying, that shall not exceed twenty-five cents ($0.25) per page... The health care provider shall ensure that the copies are transmitted within 15 days after receiving the written request. All reasonable costs, not exceeding actual costs, incurred by a health care provider in providing copies pursuant to this subdivision may be charged to the patient or representative requesting the copies. Notwithstanding any provision of this section, and except as provided in Sections 123115 and 123120, any patient or former patient or the patient's representative shall be entitled to a copy, at no charge, of the relevant portion

[19] Statutes listed in this document are not reproduced in their entirety. In some instances, selected excerpts of statutes and regulations have been utilized in order to illustrate and discuss specific legal issues. The reader should take care to consult the full and current text of any legal or ethical authority being utilized and to seek professional consultation when appropriate.

of the patient's records, upon presenting to the provider a written request, and proof that the records are needed to support an appeal regarding eligibility for a public benefit program…

Health & Safety Code, 123130(a) (summary of the record)

A health care provider may prepare a summary of the record, according to the requirements of this section, for inspection and copying by a patient. If the health care provider chooses to prepare a summary of the record rather than allowing access to the entire record, he or she shall make the summary of the record available to the patient within 10 working days from the date of the patient's request...In preparing the summary of the record the health care provider shall not be obligated to include information that is not contained in the original record. (b) A health care provider may confer with the patient in an attempt to clarify the patient's purpose and goal in obtaining his or her record. If as a consequence the patient requests information about only certain injuries, illnesses, or episodes, this subdivision shall not require the provider to prepare the summary required by this subdivision for other than the injuries, illnesses, or episodes so requested by the patient. The summary shall contain for each injury, illness, or episode any information included in the record relative to the following: (1) Chief complaint or complaints including pertinent history. (2) Findings from consultations and referrals to other health care providers (3) Diagnosis, where determined. (4) Treatment plan and regimen including medications prescribed. (5) Progress of the treatment. (6) Prognosis including significant continuing problems or conditions. (7) Pertinent reports of diagnostic procedures and tests and all discharge summaries. (8)… **Note: Under HIPAA, a patient can decline the offer of a summary in lieu of a copy of the record.**

California Law Regarding Denial Of An Adult Patient's Request To Access His/Her Record

Health & Safety Code, 123115(a)(b)

When a health care provider determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient, the provider may decline to permit inspection or provide copies of the records to the patient, subject to the following conditions: (1) The health care provider shall make a written record, to be included with the mental health records requested, noting the date of the request and explaining the health care provider's reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse or detrimental consequences to the patient that the provider anticipates would occur if inspection or copying were permitted. (2) The health care provider shall permit inspection by, or provide copies of the mental health records to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, or licensed clinical social worker, designated by request of the patient…

Federal Law (HIPAA) Regarding Denial Of An Adult Patient's Request To Access His/Her Record

45, CFR, 164.524 (HIPAA) Access Of Individuals To Protected Health Information.[20]

(a) Standard: Access to protected health information—(1)Right of access. Except as otherwise provided in paragraph (a)(2) or (a)(3) of this section, an individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set, except for:(i) Psychotherapy notes; and (i) A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person; (iii) The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

CAMFT Code of Ethics

1.10 WITHOLDING RECORDS-NON-PAYMENT:

Marriage and family therapists do not withhold patient records or information solely because the therapist has not been paid for prior professional services.

Retaining Treatment Records [21] [22]

Business and Prof. Code, 4980.49(a)

A marriage and family therapist shall retain a client's or patient's health service records for a minimum of seven years from the date therapy is terminated. If the client or patient is a minor, the client's or patient's health service records shall be retained for a minimum of seven years from the date the client or the patient reaches 18 years of age. Health service records may be retained in either a written or an electronic format.(b) This section shall apply only to the records of a client or patient whose therapy is terminated on or after January 1, 2015.

[20] 45 CFR 164.524 (Note: This content is an excerpt of a selected part of this statute)
[21] Business & Prof. Code, 4980.49(a)(b)**,.** Sectio**n** 4993.(a)(b) applies to Social Workers, 4999.75 applies to Prof. clinical Counselors, 2929 applies to Psychologists
[22] 2.4 CAMFT Code of Ethics Marriage and family therapists' store, transfer, transmit, and/or dispose of patient records in ways that protect confidentiality.

HYPOTHETICAL SCENARIO# 4

Therapist works with Ben and Mary in couples treatment for about 9 months. When progress appears to be at a standstill, Ben announces that he is "done" with the marriage and no longer intends to participate in therapy. After Mary expressed to the therapist that she wanted to continue with her in therapy, they continued to meet on a weekly basis. The therapist continued to document Mary's sessions in the same treatment record. After about 3 months, Ben leaves a voicemail message for the therapist, requesting that a copy of the marital treatment record be sent to his attorney as soon as possible. In his message, Ben also asked the therapist to let him know whether she had documented in the marital record, the fact that Mary had (allegedly) admitted during a marital session that she was intoxicated on one occasion when caring for their 3 year-old daughter.

1. What issues exist here, concerning rights of access to the treatment record, confidentiality, psychotherapist-patient privilege, clarifying the specific unit of treatment (e.g., who the client is) and/or engaging in subsequent treatment modalities with members of the same family unit?

VIII. WORKING WITH CLIENTS WHO ARE INVOLVED WITH THE LEGAL SYSTEM

To a significant extent, when working with clients who are involved with the legal system, the issues that get therapists into hot water have to do with client requests for professional opinions, either in the form of testimony from the therapist, or more commonly, in requests for letters. As the topic of handling requests for letters is discussed in section VII, below, the content of section VI and section VII necessarily overlap. In this section, we will begin with a general discussion of client's who are involved in litigation and the ways in which therapists are routinely asked to interject themselves into their client's legal matters. We will also talk about the therapist as witness in court or in a deposition, identify some key issues to be aware of and help you to anticipate some of the predictable problems and pitfalls so you can better avoid them.

Testifying

You can be called to testify in a case in Family Court, Dependency Court, Civil Court or Criminal Court.

Percipient Witness

A health care professional may be called as a percipient witness, A percipient witness is one who testifies to things or events that he or she actually saw or heard. “What did you see?” or, “What did you hear?”

Expert Witness

An expert witness is someone who testifies based upon his or her specialized training or experience. Expert witnesses are usually persons from outside the case, who are retained by a party to offer an opinion.

A health care professional may be called to give an opinion based upon his or her training and experience about the case. If that is the case, he or she can request to be paid the reasonable and customary hourly or daily fee for the actual time consumed in the examination of the witness, per Government Code, Section 68092.5(a):

Government Code, 68092.5.(a) A party requiring testimony before any court, tribunal, or arbiter in any civil action or proceeding from any expert witness, other than a party or employee of a party, who is either, (1) an expert described in subdivision (b) of Section 2034.210 of the Code of Civil Procedure, (2) a treating physician and surgeon or other treating health care practitioner who is to be asked to express an opinion during the action or proceeding, or (3) an architect, professional engineer, or licensed land surveyor who was involved with the original project design or survey for which he or she is asked to express an opinion within his or her expertise and relevant to the action or proceeding, **shall pay the reasonable and customary hourly or daily fee for the actual time consumed in the examination of that witness by any party attending the action or proceedin**g. The hourly or daily fee shall not exceed the fee charged the party who retained the expert except where the expert donated his or her services to a charitable or other nonprofit organization. A daily fee shall only be charged for a full day of attendance at a deposition or where the expert was required by the deposing party to be available for a full day and the expert necessarily had to forego all business he or she would have otherwise conducted that day but for the request that he or she be available all day for the scheduled deposition…

Testifying In General (A few suggestions)

* Always wait to hear the entire question before responding.

* Before you answer, wait to hear whether there will be any objection raised and if so, wait for the judge to rule.

* Think about the question before you answer it.

* It is OK to say that you "don't know" the answer, or that you "don't remember."

* Don't speculate.

* You can ask for a question to be repeated.

* You can ask that a question be clarified if confusing.

* State what you saw or heard vs. stating something as a fact, e.g., "Sue was abused by her father" vs. "Sue described her recollection of being abused by her dad."

Opinion Questions (examples)

You may be asked your opinion about the treatment you provided.

You may be asked about you're your assessment and diagnosis and how you arrived at it.

Take your time when answering.

If you express an opinion, you may be asked how you arrived at it. Before you go to Court (or to the deposition), think about what your opinions are, and how you would support your opinions if asked.

Be careful about offering opinions that concern issues that are outside the purpose of your treatment. E.g., you may have been acting as the therapist to the child and not as an evaluator of the parent's abilities. Unless you directly evaluated the mom or dad on some issue you shouldn't be offering an opinion that suggests that you did.

If your opinion on an issue is based upon limited information, make sure that you indicate the limited source of your information (if, for some reason, you think it's a good idea to offer an opinion in such a circumstance!)

Testifying at a Deposition

The purpose of discovery

What is the purpose of a deposition?

What to expect

Who will be there and what will they be doing?

What kind of questions will I be asked?

It's different than in court. Attorneys have more leeway in the questions they ask. Questions must simply be "reasonably calculated to lead to the discovery of admissible evidence."

Try to relax. Keep in mind that you are not one of the parties.

Stick to what you know and remember that you are under oath.

Take your time. You can say if you don't understand the question, and you are free to ask for a question t be repeated.

Don't advise your client about what your testimony should or shouldn't be.

Don't speculate.
Don't get irritated or sarcastic, etc.

Don't offer more information that what is being asked in the particular question.

Don't express opinions about the legal issues in the case.

Don't offer an opinion about someone who you didn't evaluate.

Don't give an opinion unless you have some basis for doing-so.

Don't take it personally when your opinion is challenged.

Remember that you are not responsible for the client's success in his or her legal matter.

Becoming an advocate for the client in his or her legal matter may expose the therapist to allegations of engaging in an improper dual-relationship

CAMFT Code of Ethics

1.2 DUAL RELATIONSHIPS-DEFINITION:

Marriage and family therapists are aware of their influential position with respect to patients, and they avoid exploiting the trust and dependency of such persons. Marriage and family therapists therefore avoid dual relationships with patients that are reasonably likely to impair professional judgment or lead to exploitation. A dual relationship occurs when a therapist and his/her patient engage in a separate and distinct relationship either simultaneously with the therapeutic relationship, or during a reasonable period of time following the termination of the therapeutic relationship. Not all dual relationships are unethical, and some dual relationships

1.2.1 UNETHICAL DUAL RELATIONSHIPS:

Other acts that would result in unethical dual relationships include, but are not limited to, borrowing money from a patient, hiring a patient, engaging in a business venture with a patient, or engaging in a close personal relationship with a patient. Such acts with a patient's spouse, partner or family member may also be considered unethical dual relationships.

1.9 FAMILY UNIT/CONFLICTS:

When treating a family unit(s), marriage and family therapists carefully consider the potential conflict that may arise between the family unit(s) and each individual. Marriage and family therapists clarify, at the commencement of treatment**,** which person or persons are clients and the nature of the relationship(s) the therapist will have with each person involved in the treatment.

3.13 PUBLIC STATEMENTS:

Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise care when making public their professional recommendations and opinions through testimony or other public statements.

3.14 LIMITS OF PROFESSIONAL OPINIONS:

Marriage and family therapists do not express professional opinions about an individual's mental or emotional condition unless they have treated or conducted an examination of the individual, or unless they reveal the limits of the information upon which their professional opinions are based, with appropriate cautions as to the effects of such limited information upon their opinions.

8. RESPONSIBILITY TO THE LEGAL SYSTEM:

Marriage and family therapists recognize their role in the legal system and their duty to remain objective and truthful.

8.1 TESTIMONY:

Marriage and family therapists who give testimony in legal proceedings testify truthfully and avoid making misleading statements.

8.2 EXPERT WITNESSES:

Marriage and family therapists who act as expert witnesses base their opinions and conclusions on appropriate data, and are careful to acknowledge the limits of their data or conclusions in order to avoid providing misleading testimony or reports.

8.3 CONFLICTING ROLES:

Whenever possible**,** marriage and family therapists avoid performing conflicting roles in legal proceedings and disclose any potential conflicts. At the outset of the service to be provided and as changes occur, marriage and family therapists clarify role expectations and the extent of confidentiality to prospective clients, to the courts, or to others as appropriate.

8.4 DUAL ROLES:

Marriage and family therapists avoid providing both treatment and evaluations for the same clients or treatment units in legal proceedings such as child custody, visitation, dependency, or guardianship proceedings, unless otherwise required by law or initially appointed pursuant to court order.

8.5 IMPARTIALITY:

Marriage and family therapists, regardless of their role in a legal proceeding, remain impartial and do not compromise their professional judgment or integrity.

8.6 MINORS AND PRIVILEGE:

Marriage and family therapists confirm the holder of the psychotherapist patient privilege on behalf of minor clients prior to releasing information or testifying.

8.7 OPINIONS ABOUT PERSONS NOT EVALUATED:

Marriage and family therapists shall only express professional opinions about clients they have treated or examined. Marriage and family therapists, when expressing professional opinions, specify the limits of the information upon which their professional opinions are based. Such professional opinions include, but are not limited to, mental or emotional conditions or parenting abilities.

8.8 CUSTODY EVALUATORS:

Marriage and family therapists who are custody evaluators (private or court-based) or special masters provide such services only if they meet the requirements established by pertinent laws, regulations, and rules of court.

8.9 CONSEQUENCES OF CHANGES IN THERAPIST ROLES:

Marriage and family therapists inform the patient or the treatment unit of any potential consequences of therapist-client role changes. Such role changes include, but are not limited to, child's therapist, family's therapist, couple's therapist, individual's therapist, mediator, evaluator, and special master.

8.10 FAMILIARITY WITH JUDICIAL AND ADMINISTRATIVE RULES:

Marriage and family therapists, when assuming forensic roles, are or become familiar with the judicial and administrative rules governing their roles. cannot be avoided. When a concurrent or subsequent dual relationship occurs, marriage and family therapists take appropriate professional precautions to ensure that judgment is not impaired and that no exploitation occurs.

IX. HANDLING REQUESTS FOR PROFESSIONAL OPINIONS (LETTERS)

Therapists are asked to write letters for a variety of reasons, some more important than others. More often than not, a request for a letter is really a request for the therapist to provide his or her professional opinion or recommendations regarding the client.

The Right to Say "No"

There is no legal or ethical "duty to write a letter" and a client's request, in and of itself, does not obligate a therapist to act in a particular manner.

High Risk Scenarios One of the most challenging situations occurs when a therapist is asked to provide his or her recommendations concerning a child or adolescent client, whose parents are engaged in family court litigation.

A therapist may be informed that a letter is needed for an important legal action, which concerns the child, or that the therapist's help is urgently necessary in order to protect the child from a dangerous person or circumstance.

The general rule is that a therapist should avoid offering his or her opinion on a legal issue, such as custodial rights or the child's visitation schedule.

Generally speaking, when a therapist writes a letter on a matter that is the subject of contention in a family court matter, there is a significant risk that he or she will encounter legal and ethical problems, as evidenced in numerous complaints that are filed with licensing boards and ethics committees.

Legal and Ethical Issues

Prior to offering a professional opinion, a therapist needs to determine whether it is appropriate for him or her to express such an opinion. In making such a determination, the therapist would be expected to consider any relevant legal and ethical standards.

Generally speaking, the standards that are relevant to this area concern the following subject matter:

Scope of Competency

In order for the therapist to provide his or her professional recommendations regarding a particular topic or issue, he or she must possess a sufficient degree of education, training and experience to competently render such an opinion. Consequently, a therapist who offers his or her assessment of, or recommendations concerning, some issue, while lacking the competency to do so, may be accused of engaging in unprofessional conduct.[23]

Dual Relationships/Conflicts of Interest [24] [25] [26]

A therapist is expected to avoid performing multiple roles for the same clients or treatment units, particularly when doing so is likely to impair his or her professional judgment, or where there is a potential conflict of interest. There is a potential conflict of interest, when a treating therapist provides an evaluation of his or her psychotherapy client for use in a legal proceeding.

[23] Business & Professions Code, 4982(s) Performing or holding oneself out as being able to perform professional services beyond the scope of one's competence, as established by one's education, training or experience is unprofessional conduct.

[24] 1.2, CAMFT Code of Ethics Marriage and family therapists are aware of their influential position with respect to patients, and they avoid exploiting the trust and dependency of such persons. Marriage and family therapists therefore avoid dual relationships with patients that are reasonably likely to impair professional judgment or lead to exploitation. A dual relationship occurs when a therapist and his/her patient engage in a separate and distinct relationship either simultaneously with the therapeutic relationship, or during a reasonable period of time following the termination of the therapeutic relationship. Not all dual relationships are unethical, and some dual relationships cannot be avoided. When a concurrent or subsequent dual relationship occurs, marriage and family therapists take appropriate professional precautions to ensure that judgment is not impaired and that no exploitation occurs.

[25] 8.4, CAMFT Code of Ethics*:* Marriage and family therapists avoid providing both treatment and evaluations for the same clients or treatment units in legal proceedings such as child custody, visitation, dependency, or guardianship proceedings, unless otherwise required by law or initially appointed pursuant to court order.

[26] 8.3, CAMFT Code of Ethics: Whenever possible, marriage and family therapists avoid performing conflicting roles in legal proceedings and disclose any potential conflicts. At the outset of the service to be provided and as changes occur, marriage and family therapists clarify role expectations and the extent of confidentiality to prospective clients, to the courts, or to others as appropriate.

Bias/Lack of Objectivity [27] [28]

A therapist is expected to remain impartial in a legal proceeding and to avoid compromising his or her judgment. When a therapist offers an opinion or recommendation regarding his or her psychotherapy client, for use in a legal matter, he or she may be subject to an allegation that his or her opinion was biased, because of his or her concurrent role as the person's therapist. Should the opinion concern a legal issue such as custody, an aggrieved party may decide to complain of bias, and point out that opinions regarding custody are supposed to be issued by individuals who have met specific requirements and guidelines.

Disclosing the Limits of Opinions/Offering Opinions About Persons Not Evaluated [29]

It is unethical for a therapist to offer an opinion about a person that he or she has not evaluated. Furthermore, it is expected that a therapist will disclose the limits of the information upon which his or her opinion is based. Consequently, when a therapist offers an opinion, which describes the alleged problems of some person whom he or she has never met, there is a significant possibility that the individual may accuse the therapist of unethical conduct.

Questions to Consider

Before responding to a request for a letter, a therapist may find it helpful to consider the following questions:

*** What is the specific nature of the request?**

*** What does the requesting person want from you?**

*** Are you reluctant to respond to the request? Why?**

*** What does the request have to do with your role as a therapist?**

*** Are there any reasons that you should not honor the particular request?**

*** Do you feel pressured or compelled to honor the request? If so, why?**

*** Is it appropriate to provide the information that is being requested?**

*** Are you qualified to address the particular issue?**

[27] 8.5 CAMFT Code of Ethics: Marriage and family therapists, regardless of their role in a legal proceeding, remain impartial and do not compromise their professional judgment or integrity.
[28] 8.8 CAMFT Code of Ethics: Marriage and family therapists who are custody evaluators (private or court-based) or special masters provide such services only if they meet the requirements established by pertinent laws, regulations, and rules of court.
[29] 8.7 CAMFT Code of Ethics: Marriage and family therapists shall only express professional opinions about clients they have treated or examined. Marriage and family therapists, when expressing professional opinions, specify the limits of the information upon which their professional opinions are based. Such professional opinions include, but are not limited to, mental or emotional conditions or parenting abilities.

Examples

Client tells therapist at intake session that: He/she would like to get a letter from the therapist stating that he/she is unable to work due to emotional problems, stress, etc.

Client tells therapist at intake session that He/she is involved in litigation in family court, and will need a letter from the therapist, attesting to the fact that he/she is an appropriate parent and that his/her child doesn't want to live/visit with the other parent, etc.

In the foregoing examples, the therapist occasionally responds to the client by stating that he/she is unwilling to write such a letter. The client either gets irritated in response, or, says nothing further about the issue. Therapist and client have no further discussion on the issue and continue to meet in therapy. After several weeks, the client again states (often at the end of the session, or as the client is walking out the door) that he needs the letter "right away." The therapist thought that he/she addressed the issue at the initial session and is confused by the client's request while the client states that he/she told the therapist about the need for a letter.

HYPOTHETICAL SCENARIO #5

A therapist is asked to work with a 12 year old boy concerning a variety of issues related to his behavior at home at school. The minor's parents are divorced and the therapist is informed that the boy has not had contact with his father since he was 5 years old. The therapist is further informed that the father has been "out of the picture" and uninvolved with the minor during that entire period of time. After a few months of treatment, the boy's mother informs the therapist that the boy's father has decided to pursue reunification with the minor and that the therapist should expect a call from her lawyer in the matter. Shortly thereafter, the mom's attorney requests a declaration from the therapist, asking her to convey that it would not be in the boy's best interest, if he were forced to have contact with his dad. The attorney said that the boy's mother had previously informed him that this was the therapist's expressed opinion.

1. What it the best course of action for the therapist in this situation? How should the therapist respond to the request to provide a declaration? What are the issues of confidentiality and psychotherapist-patient privilege?

2. Alternately, what if the therapist is asked to provide "reunification therapy" sessions for the boy and his dad?

X. WORKING WITH SUICIDAL AND/OR DANGEROUS CLIENTS

The Suicidal Client

Bellah v Greenson (1978) 81 Cal. App.3d 614

The case entitled Bellah v. Greenson provides an example of what is generally expected of a therapist when he or she is working with a suicidal client.[30] In this case, the parents of an adolescent girl who committed suicide brought a lawsuit against their daughter's former psychiatrist, wherein they alleged that he was negligent in the care of her daughter because he failed to use reasonable care to prevent her suicide. However, in this case, the girl's parents also contended that Dr. Greenson was negligent, because he failed to inform them of the fact that she was engaging in high-risk behavior during the time that she was in treatment. [31] [32] In its' decision, the Court of Appeal agreed that Dr. Greenson had a duty to exercise reasonable care in his treatment of the girl; meaning that he was expected to take "appropriate preventive measures" concerning her risk of suicide.[33] But, the court did not agree with the plaintiff's contention that Dr. Greenson had a specific duty to disclose his client's confidential information to her parents.[34]

Although the adolescent client in Bellah v. Greenson was at risk for suicide during the course of her treatment, the court was not inclined to rule that Dr. Greenson was *required* to disclose her confidential information to her parents. The court recognized that, if every therapist was faced with a broad mandate to disclose confidential information regardless of whether it was clinically appropriate to do so, the disclosure itself could result in the rupture of the therapist-client relationship and potentially increase the client's risk of suicide.

Furthermore, the existence of such a rule would be at odds with the fundamental privacy of a therapist-patient relationship. On this issue, the court of appeal also rejected the plaintiff's contention that the landmark case, Tarasoff v. Regents of University of California, created a "duty to warn" under the circumstances found in Bellah v.Greenson:

"We disagree with plaintiffs in their contention that Tarasoff v. Regents of University of California, created a duty on the part of the defendant in this instance to breach the confidence of a doctor-patient relationship by revealing to them disclosures made by their daughter about conditions which might cause her to commit suicide. In Tarasoff, the California Supreme Court held that, under certain circumstances, a therapist had a duty to warn others that a patient under the therapist's care was likely to cause personal injury to a third party…The imposition of a duty upon a psychiatrist to disclose to

[30] Bellah v Greenson, Id.
[31] Bellah v. Greenson, Id.
[32] The argument of the parent's on this issue was premised on their belief that they could have prevented their daughter's death, had they been informed of the fact that she was associating with heroin addicts during the time that she was in treatment.
[33] Id.
[34] Id.

others vague or even specific manifestations of suicidal tendencies on the part of the patient who is being treated in an out-patient setting could well inhibit psychiatric treatment." [35]

The Issue Of Foreseeability [36]

If a therapist (or any health care provider for that matter) is sued for malpractice, it is really a negligence lawsuit. In any negligence lawsuit, it must be shown that the harm in question was actually foreseeable to the therapist as a possible consequence of his or her actions. [37] A therapist cannot be expected to implement preventive measures in a case where the potential suicide of his or her client was not reasonably foreseeable. Thus, in a case involving the alleged negligent failure of a therapist to prevent his or her patient's suicide, one of the fundamental issues is whether or not the therapist was aware of facts from which he or she could reasonably conclude that the client was likely to self-inflict harm in the absence of preventative measures.[38]

Identifying And Responding To Risk Factors For Suicide

There is no list of questions, which will be appropriate for all clients. One client may be relatively forthcoming when asked about his or her ideation. Another client may minimize his or her prior history of depression but have a history of psychiatric hospitalization, wherein, documentation ma y exist which could prove to be enlightening to the therapist, if he or she elected to request such records. Alternately, a consultation with a client's psychiatrist may provide the therapist (or the psychiatrist) with valuable diagnostic information, etc.

Things You Should Always Do

The therapist is expected to make reasonable efforts to identify any "risk factors" for suicide that may be present in a given case. [39]

* No therapist is expected to predict, with certainty, what his or her client will do in the future, nor can he or she control the actions of his or her client. It is expected that the therapist make reasonable efforts to obtain information about the client in order to determine the risk of suicide.[40]

* Some of the key factors that a clinician may consider when assessing his or her patient's suicide risk include, but are not limited to the following: [41]

* When there is a severe risk of suicide, it is necessary to consider the need for hospitalization in order to stabilize the client's symptoms, and for the protection of the client. [42]

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[35] Bellah v.Greenson, Supra., at 620-21.

[36] The issues in a negligence case, which concern causation, will generally involve "proximate" causation, rather than "actual" causation. Proximate causation requires foreseeability of harm.

[37] A malpractice lawsuit is a negligence claim. Negligence requires that a legal duty exists, that the duty is breached, and that the breach causes harm to the client. The harm caused must have been foreseeable to a "reasonable therapist

[38] Jacoves v. United Merchandising Corp.; Supra; Bellah v. Greenson, Supra.

[39] Risk-factors" are really those facts from which the therapist could reasonably conclude that his or her client was at risk of harming him or herself in the absence of preventative measures.

[40] Id.

[41] The factors, which are listed, are a sample of those mentioned in the literature. They are not listed in any hierarchical order and are not intended to serve as a comprehensive list.

* When evaluating a client, it is important to consider any preexisting risk for suicide, including the client's history of depression and suicidal behavior. [43] Previous suicide attempts are associated with an increased risk for suicide, especially when there is a history of two or more attempts. [44]

* There is evidence that clients face an elevated risk for suicide during the first year following an admission for inpatient psychiatric treatment, especially during the first few months after discharge. [45]

* Depending on the client's diagnosis, there may be a need to refer the client for psychiatric evaluation. When a referral to a psychiatrist is indicated, the therapist should make a reasonable effort to consult and collaborate with him or her regarding the client's treatment.

* The presence of a major mood disorder is a significant risk factor for suicide. [46]

* Borderline personality disorder and antisocial personality disorder are also associated with an increased risk of suicide. [47]

* Numerous studies have reported that a client's experience of hopelessness is a substantial risk factor for suicide. [48]

* A history of alcohol or drug abuse is associated with an increased risk of suicide.[49]

* A history of impulsive behavior is associated with an increased risk of suicide.[50]

* The availability of a support system for the client is a key consideration in assessing suicide risk and treatment planning. [51]

* A therapist is not legally required to be correct in his or her assessment of a client's risk for suicide. Therapists are really no better at predicting the future than anyone else. Thus, the fact that a suicide may occur does not, in itself, prove that there was a breach in the standard of care. [52]

* No two clinicians are alike and every therapist will employ his or her own style or approach to gathering information about a client (e.g., taking a psychosocial history), conducting an assessment of the client and arriving at a diagnosis and treatment plan.

* It is important to inquire about any history of prior treatment, and the client's history of problems with depression, including any prior suicidal ideation or attempts.

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[42] Id.,"Severe risk," in the opinion of the evaluating clinician.
[43] Brian, Craig, J. & Rudd, David, M., "Advances in the Assessment of Suicide Risk," Supra.
[44] Id.
[45] Id.
[46] Id.
[47] Id.
[48] Brian, Craig, J. & Rudd, David, M., "Advances in the Assessment of Suicide Risk," Id.; Berman, Alan, L, "Risk Management with Suicidal Patients, Supra.
[49] Id.
[50] Id.
[51] Id.
[52] Berman, Alan, L., "Risk Management with Suicidal Patients," *Journal of Clinical Psychology in Session*, Vol. 62(2), 171-184(2006)(Published online in Wiley InterScience).

* When a therapist is aware that his or her client is at risk of committing suicide, courts have generally held that he or she has a duty to take "reasonable" or "appropriate" steps to prevent the client's suicide. Such efforts *may include*, *but are not limited to*:

* Facilitating the client's hospitalization; consulting with his or her psychiatrist; increasing the intensity of the client's treatment; asking the client to sign a no-self-harm agreement; attempting to increase the degree of social support available to the client; involving a family member or friend in the treatment plan, etc.

* When the client has been treated previously in an inpatient setting, it is also generally a good idea to seek authorization from the client to request a copy of his or her prior treatment records.

* A therapist should strive to implement a course of action, which he or she considers to be reasonable and appropriate for his or her client, at that point in time.

* In cases where there is a risk of suicide, it is advisable for the therapist to consistently and thoroughly document his or her treatment efforts and corresponding clinical rationale, including the client's degree of cooperation with any recommendations given.

* The preventive measures which a therapist employs when working with a particular client, depends on the needs of the client, the surrounding circumstances, and any information which may be available to him or her regarding the client.

The Use Of No-Suicide Contracts

* The use of no-suicide contracts by clinicians working with high-risk clients is common practice in both in-patient and outpatient settings. Also referred to as "no-self harm" agreement, a no-suicide contract is an agreement between the clinician and his or her client, wherein the client agrees not to harm him or herself, and to seek help from the therapist or other identified person, when he or she experiences suicidal urges.[53]

* In spite of their prevalent use, there is little empirical evidence that no-suicide contracts are effective in preventing suicide, in the absence of other treatment efforts. [54] Various criticisms have been levied against the use of no-suicide contracts, including: [55]

* The use of a no-suicide contract may create an illusion of safety.[56]

* The refusal of a client to agree to a no-suicide contract does not necessarily mean that he or she is at imminent risk of suicide.[57]

[53] Id.
[54] Id.
[55] Id.
[56] Id.
[57] Id.

* The willingness of a client to agree to a no-suicide contract does not necessarily mean that the risk of suicide has been lessened.[58]

* The presence of psychiatric symptoms, such as severe depression or psychosis, may impede a client's mental capacity to enter into such an agreement.[59]

* The client may be willing to sign such an agreement simply to placate the therapist.[60]

* The therapist is asking a client to enter into an agreement with life and death consequences, even thought he or she may have had time to develop genuine rapport with the client.[61]

* The client who feels amendable to entering such into the agreement at one moment in time may feel quite differently after leaving the therapist's office.

* The evidence is that these agreements should not be relied-upon, by themselves, as a sufficient preventive measure**.** A therapist should exercise his or her clinical judgment as to when, and if, a no – suicide contract is of value in a particular case. In spite of its shortcomings, a "no self-harm or "no-suicide" agreement may have some clinical utility as part of a therapeutic plan. When used cautiously, depending on the circumstances and the client's needs, the possible benefits of a no-suicide agreement include: [62]

* It may help facilitate honest and direct communication between the therapist and his or her client. [63]

* It expresses an expectation that the client actively participate in his or her treatment.[64]

* It defines a process for handling emergencies.[65]

* It may help alleviate some of the client's anxiety by providing a structure to follow. [66]

Gross v Allen (1994) 22 Cal. App. 4th 354

The case of Gross v. Allen involves a female patient with a history of suicide attempts[67]. The patient, Karen Joy Scancarello, had a history of depression and attempted suicide. In 1982, her psychotherapist referred her to Dr. Robert Allen and Dr. Ferris Pitts, two psychiatrists, for medication and medication management.

On February 27, 1985, after driving her car into a tree and informing the emergency room doctor that she wanted to kill herself, the patient was admitted into U.S.C. Medical Center. While in U.S.C. Medical

[58] Id.
[59] Id.
[60] Id.
[61] Id.
[62] Rudd, et.al, Id.
[63] Id.
[64] Id.
[65] Id.
[66] Id.
[67] See, Jensen, David, JD, "Don't fumble the information concerning a patient's risk of suicide," *The Therapist*, Nov./Dec., 2005

Center, she attempted to strangle herself. On May 16, 1985, Ms. Scancarello ingested fifty Halcion tablets in an unsuccessful suicide attempt. On June 24, 1985, barely one month removed from her last suicide attempt, Ms. Scancarello met with Dr. Michael Gross, the admitting psychiatrist for Northridge's eating disorder program. Dr. Gross interviewed Ms. Scancarello and admitted her into the program. However, she did not tell Dr. Gross about her suicide attempts. We don't know whether Dr. Gross inquired about such attempts, however. On June 25, 1985, Dr. Gross telephoned Dr. Allen and informed him that Ms. Scancarello had entered Northridge's eating disorder program. Although Dr. Gross inquired about her psychiatric history, Dr. Allen did not inform Dr. Gross about patient's suicide attempts. On the morning of June 26, 1985, patient ingested an overdose of Nardil, which had been prescribed by Dr. Allen and Dr. Pitts. patient suffered severe neurological damage.

The Resulting Lawsuit [68]

Ms. Scancarello filed a lawsuit against Northridge Hospital, Dr. Gross and other doctors from Northridge Hospital. She did not name Dr. Allen or Dr. Pitts as defendants, but Dr. Gross Cross-complained against them and brought them into the lawsuit on a theory of equitable indemnity. (This allows one party to shift part of the blame onto another party who is also responsible, at least in part). In the trial, there was evidence presented that demonstrated that Dr. Allen was negligent by virtue of failing to inform Dr. Gross regarding the patient' past suicide attempts and present suicide risk. In his appeal, Dr. Allen argued that the Tarasoff case did not impose any duty on him to communicate his patient's suicide attempts because she had not threatened any third person with harm, she was only threatening herself.

The Court of Appeal said: "Dr. Allen correctly, but irrelevantly argues that Tarasoff imposed no such duty (to communicate past suicide attempts and risk of suicide) because Ms. Scancarello, unlike the person in Tarasoff posed no threat to a third person, only to herself. But Tarasoff does not state, as Dr. Allen implies, that a therapist may be silent when to speak may save the life of the patient. To the contrary, to the extent Tarasoff considers the matter, it finds a duty to speak." Dr. Allen also tried to rely on Bellah v. Greenson for the proposition that he had no duty to inform Dr. Gross of Ms. Scancarello's history of suicide attempts and her present risk of suicide. In response, the Court of Appeal said that they thought that the Bellah v. Greenson case was a different situation, and that in this case, the idea that Dr. Allen should have informed Dr. Gross of the patient's history concerned a reasonable and appropriate preventive measure that should have been undertaken.

Preventing the Client from Harming Himself/Herself: Relevant Exceptions To Confidentiality

When dealing with a client who is a danger to him or herself, a therapist may determine that it would be helpful or even necessary, for him or her to communicate with a third-party in order to provide appropriate treatment for the client. For example, the therapist may wish to speak to the client's physician, family member, spouse, etc., because he or she believes that such communication will yield critical information, or, that it is necessary in order to prevent the client from harming himself. In another example, a therapist may determine that calling the police is an urgent necessity in order to

[68] Id.

prevent the client (or some other person) from being seriously harmed. In such circumstances, a therapist is permitted to disclose confidential information about his or her client, subject to the

Civil Code, 56.10(c)(1)

The information may be disclosed to providers of health care, health care service plans, contractors, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient…"[69] (This means that a therapist would be permitted to communicate with a client's physician, or with another mental health care professional (to name just a few examples) without a release, if such communication was for the purpose of diagnosing or treating the client.)

[70]**Civil Code, 56.10 (c)(19)**

(**19) The information may be disclosed, consistent with applicable law and standards of ethical conduct, by a psychotherapist, as defined in Section 1010 of the Evidence Code, if the psychotherapist, in good faith, believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable victim or victims, and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.**

The Dangerous Client

Tarasoff v. Regents of Univ. of Calif.,(1976) 17 Cal.3d 425

The "Duty to Protect."

The Tarasoff case came to be known as the case that established a "duty to warn," but it is more accurate to say that the duty created by Tarasoff is a "duty to take reasonable care to protect the intended victim." It should be noted that a therapist may discharge the"duty to protect" under Tarasoff, by taking actions other than warning the victim. The specific facts and circumstances determine whether the therapist's action is sufficient to discharge the duty. Examples may include, but are not limited to: increasing the intensity of treatment, arranging for involuntary or voluntary hospitalization, or other actions.

"When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances." Tarasoff v. Regents of Univ. of Calif., (1976) 17 Cal.3d at p. 431.

[69] Id., Section 56.10(c)(1).
[70] Some sections of Section 56.10 are not copied in their entirety in this handout.

A "Serious Danger Of Violence"

The Tarasoff case contains the phrase, "a serious danger of violence," not, "a danger of serious violence." There isn't a specific requirement that the patient is threatening murder/homicide for a duty to exist.

The Existence Of An Imminent Threat

The use of the phrase "serious danger of violence" is generally interpreted to mean that the threat must be "imminent" in order for the duty to arise.

Reasonably Identifiable Victim Or Victims

A "Tarasoff duty" does not exist when there are nonspecific threats made against non-specified persons. If the patient expresses a threat, it must concern a reasonably identifiable victim or victims.

The duty pertains to actions taken by the therapist's patient, not actions taken by some other person.

For example, if the patient communicated that his spouse, or his co-worker were threatening to harm some person, there is no duty for the therapist. (The fact that the therapist didn't have a duty doesn't mean that he or she couldn't discuss how the patient could act to prevent the harm).

Civil Code, 43.92

This section was enacted to limit the liability of therapists under the holding of Tarasoff, regarding a therapist's duty to warn an intended victim. It affords immunity to psychotherapists from Tarasoff claims, except where the plaintiff proves that the patient has communicated to his or her psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

Civil Code, 43.92(a)

There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to protect from a patient's threatened violent behavior or failing to predict and protect from a patient's violent behavior **except if the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.**

(b) There shall be no monetary liability on the part of, and no cause of action shall arise against, a psychotherapist who, under the limited circumstances specified in subdivision (a), discharges his or her duty to protect by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.

The Ewing Cases

Ewing v. Goldstein, Ph.D (2004)120 Cal.App.4th 807
Ewing v. Northridge Hospital Center (2004) 120 App.4th 807

On July 16, 2004 the Court of Appeal, Second District, issued an opinion in the case of Ewing v. Goldstein, Ph.D. (2004) 120 Cal. App. 4th 807 ("Ewing I"). On July 27, 2004 the same court issued an opinion in Ewing v.Northridge Hospital Medical Center (2004) 120 Cal. App. 4th 1289 ("Ewing II").

These cases arose from a murder-suicide that occurred in the Los Angeles area on June 23, 2001. On that day, Gene Colello, a former member of the Los Angeles Police Department, shot and killed Keith Ewing, who was the boyfriend of Collelo's former girlfriend, Diana Williams. Colello shot and killed Keith Ewing as he was washing his car in the driveway of his home. He then turned the gun on himself and committed suicide.

In 1997, Gene Colello began therapy with David Goldstein, Ph.D. Sometime during 2001, Colello reportedly became despondent over the termination of his seventeen-year relationship with Williams. In June, 2001, he learned that she was romantically involved with Ewing.

During a conversation with Colello, Dr. Goldstein asked Colello if he was suicidal, and Colello admitted to thinking about suicide. Goldstein discussed voluntary hospitalization with Colello, and he also obtained permission from Colello to speak with Colello's father, Victor Colello. During a phone call, Victor Colello informed Dr. Goldstein that his son had asked him for a gun so that he could shoot himself. When Victor Colello refused to honor his son's request, Colello reportedly told his father that he intended to get a gun and kill Williams' new boyfriend (Keith Ewing) and then commit suicide. Victor Colello then called Dr. Goldstein and reported what his son had said about harming Williams' new boyfriend. (At trial, Dr. Goldstein denied that Victor Colello told him that Gene Colello had threatened to kill Keith Ewing). Dr. Goldstein asked Victor Colello to take his son to Northridge Hospital Medical Center. He did. At Northridge hospital, an LCSW named Art Capilla assessed Colello. During the assessment, Colello's father says that he informed Mr. Capilla about the threat that his son had made regarding Keith Ewing. Capilla denied that Victor Colello told him about the threats made by his son regarding Ewing. According to the record, Capilla intended to have Colello involuntarily hospitalized, but fearful of the effect such an action would have on his career as a policeman, Colello said that he would agree to voluntarily enter Northridge, and that is what occurred. Colello came under the care of Dr. Gary Levinson, a staff psychiatrist. Dr. Levinson did not believe that Colello was suicidal, and despite Dr. Goldstein's objections, he discharged Colello from Northridge on June 22, 2001. No one ever warned Keith Ewing that Colello was dangerous to him, and on June 23, 2001, one day after being discharged from Northridge, Colello murdered Keith Ewing.

In February 2002, the Ewing family filed a wrongful death action for professional negligence against Dr. Goldstein, which resulted in Ewing I, and a wrongful death action for professional negligence against Northridge, which resulted in Ewing II. The Ewing family also filed suit against the Colellos and Dr.

Levinson. In Ewing I' Goldstein contended that he could not be held liable for failing to warn Ewing about the danger that Colello posed to Ewing, because Gene Colello had not directly communicated to Goldstein that he intended to harm Ewing. The Ewing family countered Goldstein's argument by claiming that Colello's interactions with Goldstein, along with the information Victor Colello allegedly communicated to Dr. Goldstein about intending to harm Keith Ewing, made Goldstein aware of the threat that Colello posed to Ewing. Therefore, they argued, Goldstein should have warned Ewing.

The Ewing family's contention runs counter to Civil Code §43.92, which generally immunizes psychotherapists for failing to warn of, protect against, or predict a patient's violent behavior except in cases where the "patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims" and the therapist fails to make reasonable attempts to notify the intended victim and law enforcement. The trial court sided with Goldstein, due to the fact that Colello did not tell Goldstein that he intended to harm Ewing and dismissed the case. The decision was appealed to the Court of Appeal, Second District.

The Court of Appeal, Second District examined the question of whether a communication from a patient's family member, made for the purpose of advancing the patient's therapy, is a "patient communication" within the meaning of Civil Code § 43.92. The Court of Appeal, Second District, in *Ewing* I, and, in *Ewing* II, held that communications from family members are "patient communications" within the meaning of Civil Code § 43.92. Therefore, a communication from a patient's "family member" to the patient's therapist about a serious threat of physical violence by the patient, against a reasonably identifiable victim, may create a duty to protect the intended victim.

The "Duty To Report"

In addition to the Tarasoff case, the related Ewing cases and section 43.92 of the Civil Code , which set forth a "duty to protect," there is now a "duty to report" in California, pursuant to the action of California legislators, following the May 23, 2014 tragedy in Isla Vista, California, on May 23, 2014. On that day, six people were shot and killed, and thirteen other innocent people were seriously injured in a mass shooting. After that event, the legislature passed two laws in the Welfare and Institutions Code, the primary intent of which was to get firearms and other deadly weapons out of the hands of dangerous patients, under certain conditions. Under Welfare and Institutions Code, Section 8105(c), a licensed psychotherapist shall report to a local law enforcement agency, within 24 hours, the identity of a person (patient) who is subject to subdivision (b) of Section 8100 of the Welfare and Institutions Code. A patient is subject to 8100(b), if he or she communicates to his or her therapist, **a serious threat of physical violence against a reasonably identifiable victim or victims**. Law enforcement is then required to notify the Department of Justice, who will in turn, notify the patient that he or she is barred from possessing, having custody or control over, receiving, or purchasing any firearm for a period of five years from the date of report to law enforcement by the licensed psychotherapist. The individual can petition the superior court and ask the court to permit him or her to possess a firearm, if the court finds, according to a preponderance of the evidence, that the person is likely to use firearms in a safe and lawful manner. [71]

Unlicensed Psychotherapists

The law only names licensed psychotherapists, but since trainees and interns practice under the supervision of a licensed psychotherapist, it would make sense that the licensed psychotherapist who is supervising the intern or trainee make the report on behalf of his supervisee.

[71] A therapist is civilly immune for making the report, meaning that the therapist cannot be successfully sued, even if the patient is successful in getting his right to gun possession restored by the court.

Welfare and Institutions Code, 8100(b)(1)

A person shall not have in his or her possession or under his or her custody or control, or purchase or receive, or attempt to purchase or receive, any firearms whatsoever or any other deadly weapon for a period of five years if, on or after January 1, 2014, he or she communicates to a licensed psychotherapist, as defined in subdivisions (a) to (e), inclusive, of Section 1010 of the Evidence Code, a serious threat of physical violence against a reasonably identifiable victim or victims. The five-year period shall commence from the date that the licensed psychotherapist reports to the local law enforcement agency the identity of the person making the communication. The prohibition provided for in this subdivision shall not apply unless the licensed psychotherapist notifies a local law enforcement agency of the threat by that person. The person, however, may own, possess, have custody or control over, or receive or purchase any firearm if a superior court, pursuant to paragraph (3) and upon petition of the person, has found, by a preponderance of the evidence, that the person is likely to use firearms or other deadly weapons in a safe and lawful manner.

Welfare and Institutions Code, 8105(c)

A licensed psychotherapist shall report to a local law enforcement agency, within 24 hours, in a manner prescribed by the Department of Justice, the identity of a person subject to the prohibition specified by subdivision (b) of Section 8100. Upon receipt of the report, the local law enforcement agency, on a form prescribed by the Department of Justice, shall notify the department electronically, within 24 hours, in a manner prescribed by the department, of the person who is subject to the prohibition specified by subdivision (b) of Section 8100.

HYPOTHETICAL SCENARIO #6

A client informs his therapist that he "hates" his supervisor at work, and says that "it wouldn't bother him one bit" if something bad ever happened to the man. When the therapist asked what he meant by the comment, the client responded by saying, if he ever ran into that supervisor at work, "he couldn't promise that he wouldn't beat the hell out of him." The client adds, however, that the supervisor works on the first (daytime) shift, and the client recently transferred to third (night) shift, to get away from him permanently. The client assures the therapist that he has no intention of pursuing the supervisor, it is just that he knows how mad he could become if he actually encountered him "face to face." In his opinion, the supervisor is responsible for him failing to get a raise for the last few years. The main reason for transferring to the night shift was to avoid any problems from occurring. Although it is uncommon, an employee (or a supervisor) may occasionally be asked to fill-in for someone on a different shift, in case of sickness, etc.

1. How would you evaluate the therapist's duty to protect, and/or duty to report, based upon these facts? What additional information would you like to have?

XI. CLINICAL DOCUMENTATION/MAINTAINING AN APPROPRIATE TREATMENT RECORD

According to Section 4982(v) of the Business & Professions Code,

The failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered is considered to be unprofessional conduct.

CAMFT Code of Ethics

1.15 DOCUMENTING TREATMENT DECISIONS:

Marriage and family therapists are encouraged to carefully document in their records when significant decisions are made, e.g., determining reasonable suspicion of child, elder or dependent adult abuse, determining when a patient is a danger to self or others, when making major changes to a treatment plan, or when changing the unit being treated.

3.3 PATIENT RECORDS:

Marriage and family therapists create and maintain patient records, whether written, taped, computerized, or stored in any other medium, consistent with sound clinical practice.

What Does This Really Mean In Practice?

Basically, if your colleagues were to read your record, at minimum, it should be possible to get a sense of your assessment of the client, the nature of your treatment plan, the services being rendered and your opinion of the progress made/not made.

What About Progress Notes?

In simple terms, progress notes are brief, written notes in a patient's treatment record, which are produced by a therapist as a means of documenting aspects of his or her patient's treatment. Progress notes may be used to document important issues or concerns that are related to the patient's treatment, including:

Documenting Competent Treatment

As one component of the patient's treatment record, progress notes allow a therapist to describe his or her work with a patient. Without progress notes, it would be difficult, if not impossible, for a therapist to create a health care record that accurately reflects his or her sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

Progress notes provide a therapist with an opportunity to document his or her exercise of judgment.

For example, progress notes may reflect a therapist's ongoing efforts to assess and manage his or her patient's symptoms, or demonstrate his or her therapeutic skill in responding to complex risk factors.

If a therapist's conduct is challenged by the patient or by the Board of Behavioral Sciences, progress notes may help to establish that his or her conduct was ethical and lawful.

Progress notes provide evidence of the patient's need for treatment at a particular point in time.

Things You Should Always Do

Document the treatment that you provide, for each and every client. Read over your notes from time to time and ask yourself whether, in your opinion, the record meets the basic legal and ethical standards.

Things You Should Never Do

Don't Fail to keep a record.

Don't write down "everything" in the hope that you covered the basic requirements.

Things You Really Don't Have To Do

You don't have to keep a record according to one specific model. Your record doesn't have to look just like your colleague's record. But, you both have certain standards to meet.

You don't have to keep a record forever. In fact, depending on your situation, and your license type, you don't have to keep a record for a specific period of time.

Distinguishing Progress Notes From "Psychotherapy Notes" According To HIPAA. [72]

Therapists who are not HIPAA-covered entities do not have to be concerned with this particular distinction. Therapists who are HIPAA covered entities should understand that progress notes are not synonymous with, and should be distinguished from, the HIPAA-created category known as "Psychotherapy Notes."

The HIPAA Final Privacy Rule Created A Special Category Of Documentation Entitled "Psychotherapy Notes," Which Are[73]

"Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record."

"Psychotherapy Notes" Under HIPAA Exclude

"Medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date." According to HIPAA, so long as Psychotherapy Notes do not contain the aforementioned excluded content, and

[72] 45, CFR, § 164.508; 45 CFR,§164.524
[73] See, HIPAA articles and sample forms on the CAMFT website: www.CAMFT.org

they are separated from the rest of the patient's medical record, then, they are not considered to be a part of his or her record. Because Psychotherapy Notes, as they are defined by HIPAA, are not part of the patient's medical record, they should not be released by the therapist in response to a request for a release of that record. In order for a therapist to release Psychotherapy Notes, he or she is required to obtain a specific authorization from the patient for their release. However, in circumstances where a subpoena is served upon a therapist, the therapist would be required to produce his or her Psychotherapy Notes, regardless of the fact that he or she kept them separate from the medical record. For example, a civil subpoena in California will ordinarily demand the production of any and all materials that have been created by the therapist in relation to the particular patient. That means, "…any copy of books, documents, other writings, or electronic data…which are maintained by [the therapist]…"[74]

XII. AVOIDING PROBLEMS DURING TERMINATION

The termination process varies from client to client. Depending upon the client's needs and the nature of his or her treatment, it may take place over a few sessions, or it can unfold over the course of several months.

Although there is no ideal model for termination with a client, a therapist is expected to manage the termination process with his or her client in a manner that is consistent with the relevant standard of care.

The standard of care that applies to a given circumstance is simply that the therapist exercised the reasonable degree of skill, knowledge and care that would ordinarily be exercised by other therapists, when practicing under similar circumstances.[75] Thus, the standard of care, which applies to particular client, depends on the facts and circumstances present in his or her case.[76] In view of the foregoing, it is important for a therapist to provide some documentation in the treatment record concerning the client's termination plan.[77] [78]

CAMFT Code of Ethics

1.31 TERMINATION:

Marriage and family therapists use sound clinical judgment when terminating therapeutic relationships and do so in an appropriate manner. Reasons for termination may include, but are not limited to, the patient is not benefiting from treatment; continuing treatment is not clinically appropriate; the therapist is unable to provide treatment due to the therapist's incapacity or extended absence, or in order to avoid an ethical conflict or problem.

[74] California Code of Civil Procedure, 1985.2.
[75] Black, H.C. (1990) *Black's Law Dictionary*, St. Paul MN: West
[76] In the event of litigation, in order to determine what the standard of care is, a court will typically seek the opinion of a qualified expert.
[77] If there is anything remarkable about the termination process, such as the client's lack of cooperation, or, if the client refused to accept or follow-thru with a referral, etc., it is appropriate to document such information in the record. It is also suggested that the therapist comment in the record, when termination progresses smoothly and according to plan.
[78] See, Atkins, Catherine, J.D., "Termination of a Client: Four Vignettes Answered," *The Therapist*, July/Aug., 2009

1.32 ABANDONMENT:

Marriage and family therapists do not abandon or neglect patients in treatment. If a therapist is unable or unwilling to continue to provide professional services, the therapist will assist the patient in making clinically appropriate arrangements for continuation of treatment.

Planning For Termination

Many therapists believe that it is important to begin thinking about termination from the outset of treatment. The rationale for doing so is based on the assumption that it is desirable for a therapist and his or her client to define the proposed intent of therapy sooner, rather than later. By clarifying the proposed goals and objectives of therapy, it becomes possible to say what the criterion for termination should consist of. Whether or not the prediction is perfectly accurate is not as important as the collaboration between therapist and client, and the fact that a treatment plan exists.

How Much Notice Should Therapists Provide?

It is important to provide clients with the opportunity to prepare for termination. The amount of notice that should be provided to a client regarding termination depends on the needs of that client and the clinical judgment of his or her therapist. Many therapists believe that it is desirable to provide clients with sixty to ninety days advance notice (if it is possible to have that amount of time) but some clients may require a longer period of time, such as those who are in long-term treatment.[79] [80] Ordinarily, when the therapist and his or her client have maintained a dialog about the client's progress in treatment, the timing of termination should be foreseeable to the client.

Special Challenges

Regardless of the therapist's careful planning, the termination process with some clients can prove to be especially challenging. A therapist should be prepared to encounter and appropriately manage, each of the following issues/scenarios.

Termination Due To A Lack Of Benefit From Treatment

CAMFT Code of Ethics

1.7 PATIENT BENEFIT:

Marriage and family therapists continually monitor their effectiveness and take steps to improve when necessary. Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that patients are benefiting from the relationship.

[79] Leslie, Richard, S., JD,"Closing a Practice," *The Therapist,* March/April, 2010
[80] Griffin, Michael, JD, "Closing a Psychotherapy Practice: Further Considerations," *The Therapist*, March/April, 2010

Termination Due To A Conflict Of Interest

A therapist has a conflict of interest, if he or she is engaged in some activity or relationship, which conflicts with his or her ability to discharge his or her duties to a client.[81] Ideally, most conflicts of interests are identified at the beginning of treatment. When this occurs, the therapist typically informs the person that he or she is unable to assume the role of therapist in his or her case, due to a conflict of interest. Obviously, this situation can be uncomfortable for the therapist and his or her client. An even less-desired circumstance arises, when a therapist discovers that he or she has a conflict of interest in continuing to provide therapy to an existing client. There are a number of circumstances where this might occur. For example: A prospective client may have failed to inform the therapist (or may not have known) that he or she is related to one of the therapist's other clients. Or, a therapist might discover that one of his clients was previously involved in a business venture with the therapist's spouse, etc.

Generally Speaking, When A Conflict Of Interest Is Discovered

it is necessary for the therapist to terminate the client's treatment and provide him or her with an appropriate referral. Although the therapist may not be able to offer a detailed explanation to the client (because of confidentiality issues) it is important for him or her to provide a general explanation to the client about why it is necessary to terminate his or her treatment under the circumstances.

Termination Due To The Closure Of A Practice

Eventually, when a therapist decides to close his or her psychotherapy practice, he or she must plan for the appropriate termination of his or her clients. A therapist has to decide how far in advance that he or she will provide notice to his or her clients regarding the closure of the practice, and, whether it should be communicated verbally or in writing. No single method is equally suited to all therapists and/or to all clients, but it is not unusual for a therapist to inform all of his or her clients during the same period of time. A therapist may also provide written information to his or her clients, confirming his or her verbal communications with the client regarding termination. In view of the sensitivity of termination for many clients, when first discussing this topic, a therapist may decide to ask his or her clients to refrain from sharing the information with other clients for a period of time, in order to minimize the likelihood that a client will hear the news from another client, rather than from the therapist.

Termination Due To A Change Of Employment

When a therapist decides to leave his or her place of employment, there can be disagreements between the therapist and his or her employer regarding the disposition of the therapist's clients. In such circumstances it is important for the therapist (and his or her employer) to remember that he or she is expected to primarily consider the client's best interests throughout the process. Section 1.8 of the *Code of Ethics* addresses this issue:

[81] A dual-relationship exists when a therapist has a concurrent, non-therapy relationship with a client. A dual-relationship in itself is not unethical, unless there is an associated conflict of interest.

CAMFT Code of Ethics

1.8 EMPLOYMENT AND CONTRACTUAL TERMINATIONS:

When terminating employment or contractual relationships, marriage and family therapists primarily consider the best interests of the patient when resolving issues of continued responsibility for patient care.

Termination Triggered By The Departure Of Interns Or Trainees

When an intern trainee or other therapist in training provides treatment, there is some likelihood that termination will be triggered by the therapist's completion of his or her internship, practicum or similar training experience. Even when the client is aware of the fact that his or her therapist will depart at a specified point in time, the "forced" termination may elicit a strong reaction by the client. In some settings, such as agencies or public mental health clinics which serve as training sites for therapists, there are clients who have been treated by several interns, in a progression that extends over the course of several years. In such settings, a client should be informed at the start of treatment if his or her therapist is available for a limited period of time, due to the therapist's training schedule

Termination With Clients Who Have Delinquent Accounts

A common question that therapists ask is whether or not it is permissible to discontinue treatment with a client based upon his or her non-payment of fees.

CAMFT Code of Ethics

1.3.4 NON-PAYMENT OF FEES:

Marriage and family therapists do not terminate patient "'relationships for non- payment of fees except when the termination is handled in a clinically appropriate manner.

Although a therapist is not required to treat someone indefinitely if he or she is unable or unwilling to pay for services, when considering termination for non-payment of fees, it may be helpful to consider the following questions:

At the start of treatment, was the client given clear and specific information about the fees to be charged and did he or she agree to those terms?

Did the client understand that there was a possibility that his or her therapy would be terminated for non-payment of fees?

What were the reasons given by the client for non-payment? Were they reasonable?

Was the client given an opportunity to rectify the issue? Did he or she promise to address the payment issues and then fail to do so?

Did the therapist contribute to the problem by permitting the client to accumulate a large debt over a long period of time?

Termination Of The Vulnerable Or "At Risk" Client

One of the issues that a therapist must consider during the termination process with a client, is whether or not his or her client is particularly vulnerable or "at risk" at that moment in time.

Examples

* The client with a history of suicide attempts

* The client with a history of hospitalizations

* The client with a borderline spectrum diagnosis

* The impulsive/acting-out client.

In any of these circumstances, the therapist may find that he or she has to spend more time and almost always document considerably more, than my be the case with less complicated clients.

This can be a very difficult issue to manage. As an example, the therapist may find that it is entirely appropriate to refer a client, based upon the client's lack of progress in treatment, or because of the client's need for specialized treatment, etc. But the desired treatment resource may or may not be available, the client may or may not agree with the therapist's recommendation, or, he or she may lack the necessary insurance or financial resources necessary to utilize the recommended resource.

Generally speaking, if a therapist believes that his or her client would be at risk if treatment was discontinued at that time, then the therapist has to re-evaluate his or her options and consider whether it may be prudent to continue treating the client, at least for the moment. Without a doubt, this can be a frustrating situation for the therapist and for his or her client. In view of the complexity of such situations, it is a good idea for the therapist to seek consultation when appropriate and to thoroughly document his or her actions and the corresponding clinical rationale.

Ambiguous Terminations

It is not uncommon to hear a therapist state that his or her client has failed to appear for several sessions, leaving the therapist uncertain about the client's intent to continue in treatment. In another common example, a client may inform his or her therapist that he or she is "taking a break" for a while from treatment. In these or similar circumstances, one of the concerns which exists is that the therapist cannot state with any clarity, whether he or she is currently serving as the client's therapist. Unless the therapist can unambiguously say that the client's treatment has been terminated, there is a distinct possibility that the therapist has a continued responsibility to the individual in question, because the therapist-client relationship has never ended. Therefore, it is the responsibility of the therapist to pursue the issue and to overtly clarify with his or her client(s) whether treatment is, or is not continuing. Depending on the circumstance, and the therapist's clinical judgment, this may mean that the therapist

calls the client and insists upon having a face to face meeting with him or her or, at the very least, a telephone conversation to discuss the matter. The therapist may recommend that treatment continue, or that termination be conducted over the course of several sessions, as appropriate. In the event that the client refuses to contact or cooperate with the therapist, the therapist should clearly communicate, either verbally or in writing if preferred, that the client's therapy will be considered concluded as of a specified date. Of course, the therapist should carefully document all such communications in the treatment record.

High-Risk Scenarios

It may be helpful to identify and discuss a few examples of clinical scenarios where termination-related legal and ethical problems predictably arise. Variations of these examples are often described in the disciplinary cases reported by licensing boards; in ethics complaints lodged against therapists, and in malpractice (negligence) lawsuits filed against therapists.

Open-Ended Treatment Without A Plan

Where treatment takes place over a long period time without identifiable goals, a client may experience the eventual termination of his or her treatment as a personal rejection by the therapist, rather than a logical end to the therapy.

An example of this situation typically involves long-term treatment (often several years In duration) where the clinical record is sparsely documented regarding the goals of treatment and the client's progress. When the therapist brings up the issue of termination, the client becomes angry, alleging that the therapist has arbitrarily/unilaterally decided to end the relationship, and that he or she was unprepared for such an eventuality. In this situation, although there may or may not have been a treatment plan, the lack of clinical documentation makes the therapist vulnerable to accusations of unprofessional conduct. The therapist may also face a negligence lawsuit, if it were alleged that he or she provided treatment that failed to meet the expected standard of care.

Lack Of Therapist/Client Boundaries

This situation is similar to the scenario described in the last example. In this example, the client and his or her therapist often talk about the therapist's life, and/or they sometimes meet at locations outside of the office without a clear reason for doing-so. There is likely to be an excessive (unnecessary) number of phone conversations in between sessions. Here, the therapist's relationship to his or her client may seem more like a personal friendship, than a therapist-client relationship. In a variation of this example, the client may have become increasingly dependent on his or her therapist over a long period of time, with the therapist assuming a parental role. Similar to the prior example, when there are few treatment goals in existence, the client may regard the therapist's attempt to terminate the client's treatment as a rejection by a friend. The therapist is vulnerable to the same accusations and allegations as described in the prior example.

Things You Should Always Do

Don't be reluctant to seek consultation. Although it is possible to encounter some complex and/or difficult issues during termination, most of the issues described can be avoided, or managed, by the therapist who carefully monitors his or her client's progress, and who plans for an appropriate termination process. When problems arise, a therapist should not be reluctant to seek consultation from a trusted colleague who would be willing to offer the benefit of his or her own experience in managing these situations.

Take care to follow the law and document your actions in the record. Don't hesitate to consult and double-check the requirements.

Things You Should Never Do

Terminate a client impulsively

Terminate a client because you are angry or frustrated with him or her.

HYPOTHETICAL SCENARIO #7

John is a 58 year old male patient with a history of recurrent major depression. After treating John for over a year, his therapist is of the opinion that continued therapy with John is unlikely to yield additional benefits. It is a difficult case: John continues to tell Mary that he really appreciates her help and that he values his relationship with her. Mary is not sure how to think about what John says. On the one hand, she believes that John has benefitted by the relationship. But Mary also knows that John has persistent problems with depression and that he is probably concealing the amount of alcohol that he consumes. He also has never really had a consistent trial of antidepressant medication because he doesn't like the idea of taking medication. To make matters worse, John has fallen behind in his payments for therapy.

1. What are they key issues for Mary to consider in this matter?

2. What would you recommend to Mary as her consultant? What information would you like to have before making a recommendation to her?