California Law & Ethics – 18 Hours

Introduction

Most mental health professionals have a working definition of ethics, such as this one: “codes developed by mental health associations for the purpose of setting professional standards for appropriate behavior, defining professional expectations, and preventing harm to clients.” Ethics, then, refers to professional rules of conduct, rules that are codified in various ethical codes.

While the definition of ethics contained above is comprehensive, another important aspect of our professional codes is the idea that they are enforceable. Take, for example, this paragraph from the preamble of the American Association of Marriage and Family Therapist Code of Ethics:

The AAMFT strives to honor the public trust in marriage and family therapists by setting standards for ethical. The ethical standards define professional expectations and are enforced by the AAMFT Ethics Committee. The absence of an explicit reference to a specific behavior or situation in the Code does not mean that the behavior is ethical or unethical. The standards are not exhaustive. Marriage and family therapists who are uncertain about the ethics of a particular course of action are encouraged to seek counsel.

This statement reminds us that ethical standards are generally written in broad statements and apply in varied roles and contexts. Ethical standards are not exhaustive and when conduct is not specifically addressed by a standard it does not mean that the conduct is necessarily either ethical or unethical.

Professional ethics play an important role in our daily lives as mental health professionals. When asked what ethical issues they have recently faced, many people in these fields are unable to point to any recent ethical dilemmas. In reality, that is rarely the case and often we have internalized ethical principles to such an extent that we don’t stop to ponder whether a decision we make has ethical ramifications.

Part I of this material, Ethics Refresher, provides a review of California-specific laws and professional ethics. Part II focuses on legal and ethical issues in treating victims of domestic violence. Part III provides a comprehensive look at the federal Health Insurance Portability and Accountability Act (HIPAA), a key topic for providers who take third-party reimbursement. Part IV of this document discusses the provision of E-Therapy, a growing trend among mental health providers. Part V of this document provides an alternative lens through which to look at ethical issues, using the framework of medical errors and root cause analysis.
California Law & Ethics Refresher
Chapter 1

The Statutes And Regulations Relating To The Practice Of Marriage And Family Therapy, Educational Psychology, and Clinical Social Work. The Statutes begin with the reminder that “many California families and many individual Californians are experiencing difficulty and distress, and are in need of wise, competent, caring, compassionate, and effective counseling in order to enable them to improve and maintain healthy family relationships.” Although this passage refers to the practice of marriage and family therapy, the concerns highlighted in these statutes apply to the ethical practice of counseling in an overall sense. The statutes are broad in scope and cover a multitude of issues upon which marriage and family therapists, educational psychologists, and clinical social workers can make informed judgments and choices concerning their efforts, and can address many ethical issues that arise from working with people.

The population in California encompasses a range of socioeconomic and demographic characteristics. This diversity suggests that mental health professionals in California will see a range of clients with varied mental health needs. In order to address these needs the services of skilled marriage and family therapists, educational psychologists, and clinical social workers are critical.

Continuing educational requirements for California mental health professionals contain an ethics requirement that include training in California-specific laws as well as ethical principles. This course will introduce mental health professionals to ethical and legal requirements contained in the Statutes And Regulations Relating To The Practice Of Marriage And Family Therapy, Educational Psychology, and Clinical Social Work (California Board Of Behavioral Sciences) as well as to many common ethical dilemmas and professional issues that they may encounter. Mental health professionals must also be familiar with the ethical guidelines for their specific professions and are encouraged to review these as well. Highlights from the various ethical codes will be covered in this training manual. Case studies and “Questions to Consider,” will also demonstrate this material. Participants in this training are encouraged to reflect on the questions contained prior to each section and before reviewing the material within the segment. A key part of learning and reflection is to develop sound ethical judgment through activities such as:

- Familiarizing yourself thoroughly with established standards
- Being sensitive to ethical problems as they arise, and take into account the complexity of these issues
- Remembering that ethical decision-making is an evolutionary process that requires you to be continually open and self-critical

Educational Objectives
• Discuss established ethical and legal requirements contained in the *Statutes And Regulations Relating To The Practice Of Marriage And Family Therapy, Educational Psychology, and Clinical Social Work* and specified in the ethical codes for the professions covered in this training
• Be sensitive to ethical problems as they arise, including the complexity of these issues
• Respond to common ethical dilemmas
• Describe why licensure is important for mental health professionals
• Discuss the issue of competence and the steps a provider should take to maintain competence
• Discuss specific areas related to competence, including self-assessment, compassion fatigue and multicultural competence
• Define confidentiality, and discuss informed consent and limits of confidentiality
• Discuss Laura’s Law
• Discuss California law with regard to subpoenas
• List the legal requirements for mandated reporting of child and elder abuse
• Define California laws with regards to minors, consent and confidentiality
• Discuss the dynamics of dual relationships
• Discuss issues related to sexual relationships with clients including harm to therapist and client
• Distinguish between termination and patient abandonment
• Discuss the Tarasoff and Ewing rulings related to the professional Duty to Warn

While this document provides a comprehensive overview of California law and ethics, additional resources which may prove helpful in delving deeper into ethical issues and scenarios includes Knapp & VandeCreek, (2012) and Welfel, (2012).

**Scope of Practice for the Professions**

Before turning our attention to the specific legal and ethical requirements for mental health professionals, it is important to review our definition of each of these professions.

According to the American Association of Marriage and Family therapy, *Marriage and Family Therapists (MFTs)* are trained in psychotherapy and family systems, and are licensed to diagnose and treat emotional disorders within the context of marriage, couples and family systems. The practice of marriage, and family therapy and psychotherapy is both an art and a science. It is varied and often complex in its approach, technique, modality and method of service delivery. Marriage and family therapists evaluate and treat mental and emotional disorders, other health and behavioral problems, and address a wide array of relationship issues within the context of the family system. Marriage and family therapy seeks to broaden the traditional
emphasis on the individual to attend to the nature and role of individuals in primary relationship networks such as marriage and the family. Marriage and family therapists have graduate training in marriage and family therapy and at least two years of clinical experience. Marriage and family therapists are recognized as a core mental health profession. The practice of marriage and family therapy is defined as services 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 includes relationship and pre-marriage counseling as well as client-centered advocacy efforts.

**Educational Psychologists** are mental health professionals that are concerned primarily with the study of how humans learn in educational settings, the effectiveness of educational interventions, the psychology of teaching, and the social psychology of schools as organizations. The practice of educational psychology includes the performance of any of the following professional functions pertaining to academic learning processes or the educational system or both: (a) Educational evaluation (b) diagnosis of psychological disorders related to academic learning processes (c) administration of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors. (d) interpretation of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors (e) providing psychological counseling for individuals, groups, and families. (f) consultation with other educators and parents on issues of social development and behavioral and academic difficulties (g) conducting psychoeducational assessments for the purposes of identifying special needs (h) developing treatment programs and strategies to address problems of adjustment. (i) coordinating intervention strategies for management of individual crises.

**Clinical Social Workers** seek to apply social theory and research methods to study and improve the lives of people, groups, and societies. According to a mission statement contained in the National Association of Social Work (NASW) Code of Ethics The core task of social work is to “enhance human well being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty.” One essential feature of social work is the profession’s focus on individual well being in a social context and the well being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living. Clinical social workers provide mental health services for the prevention, diagnosis, and treatment of mental, behavioral, and emotional disorders in individuals, families, and groups. Their goal is to enhance and maintain their patients’ physical, psychological, and social function (see appendix for core competencies of social work).

Core values of social work include:

- Service
- Social justice
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- Dignity and worth of the person
- Importance of human relationships
- Integrity
- Competence

Although specific to social work, these values can provide guidance in the application and understanding of all mental health professions.

**Professional Clinical Counselors (LPPCs)** are mental health professionals who apply “mental health, psychological, or human development principles through cognitive, affective, behavioral, or systemic intervention strategies that address wellness, personal growth, or career development, as well as pathology. The primary purpose of counseling is to empower the client to deal adequately with life situations, reduce stress, experience personal growth, and make well-informed, rational decisions.” (U.S. Dept. of Human Services, Mental Health, United States, 2002). With legislation that passed in 2009, all 50 states now license LPPCs. In California, LPPCs are among the professionals who can be termed “psychotherapists.”

**Content of Statutes And Regulations Relating To The Practice Of Marriage And Family Therapy, Educational Psychology, and Clinical Social Work**

*Statutes And Regulations Relating To The Practice Of Marriage And Family Therapy, Educational Psychology, and Clinical Social Work* was developed by the California Board of Behavioral Sciences (BBS) to outline the important considerations related to regulation of the professions, denial, suspension, and revocation of licenses, revenue information, professional corporations, continuing education requirements, and information related to disciplinary actions. The California Board of Behavioral Sciences website is located at [http://www.bbs.ca.gov/](http://www.bbs.ca.gov/). This training manual is meant to be used as a reference, and as such this training manual will not cite specific information such as fees or specific number of hours required for education, but will describe the broader issues related to these topics. For example, continuing education requirements are related to the need for BBS licensees to maintain competence in practice. Participants reading this training manual are encouraged to become familiar with the Statutes as well as the specific ethical codes for their specialty areas. References as well as appropriate website information can be found in the References section at the end of this text.

**Ethics vs. Law**

**Questions to consider:**  
Are ethical standards and legal standards always consistent?  
If they are not, what is the best way to handle this?
Many ethical issues faced by mental health professionals involve legal issues. Ethical decisions in social work and marriage and family therapy that involve legal issues do not always involve ethical dilemmas. In many cases such decisions are compatible with both legal and ethical standards.

However, other situations are more difficult ethical dilemmas, particularly when clinicians’ decisions are compatible with legal standards but not consistent with prevailing ethical standards or vice versa. In reading the following training material, such conflicts will be highlighted. It is important for professionals to use their own judgment or to seek consultation with colleagues when such conflicts arise (Reamer, 2008).

**Licensure of Mental Health Professionals**

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<td>Why is licensure important?</td>
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<td>What standards do you believe are important in the licensure of the state's mental health professionals?</td>
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<td>What specific coursework and training is necessary for your specialty area?</td>
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The following is an excerpt from a letter posted on a large Internet site:

My daughter is 30 years old and is one of the wisest people I have ever known. She has an extraordinary ability to effectively help other people with their most difficult emotional or psychological problems. Up until now she has been providing her counseling "services" to friends and relatives on a gratuitous basis. I am suggesting that she start providing counseling or psychotherapy services to residents of her small California town on a fee basis. She seems interested in the idea but is concerned that it might not be legal for her to provide such services for money since she lacks any formal degrees, credentials, licenses or certificates. Please inform me as to whether or not my daughter could provide counseling or psychotherapy services in California without obtaining any formal degrees, licenses, credentials, or certificates.

One important topic discussed in the Statutes is that of licensing for mental health professionals. The letter above illustrates many of the potential problems involved in not requiring licensure of mental health providers. Legal standards pertaining to licensure govern the establishment of a minimum set of requirements involving training and experience that are considered necessary to adequately serve the needs of clients. Specific requirements differ based on the professional's specialization (e.g., marriage and family therapy) but share some general characteristics. For example all mental health professionals need adequate preparation in the diagnosis, evaluation, prognosis, and treatment of mental disorders, must develop the qualities necessary for compassionate therapy, be able to apply specific therapeutic techniques, and must be prepared to counsel diverse clients. With regard to specializations in marriage and family counseling, social work, and educational counseling, there are also needed skill sets that are required for licensure, such as familiarity with specific testing protocols.
which are needed for educational psychologists but are not necessarily required for the other professions.

Marriage and family therapists must be familiar with a broad range of matters that may arise within marriage and family relationships and counseling techniques that are appropriate to individuals, families and couples. Coursework for initial licensure must include developmental aspects of the family life cycle including issues such as childbirth, child rearing, childhood, adolescence, adulthood, marriage, divorce, blended families, step-parenting, and geriatric psychology. As many of the clients MFTs see are children, specific training in child therapy is also needed. In addition, MFTs must attend a graduate degree program that provides training in the diagnosis, assessment, prognosis, and treatment of mental disorders, and prepare participants for a broad range of matters that may arise within marriage and family relationships, trains students to utilize effectively marriage and family relationship counseling principles and methods, and provides training in diversity issues (including work with Blacks, Hispanics, Asians, and Native Americans). Applicants licensed after 2004 must have additional coursework in aging and long-term care. In addition there are also licensure requirements with regard to fieldwork and supervised experience. The current statutes regarding licensure requirements have been in effect since 1988, and are currently under review with the Board. Some of the proposed changes to these requirements include additional hours of fieldwork and training and recommendations on specific degree program content. Licensure for MFTs is through examination. Please see http://www.bbs.ca.gov/app-reg/mft_requirement.shtml for MFT licensure requirements.

Educational psychologists must be familiar with the areas discussed previously, including a thorough understanding of academic learning and psychoeducational processes and educational testing. Candidates for initial licensure must have at minimum, a master's degree in psychology, educational psychology, school psychology, counseling and guidance, or a degree deemed equivalent by the board from an accredited educational institution approved by the board as well as successful completion of post-graduate work in pupil personnel services experience as a credentialed school psychologist in the public schools. Applicants must pass an examination specified by the board.

Clinical social work applicants must have 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 counseling and using applied psychotherapy 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 communities to organize, to provide, or to improve social or health services; or doing research related to social work. Thus, social work applicants must be comfortable working with a range of individuals and groups. In order to be considered for licensure an individual must have received a master's degree from an accredited school of social work and have two years of supervised post-
master’s degree experience. Specific training in alcoholism and other chemical substance dependency, spousal or partner abuse, child abuse and neglect and human sexuality is also required for current applicants. Please see http://www.bbs.ca.gov/app-reg/lcs_requirement.shtml for specific and current information on licensure.

The practice of professional counseling includes, but is not limited to, the diagnosis and treatment of mental and emotional disorders, including addictions; psychoeducational techniques aimed at the prevention of such disorders; consultation to individuals, couples, families, groups, and organizations; and research into more effective therapeutic treatment modalities. Counselors’ training in the provision of counseling and therapy includes the etiology of mental illness and substance abuse disorders, and the provision of the established, research-based “talk therapies” of cognitive-behavioral, interpersonal, and psychodynamic therapy. Counselors’ education and training is oriented toward the adoption of a truly client-centered, approach to therapy.

**Ethics vs. Law**

**Questions to consider:**
Describe a recent situation you had in which ethical and legal standards came into conflict.
Why are ethics important?
How do ethical problems occur?

Professional ethics and state law bind California mental health professionals. Consider the following statement found in the AAMFT code of ethics:

Both law and ethics govern the practice of marriage and family therapy. When making decisions regarding professional behavior, marriage and family therapists must consider the AAMFT Code of Ethics and applicable laws and regulations. If the AAMFT Code of Ethics prescribes a standard higher than that required by law, marriage and family therapists must meet the higher standard of the AAMFT Code of Ethics. Marriage and family therapists comply with the mandates of law, but make known their commitment to the AAMFT Code of Ethics and take steps to resolve the conflict in a responsible manner. The AAMFT supports legal mandates for reporting of alleged unethical conduct.

Ethical decisions in mental health that involve legal issues do not always involve ethical dilemmas. In many cases such decisions are compatible with both legal and ethical standards. However, other situations are more difficult ethical dilemmas, particularly when clinicians’ decisions are compatible with legal standards but not consistent with prevailing ethical standards or vice versa. In reading the following training material, such conflicts will be highlighted. It is important for professionals to
use their own judgment or to seek consultation with colleagues when such conflicts arise (Reamer, 2008).

Both law and ethics provide the boundaries through which to consider the many potential conflicts that may occur in a therapeutic relationship. Mental health professionals have a responsibility to the clients they serve. Although the scope of services may vary, the fundamental need to protect our clients’ interests does not. Ethical dilemmas occur frequently; ethical problems also occur but can be reduced through vigilance on the part of the provider and knowledge of ethical and legal codes.

The following is a list of some common reasons that ethical problems occur. As you will note by reading the list, some of these things are in the providers’ control and others are not.

How do ethical problems occur?

- People are human and make mistakes
- Clients misreport
- Inexperience
- Ignorance
- Unpredictable/unforeseen situations
- Foreseen, but no way to avoid them
- Inadequate agency policies
- Guidelines not adequate for situation

By keeping these reasons in mind it is easier for the practitioner to avoid ethical pitfalls. The intersection between ethics and the law is a topic of particular interest. As such the following sections of this document will consider ethical and legal issues related to the practice of marriage and family therapy, social work and educational psychology.

Confidentiality

Questions to consider:

- Have you ever needed to break confidentiality? Why?
- Why is confidentiality so important?
- Are there times in which maintaining confidentiality proves to be limiting?
- Would you like to see additional exceptions to confidentiality mandates?

Case Study 1

John, a 16-year-old high school junior has been in treatment with clinical social worker Sandra Connell for the past year. She has become increasingly concerned by his depression, and has noted some signs that tell her that he is considering suicide. Sandra asks that they have a family session with John’s parents to discuss the
situation. She reminds John that it is a legal and ethical mandate that she get John help given the seriousness of the situation. John is very resistant and angrily storms out of the office when Sandra tells him that she will be contacting his parents. Did she handle this situation well from a therapeutic standpoint? Did Sandra handle the situation well from an ethical standpoint?

**Case Study 2**

Kelly Rankin, MFT has worked with Kimberly, a 22-year-old client who she is treating for bulimia and substance abuse. Kimberly seemed to make progress in treatment, and eventually meets a young man and moves across the country. Kelly and Kimberly terminate treatment, and lose touch with one another. Several years later Kelly receives a phone call from Kimberly’s mom, April, sharing the sad news that Kimberly has died. It appears that Kimberly’s death is related to substance abuse. April blames herself, telling Kelly that she truly believed that Kimberly had progressed. She is shocked, and requests an appointment with Kelly to process Kimberly’s death. She tells Kelly that she hopes that Kelly can help her to understand what happened. Kelly schedules an appointment with April for the next day.

Confidentiality is a therapeutic, legal and an ethical issue. At first, confidentiality would seem like a simple topic to discuss, but as the case above illustrates, it is actually a very complex issue. Despite the complexity, confidentiality is central to developing a trusting and productive counseling relationship. Confidentiality refers to the nature of information shared in therapy sessions as well as contents of a patient’s medical records. Although many of the factors related to confidentiality are familiar to mental health providers, this is central to the practice of mental health professionals (Bond, 2011, Knapp & VandeCreek, 2012).

Confidentiality is also a leading cause of ethical complaints. Pope and Vasquez’s (2007) study of ethics complaints found that failing to protect client confidentiality was the fourth most frequent basis of disciplinary action. Kenneth Pope’s (2003) review of malpractice claims also found breach of confidentiality to be a leading cause of litigation. This is particularly concerning as confidentiality is central to developing a trusting and productive therapeutic relationship. Other authors have also discussed the importance of protecting patient confidentiality. (Brendel, Wei, Schouten & Edersheim, 2010; Welfel, 2012).

Mandates related to confidentiality are found in the ethical codes of all professions. The NASW Code of Ethics, for example, states: “Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons.” A unique situation is that of Marriage and Family Therapists, who “have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.” Another unique situation involves School Psychologists, who, seek parental consent for issues such as educational or psychological testing. While confidentiality may be more of a challenge to balance, the
National Association of School Psychologists (NASP) ethical code explicitly states “School psychologists respect the right of persons to choose for themselves whether to disclose their private thoughts, feelings, beliefs, and behaviors.”

All of our legal and ethical mandates share the general expectation that mental health professionals disclose information as necessary to prevent “serious, foreseeable, and imminent harm” to a client or other identifiable person. In these instances, professionals should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed. This is open to some degree of discretion on the part of the treatment professional. In the case, for example, Sandra could disclose her concerns to John’s parents, and seek their help in arranging for hospitalization, but could choose not to provide them with specifics of information shared in therapy such as the stressors that have resulted in John’s suicidal ideation.

Confidentiality standards apply to therapeutic disclosures, release of client information, confidentiality in non-clinical activities (e.g., use client and/or clinical materials in teaching, writing, consulting, research, and public presentations), protection of client records, preparation for practice changes, confidentiality in consultations, protection of electronic information, protection of clinical records, and release of information to interested third-party (e.g., payers, schools, etc.). Confidentiality considerations also apply to clients involved in family, couples, marital, or group counseling. Additionally the NASP ethical standards explicitly mandate confidentiality of information related to sexual orientation, gender identity, or transgender status.

Confidentiality applies to living and deceased clients. The case example with Kelly and April presents a number of ethical concerns, key among them that Kelly is still bound by confidentiality not to discuss any information about Kimberly, even though Kimberly is now deceased.

One of the primary considerations in looking at confidentiality is maintaining the privacy of client disclosures that are shared in therapy. Many clients are unaware of the degree of confidentiality that they can expect, and it is important to let them know that although it is not permissible for a mental health professional to share their disclosures with third parties without the client’s written consent (verbal consent can be given in emergency situations only), there are exceptions to this rule. It is the mental health professional’s responsibility to define the degree of confidentiality that can be promised. A signed, written statement that includes information about limits to confidentiality is good practice. For those clinicians bound by HIPAA, such a disclosure is required. In emergency situations, a verbal release is permitted.

Knapp and VandeCreek (2012) also urge that clinicians using technologies such as the Internet, Skype, and emails inform clients about the limits of confidentiality through these means of communication. This guideline is also included in several ethical codes, including NASWs, which states “Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and
telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible."

Despite our best clinical efforts, situations arise in which therapists may, and in some cases must, disclose information without client consent. Clients should understand in **advance** the circumstances under which the therapist is allowed to disclose information. While this is good practice, it is also an ethical mandate. The AAMFT standards, for example, state “Marriage and family therapists disclose to clients and other interested parties, as early as feasible in their professional contacts, the nature of confidentiality and possible limitations of the clients’ right to confidentiality to Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required.” The standards go on to remind clinicians “circumstances may necessitate repeated disclosures.”

Under California law, there are several exceptions to the confidentiality of psychotherapy. The primary exceptions to confidentiality concern harm to self or others:

- Where there is a reasonable suspicion that a client is likely to harm him or herself unless protective measures are taken.
- Where there is a reasonable suspicion of child abuse or elder adult physical abuse (see Mandated Reporting section);
- Where there is a reasonable suspicion of the potential for danger of violence to others (see Duty to Warn section);

According to the Lowenthal Child Abuse Reporting guidelines, the following pertains to reasonable suspicion:

1. Reasonable suspicion does not require certainty that child abuse or neglect has occurred;
2. Reasonable suspicion does not require a specific medical indication of child abuse or neglect; any reasonable suspicion is sufficient; and
3. Reasonable suspicion may be based on any information considered credible by the reporter, including statements from other individuals.

In all of the above cases, the mental health provider is required by law to break confidentiality in order to protect a client, or someone they might endanger. There is no privileged communication if the therapist has reasonable cause to believe that the client is in such a mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.

As mentioned previously, another important concern is confidentiality with regard to counseling services to families, couples, or groups. It is important for the provider to
be specific with regard to confidentiality issues and to seek agreement among the parties involved concerning each individual’s right to confidentiality and obligation to preserve the confidentiality of information shared by others. This is particularly important if the provider will be meeting with any person on an individual basis.

In terms of group treatment, confidentiality is more complicated than in individual therapy because self-disclosure is at the core of group therapy and there are numerous people hearing the disclosures. The mental health provider cannot guarantee that group members will keep information confidential and this information is important to share with all group members in advance of group psychotherapy. For an interesting discussion of group psychotherapy privilege see Morgan (2006) or Lasky & Riva (2006).

There is also the issue of third party disclosures. Who is a third party? According to the NASP, “school psychologists discuss and/or release confidential information only for professional purposes and only with persons who have a legitimate need to know. They do so within the strict boundaries of relevant privacy statutes.” A third-party, then, is an entity with a legitimate need to know information. Examples of third parties may include teachers, school counselors, primary care physicians, members of a hospital treatment team, agency personnel, insurance companies or gatekeepers to services, such as care managers who approve hospitalization. Clinicians who accept third party payment are also “covered entities,” under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA comes with its own rules, and will be discussed in a subsequent section.

Clients must be told in advance if there is information that will be shared with third parties, such as sharing a diagnosis or other information with an insurance company in order to receive payment for rendered services. A rule of thumb is that third party disclosure should include a minimal amount of information, only what is necessary. For example, insurers may only require a date of service, CPT code, and a diagnosis. When possible, clients should be told the exact nature of what will be disclosed.

Confidentiality extends to clinical records. Clients may request access to their clinical records. In those instances, clinicians are ethically mandated to support clients in record review. Per the NASW ethical code: “Social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients’ access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients’ access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients’ requests and the rationale for withholding some or all of the record should be documented in clients’ files.” Social workers should also “take steps to protect the confidentiality of other individuals identified or discussed in such records.” While these guidelines come directly from the social work code, they offer good overall practice guidelines.
Privileged communication refers to a private statement that must be kept in confidence by the recipient for the benefit of the communicator." According to the CAMFT, California law recognizes 13 privileges (e.g., marital privilege, clergyman-penitent privilege). Key among these privileges is psychotherapist-patient privilege. Privilege refers to information shared verbally by the client in psychotherapy sessions, and information documented in the clinical record. Privilege is a legal right established by CA Evidence Code 1014. This code is very specific with regard to who holds privilege. According to Pelchat (2001), former Legislative Counsel for the CAMFT:

- The patient is the holder of the privilege when he or she has no guardian or conservator. If the patient has a guardian or conservator, then the guardian or conservator holds the privilege.

- If the patient is dead, the personal representative of the decedent holds the privilege.

- If your identified patient is a group, family, or couple you must receive a waiver from each and every member of the group before you can release any information.

- If your patient is a minor child, he or she holds the privilege. A minor’s parents do not hold the privilege for the minor. The only time a parent could hold the privilege for the minor is if the court has specifically appointed the parent as a guardian ad litem.

- If your patient is a minor, you must assert the privilege on his or her behalf. If the minor has an attorney, the attorney can make the decision to waive or assert the privilege.

Privilege, however, is not absolute. If the issue of a client’s mental health or psychological treatment is raised during the course of a lawsuit, a mental health provider might be forced by the court to reveal the details of the client’s treatment (per CA Evidence Code 1016). This is a situation in which law conflicts with ethics. Let us first turn to the NASW Code of Ethics, which states: “Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client’s consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.” Although it is ethically preferable, then, not to reveal treatment information, this may still be required by the court.

A legal avenue is open to mental health providers per California law. If a provider receives a subpoena from an attorney to provide copies of clinical records, he or she
may claim privilege on behalf of the client (per CA Evidence Code 1015). The client may then:

- waive privilege and allow the provider to provide the subpoenaed information; or
- invoke privilege and refuse to allow the release of information.

In the latter case, the judge will determine whether the treating professional must release information and the judge can issue a court order.

The Hernandez Medical Information Disclosures Bill permits a provider of health care to disclose medical information when a psychotherapist has reasonable cause to believe that the patient is in such a mental or emotional condition as to be dangerous to himself or herself or to the person or property of another and that disclosure is necessary to prevent the threatened danger. This bill also conforms the Civil Code to existing provisions established in case law and in the Evidence Code.

As with any situation in which there is an intersection between legal and ethical concerns, mental health providers can seek the consultation of a trusted colleague to help determine a course of action.

**Confidentiality and Minors**

**Questions to consider:**
What are some special considerations in treating minors?

At what age and under what conditions should a minor be able to consent to treatment?

Do parents always need to be involved in a minor’s treatment? If no, when should they not be involved?

Does a therapist need to disclose sensitive information to parents or guardians, such as pregnancy status, information about STDs, information about sexual or gender identity, etc.?

Before turning our discussion to the issue of confidentiality and minors, please consider these case studies that illustrate some of the

**Case Study 1**

*Cara Clark, CSW, works for a community mental health center. During a walk-in day she assesses Dawn, a precocious 13-year-old, who shares that she is seeking treatment due to severe depression. She has had intermittent suicidal thoughts, but states that she can contract for safety at this point. Dawn states that her parents do not approve of counseling but that she feels that she will get worse without this treatment. Although Dawn is not completely forthcoming, Cara believes that her home situation is*
unhealthy, and may be abusive, although she does not believe that Dawn is in current danger. Although Cara knows she must consult on this case with a supervisor, she decides to offer Dawn an appointment for outpatient therapy. She will further assess whether a report needs to be filed with social services.

Case Study 2

Katie, a 16-year-old student, went to her school social worker counselor to reveal that she was pregnant and was planning to terminate her pregnancy. She had the support of her 17-year-old boyfriend, Chris. She insisted she would not tell her mother, a single parent.

What are these client’s rights as minors? Can these minors consent to treatment, and what are the therapists’ obligations with regard to parental notification? How can these therapists avoid undermining the concept of confidentiality and privileged communication and still be able to give appropriate information to others who share concern and responsibility for the minor’s welfare?

Confidentiality also extends to minors’ rights to confidentiality and to consent to treatment. These are connected because the issue of confidentiality relies on a minor’s ability to consent to treatment. In addition to being a legal issue, this is also a therapeutic issue. For an interesting discussion, please see Barnett (2008) or Hardoff (2012). Maintaining quality standards related to confidentiality is important in mental health and has been extensively researched in settings including behavioral health in primary care (Sayal et. al, 2012) and outpatient settings (e.g., White & Viner, 2012).

In California, minors who are 12 years of age or older may consent to mental health treatment or counseling if both of the following requirements are met: a) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services AND 1) The minor would present a danger of serious physical or mental harm to self or others without the mental health treatment or counseling or residential shelter services or 2) is an alleged victim of incest or child abuse." A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol problem (California Family Code 6929). Minors cannot consent to psychotropic medication or inpatient hospitalization without parental consent.

If a minor consents to treatment, providers can share a minor’s mental health information with others, including parents, only with a minor’s written consent. The provider must attempt to involve a parent or guardian in the minor’s treatment unless the provider believes that such involvement is not appropriate. This decision, and any attempts to contact parents must be documented in the minor’s medical record. Although this part of Family Code 6924 allows providers to involve parents in a minor’s treatment it does not allow mental health providers to disclose medical records without the written consent of the minor patient.
While all mental health clinicians may work with minors, these issues are of particular concern to school psychologists. The NASP Ethical Code has several guidelines pertaining to minors and which are of note to this discussion of confidentiality. The first pertains to the issue of consent to treatment. The Code states that when a student is given a choice regarding whether to accept or refuse services, the school psychologist ensures the student understands what is being offered, honors the student’s stated choice, and guards against overwhelming the student with choices he or she does not wish or is not able to make. Additionally school psychologists are ethically bound to respect the wishes of parents who object to school psychological services and attempt to guide parents to alternative resources. The NASP Code also outlines two sensitive areas: sexual/gender preference and health information, stating that school psychologists cannot disclose information about sexual orientation, gender identity, or transgender status without the student’s permission, and cannot disclose information about sensitive health information (e.g., presence of a communicable disease).

As with other issues of confidentiality, these concerns should be discussed with the minor and with his or her parents during the informed consent process (Knapp and VandeCreek, 2012).

**Mandated Reporting**

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An estimated 896,000 children across the country were victims of abuse or neglect in 2002 (U.S. Department of Health and Human Services 2004). That is almost 1 in every 100 Americans. These numbers imply that most mental health professionals have seen several abused children throughout the course of their practice. Psychologists, counselors and social workers are in unique positions to observe and interact with children and elders. They are often pivotal in noticing changes in clients that may indicate abuse or neglect. A client may also disclose such abuse.

Professionals working with children under the age of 18 are considered mandated reporters. Simply put, being a mandated reporter means that an individual is required to report suspected cases of abuse. All states have passed some form of mandatory child abuse and neglect reporting law in order to qualify for funding under the Child Abuse Prevention and Treatment Act (CAPTA). In addition to child abuse reporting laws, many states also have laws pertaining to mandatory reporting of elder abuse. The laws apply to mental health providers working in private practice and institutional settings.
Despite this mandate, many professionals are uncertain when a report is required and practitioners vary in their understanding and opinions of these laws. Unlike the case report, researchers have found a tendency to err on the side of over reporting (Kalichman & Brosig, 1993). Renninger et al. (2002) conducted a survey of licensed psychologists. Although they had knowledge of reporting laws, their performance on a knowledge measure suggested information deficits and a tendency to over report suspected abuse. Legal considerations were the strongest factor that encouraged reporting. Opinions of the mandatory reporting laws were generally favorable, with some concerns about child protection systems and the impact of reporting on the therapeutic alliance. The latter issue is explored in more detail by Steinberg et al. (1997). There are consequences to both the over reporting and underreporting of abuse.

Once a mandated reporter files a report of suspected abuse, the family often become eligible to receive a variety of services that will improve the family’s ability to care for the child or elder. These services may include parenting classes, counseling, treatment for substance abuse, medical services and anger management classes.

**Case Study**

Vicki, a social worker in private practice sees Eric, an 8-year-old boy for the first time. His parents described “hyperactive” behavior and a propensity to get into trouble, some classic symptoms of ADHD. The evaluation today was at the request of the school, which had also noted the difficulties expressed by Eric’s parents. Vicki first meets with the family, noting that Eric actually appears quite withdrawn. There was little eye contact between Eric and his parents and at times he appeared to physically shrink away from his mother. Vicki does not see any evidence of hyperactive behavior, but she does recognize that sometimes this is not evident on first meeting a child. Vicki does note several bruises on Eric’s arms and legs, which Eric’s mother states are a result of rough play. They also state that Eric has been known to lie, and that he has done so in the past with school authorities. Eric’s parents reluctantly agree to Vicki spending time alone with Eric. In meeting individually with Eric, he makes reference to “hitting” and “screaming.” Suspicious, but uncertain what she was seeing, Vicki decides to assess the case further. She was later alerted by a local hospital that Eric had been admitted due to multiple fractures.

Gina is a social worker and has just started consulting with a geriatric day program. The group facilitator calls Gina to express concerns about Adele, a 68-year-old woman who has a dementing process. The program has noted that she becomes fearful and agitated when leaving for home at the end of the day. They have attempted to express their concerns with Adele’s son, Ronnie, but he has not returned their calls. They have not seen any signs of bruises, and Adele is well nourished.

As these cases illustrate, child and elder abuse is a special area of concern for mental health professionals. The first child abuse and reporting law was enacted in California in 1963. This law pertained only to physicians, and covered the reporting of
physical abuse. Since this time, the definition of mandated reporters has expanded, as has the type of abuse that must be reported. Mandated reporters are professionals who, in the ordinary course of their work and because they have regular contact with children or other identified vulnerable populations (such as the elderly), are required to report suspicions of physical, sexual or other types of abuse. In looking at this definition it is evident that mental health professionals, including Marriage and Family Therapists, Educational Psychologists, Social Workers and Licensed Professional Counselors fall under the scope of mandated reporters.

**Defining Child Abuse**

Child abuse or neglect is defined as “any recent act or failure to act resulting in imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation of a child (usually a person under the age of 18, but a younger age may be specified in cases not involving sexual abuse) by a parent or caretaker who is responsible for the child's welfare” (Smith, 2007). Although child abuse is divided into the categories of physical abuse, neglect, sexual abuse, and emotional abuse, it is important to note that child abuse is more typically found in combination than alone. A physically abused child, for example, is often emotionally abused as well, and a sexually abused child also may be neglected.

The National Center on Child Abuse and Neglect defines child physical abuse as: "The physical injury or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened." The parent or caretaker need not have intended to hurt the child for it to constitute physical abuse. Examples of physical abuse include: beating with a belt, shoe, or other object; burning a child with matches or cigarettes; hitting a child; shaking, shoving, or slapping a child.

Child neglect is defined as "failure to provide for the child's basic needs. Neglect can be physical, educational, or emotional. Physical neglect includes refusal of or delay in seeking health care, abandonment, expulsion from the home or refusal to allow a runaway to return home, and inadequate supervision. Educational neglect includes the allowance of chronic truancy, failure to enroll a child of mandatory school age in school, and failure to attend to a special educational need. Emotional neglect includes such actions as marked inattention to the child's needs for affection, refusal of or failure to provide needed psychological care, spouse abuse in the child's presence, and permission of drug or alcohol use by the child. The assessment of child neglect requires consideration of cultural values and standards of care as well as recognition that the failure to provide the necessities of life may be related to poverty." (National Center on Child Abuse and Neglect.)

One of the most difficult categories of abuse to prove and quantify is emotional abuse. The American Medical Association (AMA) describes emotional abuse as: "when a child is regularly threatened, yelled at, humiliated, ignored, blamed or otherwise emotionally mistreated. For example, making fun of a child, calling a child names, and
always finding fault are forms of emotional abuse. Emotional abuse is more than just verbal abuse. It is an attack on a child's emotional and social development, and is a basic threat to healthy human development.

Sexual abuse is defined as employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or any simulation of such conduct for the purpose of producing any visual depiction of such conduct; or rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children” (Smith, 1997).

Dimensions of the Problem

Research shows that the child abuse and neglect in this country has serious physical, emotional, and psychological dimensions. Some of the research findings are enlightening:

a) Child abuse and neglect has increased nationwide (Howe 2005). Every day, about four children die in the U.S. because of abuse or neglect, most of them babies or toddlers (11 Facts, 2010).

b) The trauma of abuse or neglect of a child often lingers into adulthood and even can influence the raising of that victim’s own children (Anda et al. 2005).

c) Abused children are more likely to abuse alcohol and become addicted to drugs, and one third will later abuse their own children (11 Facts, 2010).

d) Of prison inmates, 84% were abused as children (11 Facts, 2010).

e) In 2003, the total costs associated with of child abuse and neglect were estimated at more than $94 million. These costs included demands on the health care, mental health care, law enforcement, child welfare, and judicial systems. Additionally, indirect costs included special education, juvenile delinquency programs, and adult criminality (Goldman et al. 2003).

California Penal Code, Sections 11164-11166, which pertains to child abuse, requires that mandated reporters, make a report of child abuse whenever a "reasonable suspicion" of abuse exists. An abuse report is required whenever a mental health provider learns about the abuse in his or her professional capacity.

Types of child abuse covered under this statute include:

- Physical abuse/Injury – physical action that results in the presence of an injury that the child/elder sustains at the hands of his or her caregiver. Physical abuse can produce various injuries and injury patterns in children. Common examples of inflicted injury dealing with the skeleton
(e.g. fractures), skin (e.g. burns, bruises), and CNS (e.g. subdural hematoma, abusive head trauma, and shaken baby syndrome.

- Sexual abuse - Any penetration, contact, or intrusion, however slight, of the vagina or anal opening, for purposes of sexual arousal or gratification, except that, it does not include acts which may reasonably be construed to be normal caretaker responsibilities; interactions with, or demonstrations of affection for, the child; or sexual exploitation is also included.

- Neglect - the negligent treatment or the maltreatment of a child/elder by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person.

- Willful cruelty - a situation in which any person willfully causes or permits any child to suffer, or inflict thereon, unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of the child to be placed in a situation in which his or her person or health is endangered.

- Unjustifiable punishment/ unlawful, corporal punishment - means a situation where any person willfully inflicts upon any child any cruel or inhuman corporal punishment or injury resulting in a traumatic condition.

Current law authorizes but does not require the reporting of instances where a child suffers, or is at substantial risk of suffering, serious emotional injury. Emotional injury/abuse is defined as “nonphysical mistreatment, resulting in disturbed behavior by the child, such as severe withdrawal or hyperactivity. Emotional abuse includes willfully causing any child to suffer, inflicting mental suffering, or endangering a child’s emotional well-being (http://www.lao.ca.gov/1996/010596_child_abuse/cw11096a.html ).”

Sections 15610, 15630-15634 of the California Welfare and Institution Code, which pertain to elder abuse, require that mandated professionals report elder physical abuse, abandonment, isolation, financial abuse, or neglect of any elder or dependent. An “elder” is a person over age 65 who resides in the state of California. A “vulnerable elder” is one whose physical or mental health puts him or her at increased risk of abuse.

The definitions of these types of abuses are similar to those described above. Specific to elders are:

- Financial abuse - "a situation in which a person, including but not limited to, one who has care or custody of or who stands in a position of trust, of an elder or dependent adult, takes, secretes, or appropriates their money or property, to any wrongful use, or with the intent to defraud."

- Abandonment - the desertion or willful forsaking of an elder or a
dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

- Neglect - includes, but is not limited to, all of the following: failure to assist in personal hygiene, or in the provision of food, clothing, or shelter, failure to provide medical care for physical and mental health needs, failure to protect from health and safety hazards, or failure to prevent malnutrition or dehydration.

When to Report Child/Elder Abuse

Mandated reporters are required to report abuse if they observe abuse directly, if a child or elder discloses abuse, or if they have reasonable suspicion of abuse. A discussion of some of the signs of child and elder abuse is found later in this section.

If a mental health professional learns of or suspects abuse, they must file a report immediately by phone and then must prepare a written report within 36 hours of the initial report. The initial report should be made to any police department or sheriff’s department or to a county probation department (if they are set up to take reports). Professionals suspecting elder abuse must report these suspicions to Adult Protective Services. Mandated reporters of elder or adult physical abuse must report suspected instances of abuse by telephone or by a confidential Internet reporting tool immediately or as soon as practicably possible, and if reported by telephone, then submit a written report or Internet report within two working days (SB 718, Vargas Elder or Dependent Abuse).

Written reports must be submitted on a Department of Justice form which may be downloaded from their website at www.ag.ca.gov. The mandated reporter must include information supporting the report.

There are a number of safeguards in place for professionals that report child abuse. Mandated reporters have immunity from civil and criminal liability. In addition, the reporter’s name made available to only specified persons or agencies. These protections were extended in 2011 to reporters of suspected child emotional abuse.

A mandated reporter that fails to file a report is subject to misdemeanor criminal prosecution and fines. If harm comes to a child through the result of a professional’s failure to report abuse, even stiffer penalties may exist.

Due to the importance of accurate knowledge of child abuse, all persons applying for a license as a marriage and family therapist or clinical social worker needs to complete at least 7 hours of training in child abuse assessment and reporting. Additionally the BBS will not issue a license to a person who has been convicted of a crime in this or any other state or in a territory of the United States that involves sexual abuse of children or who is required to register pursuant to Section 290 of the Penal

**Signs of Physical Abuse**
Consider the possibility of neglect when the child has:
- Unexplained burns, bites, bruises, broken bones, or black eyes
- Fading bruises or other marks noticeable after an absence from school
- Fears of caretakers

**Signs of Neglect**
Consider the possibility of neglect when the child:
- Is frequently absent from school
- Begs or steals food or money
- Lacks needed medical or dental care, immunizations, or glasses
- Is consistently dirty and has severe body odor
- Lacks sufficient clothing for the weather
- Abuses alcohol or other drugs
- States that there is no one at home to provide care

**Signs of Sexual Abuse**
Consider the possibility of sexual abuse when the child:
- Has difficulty walking or sitting
- Suddenly refuses to change for gym or to participate in physical activities
- Reports nightmares or bedwetting
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Becomes pregnant or contracts a venereal disease, particularly if under age 14
- Runs away

Recognizing Elder Abuse and Neglect: Signs and Symptoms

**Signs of Elder Abuse (Elder)**

There are signs of abuse, neglect or exploitation that might alert professionals to the possibility of problems. Although it is important not to take any of these signs as a "definite," they should certainly be taken seriously. There is also the difficulty that some of these things may not be signs of abuse, but of client report skewed by declining mental state. Here are some common indicators of elder abuse (Hazeldon, 2010; Helpguide.org, 2010):

1. Sudden change in behavior such as decreased grooming staring vacantly, fear, agitation or anxiety, unexplained crying, disorientation, depression, unusual behavior, such as biting or rocking withdrawal or shame
2. Discrepancies between a person’s standard of living and his/her financial assets, or a depletion of assets without adequate explanation. Money or personal items that are missing without explanation, unpaid bills, reports of a new will or power of attorney.

3. Withdrawn, apathetic, fearful, or anxious behavior, particularly around certain persons. The victim may suddenly and without explanation express a desire not to visit or receive visits from family or friends.

4. Malnourishment, as evidenced by weight loss, including dehydration (cracked lips, sunken eyes), poor overall hygiene, over-sedation in session, inappropriate clothing, lack of healthcare appliances such as dentures or glasses.

5. Physical injuries, bruises, especially when not over bony prominences, unexplained or implausible injuries, multiple emergency room or physician visits, broken glasses.

6. Reports of urinary tract infection, vaginal or anal bleeding

7. Medical needs not attended to.

6. Sudden, unexplained changes in the victim’s living arrangements, such as a younger person moving in to "care for" them shortly after meeting.

It is frequently very difficult to detect abuse. Typically, abusive behavior occurs in private and the victim may be unwilling or unable to describe the attacks. When reports are made, they are frequently not believed.

**Signs of Elder Abuse (Caregiver)**

The following may be red flags indicating possible elder abuse. It is important to assess each situation on a case-by-case basis.

1. Caregiver not wanting elder to be seen on his/her own

2. Caregiver providing a different accounting of events (such as how elder received bruises, etc) than elder

3. Lack of cooperation by caregiver for recommended treatment plan
4. Caregiver attempts to isolate patient from family, friends or activities.

5. Caregiver denying elder right to make decisions about care, living arrangements, etc.

6. Observable behaviors, such as anger or substance use.

7. Dependence of caregiver on elder for financial support.

**Good Faith Reporting**
One common question is how certain about clinicians need to be in order to make a report of abuse. Although this will vary from situation to situation, Pass (2007) provides some guidelines that may be helpful. She states that when the professional observes only behavioral symptoms, it is best to document this and continue to assess the situation; that when the professional observes physical symptoms it is best to consult on the situation and also to speak with a parent or guardian; and that when a combination of physical and behavioral symptoms are seen a report is indicated. On a therapeutic level it is important to consider the potential consequences of reporting, and thoroughly assess the situation. There is no timeframe; a 2-3 week assessment is ok if the child is not in immediate danger. Although the clinician should certainly err in favor of the child’s safety it is also important to consider the implications of making a report.

Professionals who are concerned about their responsibility, whether mandatory or voluntary, to report suspected elder abuse often want to know if they may face civil or criminal liability for making such a report. This is often of particular concern if the report is not substantiated. CAPTA requires states to enact legislation that provides for immunity from prosecution arising out of the reporting abuse or neglect. A person who reports suspected child abuse in "good faith" is immune from criminal and civil liability. There are similar statutes that cover reporting of suspected elder abuse.

The term "good faith" refers to the assumption that the reporter, to the best of his or her knowledge, had reason to believe that the child in question was being subjected to abuse or neglect. Even if the allegations made in the report cannot be fully substantiated, the reporter is still provided with immunity. There is a "presumption of good faith" in California.

Laura’s Law

**Questions to consider:**
How have you handled situations in which clients with severe mental illnesses have been resistant to treatment? What have you tried to do to help?
Have the solutions worked and are there other things to consider?
How do you feel about Assisted Outpatient Treatment (if you are unfamiliar with the term, read on)?

**Historical Case**

Laura Wilcox, a 19-year old sophomore from Haverford College, was working at Nevada County's public mental health clinic during her winter break. On January 10, 2001, Scott Harlan Thorpe shot Laura and two other people, to death. Thorpe was a 41-year old mentally ill patient who resisted his family’s attempt to seek treatment for his mental illness. Thorpe was found incompetent to stand trial and was sent to Atascadero State Hospital. He was later transferred to California’s Napa State Hospital.
Many who are completing this training are aware of the tragic story of Laura Wilcox and have empathized with her family. Similarly many have also been frustrated in the past when being personally faced with mentally ill individuals who cannot make appropriate treatment choices.

"Laura's Law," was written in response to these concerns. Laura's Law allows California counties to decide whether to opt to implement a community-based, court-monitored outpatient treatment program. These programs require outpatient treatment for a seriously mentally ill person who is unlikely to survive safely in the community without supervision, has a history treatment noncompliance, and presents a serious risk of harm to self or others. At the present time some, but not all, California counties have adopted Laura’s Law.

Assisted outpatient treatment (AOT) programs have been utilized in other states including New York. Its goal is to provide “sustained and intensive treatment in the community for those most overcome by the symptoms of severe mental illness.” AOT is provided only until a person is well enough to maintain his or her own treatment regimen.

A person may be placed in assisted outpatient treatment only if, after a hearing, a court finds that all of the following have been met.

The person must:
1) Be eighteen years of age or older;
2) Be suffering from a mental illness;
3) Be unlikely to survive safely in the community without supervision
4) Have a history of non-compliance with treatment that has either:
5) Have been offered an opportunity to voluntarily participate in a treatment plan by the local mental health department but continue to fail to engage in treatment;
6) Be substantially deteriorating;
7) Be, in view of his or her treatment history and current behavior, in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would likely result in the person meeting California’s inpatient commitment standard, which is being:
   A.) A serious risk of harm to himself or herself or others; or
   B.) Gravely disabled (in immediate physical danger because unable to meet basic needs for food, clothing, or shelter);
8) Be likely to benefit from assisted outpatient treatment; and
9) Participation in the assisted outpatient program is the least restrictive placement necessary to ensure the person’s recovery and stability.

Only the county mental health director may file a petition for AOT, but treatment providers or family members may request that such a petition be filed. For additional information please refer to http://www.psychlaws.org/stateactivity/California/Guide-Lauras-Law-AB1421.htm.
Advertising Professional Services

**Questions to consider:**
What is must you consider in advertising professional services?

*Consider these advertising statements:*
I CAN cure addition!
Are you anxious? I am the one who can help you. Call me!
My exclusive approach guarantees success.

*And this description in a community calendar: “Conversation with a Therapist. Professional counseling is the newest in a field of mental health healing arts. This is an opportunity to spend 3 hours in a group forum setting. This is not group therapy, but a chance to see if counseling could be an option for you.”*

In a competitive marketplace, mental health professionals need to market their services in a way that allow them to stand out from others. The Statutes define advertising as “any public communication, the issuance of any card, sign, or device to any person, or the causing, permitting, or allowing of any sign or marking on, or in, any building or structure, or in any newspaper, magazine, or directory, or any printed matter whatsoever, with or without any limiting qualification.” With the proliferation of online advertising, clinicians’ claims and information is readily available to the public.

The Statutes prohibit mental health professionals from “advertising in a manner that is false, fraudulent, misleading, or deceptive.” While there is some degree of broadness to this definition, professional ethical codes contain more explicit information. Take, for example, the social work, and marriage and family therapy codes. The guidelines found in these ethical codes are helpful in reviewing your own advertising practices.

The Ethical Code for Clinical Social Work contains guidelines on public statements. The Code states that public statements, announcements of services, and promotional activities of clinical social workers serve the purpose of providing sufficient information to aid consumers in making informed judgments and choices. Clinical social workers state accurately, objectively, and without misrepresentation their professional qualifications, affiliations, and functions as well as those of the institutions or organizations with which they or their statements may be associated. In addition, they should correct the misrepresentations of others with respect to these matters.

The AAMFT code also has specific guidelines related to advertising professional services. The Code states that marriage and family therapists must “engage in appropriate informational activities, including those that enable the public, referral sources, or others to choose professional services on an informed basis.” The AAMFT code requires that marriage and family therapists: 1) accurately represent their competencies, education, training, and experience relevant to their practice of marriage
and family therapy 2) ensure that advertisements and publications in any media convey information that is necessary for the public to make an appropriate selection of professional services and consistent with applicable law, 3) do not use names that could mislead the public concerning the identity, responsibility, source, and status of those practicing under that name, and do not hold themselves out as being partners or associates of a firm if they are not, 4) not use any professional identification if it includes a statement or claim that is false, fraudulent, misleading, or deceptive 5) list and claim as evidence only those earned degrees from institutions accredited by regional accreditation sources, 5) correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist's qualifications, services, or products, 6) make certain that the qualifications of their employees or supervisees are represented in a manner that is not false, misleading, or deceptive, and 7) do not represent themselves as providing specialized services unless they have the appropriate education, training, or supervised experience.

Advertising of professional services continues to be an evolving area, especially in terms of online provision of services. An interesting recent study by Heinlen et al., (2003) entitled “The Nature, Scope, And Ethics Of Psychologists’ E-Therapy Web Sites: What Consumers Find When Surfing The Web” sampled Web-based psychological services in a manner that simulated the experience of potential consumers. The researchers obtained sample of 44 Web sites and assessed them in terms of clinical services, fees, and advertising content. The sites were also evaluated on their compliance with the American Psychological Association (2002) Ethical Principles and the guidelines of the International Society for Mental Health Online (2000). Researchers found substantial gaps in the compliance of e-therapists with established ethical standards for practice.

In the Heinlen (2003) study nearly all the sites described client benefits. Some used testimonials from former clients to demonstrate the value of e-therapy, a practice not contraindicated by the APA ethics code. Several aspects of the advertising approach of some sites were potentially inconsistent with APA standards. For example, some sites made disparaging comparisons with face-to-face treatment, suggested that a person who wanted to see an office therapist would need to wait weeks to do so, and that their privacy may be compromised by others watching them enter or leave the psychologist’s office. Often these sites did not distinguish e-therapy from traditional service, leaving the impression that the two types of service were equivalent. A few sites also offered testimonials from current online clients, a practice that violates the APA ethics code (Section 5.05) because of the risk of exploitation of the client. Less than one fifth of the online sites sampled contained avenues for dissatisfied e-clients to file a grievance about service. More than half the sample advertised books or tapes authored by the e-therapists with order information for interested consumers, a practice that while not unethical leaves the impression that the online therapist is an “expert,” without requiring them to back this up.

For more information on ethics and advertising, please see Heinlen (2003) and Derrig-Palumbo & Zeine (2005).
Duty to Protect (Tarasoff & Ewing)

Questions to consider:
What is your “Duty to Protect”?
Do you believe that the “Duty to Protect” is beneficial? Why or Why not?
What information should you consider in making a report?

Begin by considering the following excerpt from the *APA Monitor on Psychology* (Volume 36, No. 7 July/August 2005):

Geno Colello was in psychotherapy with Dr. David Goldstein and was despondent over the breakup of his long-standing relationship with Diana Williams, who had recently begun dating Keith Ewing. On June 21, 2001, Colello asked his father to loan him a gun. When his father refused, Colello said he would get another gun and "kill" the "kid" who was then dating Williams. Colello’s father relayed this threat to Goldstein, who urged him to take Colello to Northridge Hospital Medical Center. Later that evening a hospital social worker evaluated Colello. Colello’s father told the evaluator about his son’s threat. Colello was admitted to the hospital as a voluntary patient but discharged the next day. The following day he shot and killed Ewing and then himself.

Many professionals reading the above case are likely surprised that this discussion of the “Duty to Protect” mandate was not initially illustrated with the Tarasoff case. Most mental health professionals are familiar with *Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976). On October 27, 1969 Prosenjit Poddar, who was an exchange student at the University of California at Berkley, killed Tatiana Tarasoff. Poddar had pursued a romantic relationship with Tarasoff, however, she rejected his advances. Poddar sought treatment at the school’s mental health facility and was assigned to a psychologist who diagnosed him with paranoid schizophrenia. Poddar spoke about his anger at Tarasoff and his plans to murder her. The psychologist attempted to initiate commitment procedures without success, and although police questioned Poddar he was released after agreeing to stay away from Tarasoff. Two months later, Poddar murdered Tarasoff.

Tarasoff’s parents sued the university, the therapist, and the police for negligence. The case went to the California Supreme Court who found that the defendants were negligent in not notifying Tarasoff that she had been the subject of a homicidal threat. Specifically, the court ruled that the therapist is liable if (1) they should have known about the dangerousness based on accepted professional standards of conduct, and (2) they failed to exercise reasonable care in warning the potential victim.

The Supreme Court of California held that mental health professionals have a
duty to protect individuals who are being threatened with harm by a patient. The original 1974 decision mandated warning the threatened individual, but a 1976 rehearing of the case by the California Supreme Court called for a "duty to protect" the intended victim. The professional may carry out the duty in several ways, including notifying police, warning the intended victim, and/or taking other reasonable steps to protect the threatened individual.

Trends show an increase in the number of lawsuits filed against social workers in the past 25 years (Surface, 2005). Tapp and Payne (2011) state that it is important that all mental health providers be aware and knowledgeable about their liability exposure from third parties as a result of the Tarasoff II duty to protect.

California Civil Code 43.92 clarifies the Tarasoff Statute and states, with regard to the duty to warn that this is required "where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims." In these situations, the psychotherapist's duty is to make a "reasonable effort to communicate the threat to the victim or victims and to a law enforcement agency." Failure to act may also result in potential civil liabilities.

Although the Tarasoff case is much discussed and has spread to other states as well, it is not without its controversy. Some have been concerned that the Duty to Protect mandates erode therapeutic confidentiality (see Leeman, 2004) and that it will be extended to other areas including notification in the case of potentially risky sexual behaviors (see Ainslie, 1999).

Returning to the more recent Ewing case, Ewing's parents sued Goldstein and the hospital. They alleged that Colello posed a foreseeable danger to their son and that both Goldstein and the hospital were aware of the threat but failed to discharge their duty to warn either Ewing or a law enforcement agency. At trial, Goldstein claimed he was not liable for failure to warn because Colello had never directly disclosed any intention to seriously harm Ewing. The hospital claimed that expert testimony was required to prove a therapist's liability for failure to warn. The judge sided with the defendants.

On appeal, in Ewing v. Goldstein (120 Cal. App. 4th 807 [2004]) and Ewing v. Northridge Hospital Medical Center (120 Cal. App. 4th 1289 [2004]), the California Court of Appeal held that the plaintiffs had a right to take their claims to trial. Specifically, the court held that the defendants' duty to warn could have been triggered by the statements Collelo's father made to Goldstein and the social worker regarding his son's threats. The court did not differentiate between threats conveyed directly by the patient and those related by an immediate family member of the patient.

The court expanded the definition of Civil Code 43.92 to "include family members as persons covered within the statute who, upon communication to a therapist of a serious threat of physical violence against a reasonably identifiable victim, would trigger a duty to warn." Court documents state: "The intent of the statute is clear. A therapist
has a duty to warn if, and only if, the threat which the therapist has learned - whether from the patient or a family member - actually leads him or her to believe the patient poses a risk of grave bodily injury to another person." The expanded duty from now on applies to credible threats received from the patient, or the patient’s family, however, the court made clear that its decision did not go beyond “family members.”

With regard to the initial Tarasoff ruling as well as Ewing ruling, it appears clear that mental health professionals must take steps to protect the welfare not only of our clients but also of their extended circle. According to Welfel (2012) it is important for clinicians to familiarize themselves with the process of risk assessment. Borum and Reddy (2001) note six major topics for clinicians to evaluate in assessing potential violence: (1) the presence of attitudes that support violence, (2) the client’s capacity of means to carry out violence, (3) the crossing of a threshold toward violence such as purchasing a gun or breaking a law, (4) the presence of an intent to carry out an action, (5) the responses of others to the client’s plans, and (6) the degree of client compliance with professional recommendations to reduce risk.

For further information, please see Soulier, Maislen & Beck (2010), Fox (2010) and Werth et al. (2008).

**Achieving and Maintaining Competence**

**Questions to consider:**
What is professional competence?
Why is competence so critical for mental health professionals?
How do mental health professionals achieve and maintain competence?
Are there ever times when it is okay to practice outside the scope of ones competence?
What are some competence issues specific to interns?

**Case Study**

*Melanie Walters, a licensed MFT, has been working with John and Mary. She has seen the couple in counseling for 6 months, and is supporting them in managing Mary’s depression. Melanie receives a phone call from John, expressing concerns that his wife has started engaging in eating disordered behavior, including purging. Melanie is not familiar with treating bulimia, but feels that since she has already been treating the couple and that many of their communication problems are improving, the eating disorder does not need to be the focus of treatment. Mary’s symptoms continue to increase in frequency, although Melanie is not aware of this. At work one day, Mary experiences severe vertigo. She consults with her primary care physician and learns that Mary’s blood panels are abnormal. Melanie feels badly about this, but rationalizes that Mary has not made her aware that her symptoms have worsened. Had she known she would have referred Mary to a specialist (or would she?)*
The above case study focuses on the issue of professional competence. Mental health providers cannot be expected to be “experts” in all psychological disorders or in treating all populations. Professional competence is at the heart of professional practice. It is so important that NASW considers it one of the core values of their profession. The concept of professional competence, however, is not unique to social work, but is a key factor in the ethical codes and professional training of all of California’s mental health professions. Despite the importance of the concept of competence, it not always easy to identify what one means by this term and to define it. Epstein and Hundert (2002) define competence as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served” (p. 226).

The issue of attaining and maintaining professional competence has been the focus of a number of authors (e.g., Welfel, 2012; Knapp and VandeCreek, 2012; Pope and Vasquez, 2007; Roberts et al., 2005.) It is also mentioned in all professional codes. The NASW Ethical Code, for example, provides a comprehensive description of the many facets of competence, and one that encompasses the lifespan of professional counselors. The code states:

a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

Similarly, the National Association of School Psychologists states:

d) School psychologists recognize the strengths and limitations of their training and experience, engaging only in practices for which they are qualified. They enlist the assistance of other specialists in supervisory, consultative, or referral roles as appropriate in providing services. They must continually obtain additional training and education to provide the best possible services to children, families, schools, communities, trainees, and supervisees.

In looking at these provisions, it is clear that the counselor in the case, although skilled in couples work, was practicing outside the scope of competence. There are a
number of potential solutions for this, including referring Mary to an individual counselor who specializes in eating disorders. Another option would have been for Melanie to obtain supervision on the case with someone skilled in treating these issues.

Knapp and VandeCreek (2012) view four areas of competence as particularly important: technical knowledge, social skills, diversity competence and emotional competence.

Of these areas of competence, Knapp and VandeCreek (2012) see emotional competence as key, and find that clinicians often underestimate its importance. They state that clinicians who demonstrate emotional competence are more likely to make prudent decisions by thinking through complex situations and attending to factual information, social cues and personal feelings.

Additionally clinicians need to be aware of personal problems that may interfere with their ability to provide care. The Ethical Code of the National Association of School Psychologists, for example states: “School psychologists refrain from an activity in which their personal problems or conflicts may interfere with professional effectiveness.” These problems could include issues such as a divorce, a medical or psychological illness. In terms of mental illness or substance abuse that precede licensure, the BBS may refuse to issue a registration or license when it appears that an applicant may be unable to practice his or her profession safely. Should such problems be subsequent to a professional entering practice, providers may choose to limit their practice size, not see patients whose problems mirror their own, or may take a leave of absence.

Maintaining competence is also related to continuing education. The California statutes are quite specific on continuing education hours and requirements. Providers are urged to review the specific requirements listed in the Statutes for further information on continuing education hours and components (e.g., long term care requirement, spousal or partner abuse requirement). Amendments to these requirements may be found at http://www.bbs.ca.gov/pdf/regulation/2008/1887_changes.pdf.

For further resources on the topic of professional competence please see (e.g., Elman et al., 2005; Pope and Vasquez, 2007; Roberts et al., 2005.)

**Compassion Fatigue**

Alyssa Santoro is a social worker in a hospital program for women with PTSD. A dedicated therapist, she has received numerous accolades from patients and staff alike. While Alyssa has always enjoyed the work, she has lately noticed that she has been having sleep and concentration difficulties, and has been more concerned with certain of the clients in the program. While she is scheduled to work Monday through Friday, she has begun stopping by the hospital on the weekends to visit with clients and see how they are doing. Her supervisor is concerned, having noted that lately Alyssa appears more distracted and irritable with some of the clients that she feels are “not
working hard enough.” Alyssa has also lost weight, and looks tired all the time. Alyssa dismisses her supervisor’s comments, stating that she has had sleep problems in the past and that it is “nothing too worry about.”

An area of competence that merits special attention is self-monitoring for the possible effects of compassion fatigue. While there are a number of definitions of this phenomenon, all share the idea that helping professionals can be effected by their work with clients, and that these effects can sometimes be negative. Other terms for compassion fatigue are secondary traumatic stress and burnout. While those of us in the helping professions may not directly experience trauma, we care for patients in emotional pain or distress. Mental health professionals, then, experience these events emotionally (Figley, 1995, Gentry, Baggerly & Baranowsky, 2004). Symptoms of compassion fatigue include impairments to the ability to be therapeutically effective, as well as physical and effects on the clinician. Many of these are symptoms similar to the symptoms of primary posttraumatic stress disorder.

Relational/Work-Related Symptoms (Lombardo & Eyre, 2011)

- Avoidance or dread of working with certain patients
- Boundary issues, such as over-involvement with patients
- Reduced ability to feel empathy towards patients or families
- Frequent use of sick days

Physical/Emotional Symptoms

- Lack of joyfulness/Irritability
- Poor concentration, focus, and judgment
- Sleep disturbances
- Excessive use of substances
- Anxiety

It is important for treating clinicians to understand the concept of compassion fatigue, and to practice self-assessment. One resource to assess compassion fatigue is the ProQuol (www.proqol.org), developed by traumatologist Dr. Beth Hudnall and her colleagues. It is available free of charge at the website shown above.

What can the helping professional do to lessen their chances of developing compassion fatigue? Gentry (2004) suggests that clinicians develop a personal plan of care so as to and achieve a healthy work-life balance. This may include careful attention
to self-care issues (exercise, sleep, nutrition), spiritual development, mindfulness practice (Bruce et al., 2010) and support systems both within and external to the workplace. It is also important that healthcare systems create healthy work environments that prevent compassion fatigue and address the needs of caregivers who are experiencing compassion fatigue.

Propriety Identifying Level of Competence to Public

In addition to maintaining professional competence through appropriate training, supervision, and education, it is also important that clinicians appropriately identify their licensure status — a key indicator of professional competence — to potential clients. This issue is explicitly addressed for Marriage and Family Therapists. According to the Statutes, marriage and family therapist interns and trainees must inform each client, prior to performing professional services, that they are an unlicensed intern or trainee, provide the name of his or her employer, and to indicate that he or she is under clinical supervision. Marriage and family therapist interns and trainees also need to be clear in their advertising that they are not yet licensed, and are under supervision. It prohibits the acronym “MFTI” unless “Marriage and family therapy intern” is spelled out in the advertisement. While the statutes newly address this issue with marriage and family therapy interns, it is appropriate practice for all new clinicians.

Seeking Consultation

While it is important to practice within one’s scope of competence, there are times when working with a client that things may come up outside one’s areas of expertise. Consider the following case:

Case Study

Janet Grossman is a Licensed Social Worker, working with Cynthia Bowen on anxiety issues. They have been working together for two years. Cynthia comes from a family with a history of breast cancer, and recently her doctor suggested genetic testing. She comes to the next session extremely anxious about deciding whether to proceed. Janet has little experience with genetic testing, and feels over her head in the discussion. She reaches out to a colleague who is more familiar with health psychology. She reveals the basics of Cynthia’s situation, and is able to use the information she learns to help Cynthia manage her anxiety more effectively.

This is an example that occurs frequently in practice, that of an existing client presenting with an issue that may be outside the scope of a clinician’s expertise. The NASW Code of Ethics states that social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients. To support this type of consultation, social workers should keep themselves informed about colleagues’ areas of expertise and competencies. Social workers should seek consultation only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation. When consulting with colleagues about clients, social
workers should disclose the least amount of information necessary to achieve the purposes of the consultation.

Competence with Cultural/Linguistic Minorities
Non-Discrimination in Providing Services

Questions to consider:
What is “cultural competence?”
How do you assess whether you are culturally competent?
Are there circumstances in which a provider should refuse to provide services?
What are these circumstances?

Case Study

Gerald Siran, a licensed MFT, received a phone call from a couple seeking family counseling due to problems with their 14-year-old son. In a brief phone conversation, Gerald learned that the couple was from Laos, and that their son was the first generation to be raised in the United States. The mother, who had initiated the phone contact at the request of the school guidance counselor, expressed disappointment in their son, who had not been getting the grades (As) that the family expected. Gerald, who felt out of her depths due to a lack of knowledge about Laotian culture, referred the family to a colleague, who had worked with other Asian families. Has Gerald responded to the request for services ethically? Legally?

The idea of competence also encompasses the need for California mental health professionals to be culturally competent treatment providers. Legal and ethical mandates for mental health professionals stress the need for these professionals to respect and promote the welfare of individuals and families. With the amazing diversity of California’s population, special attention to non-discriminatory practices is needed. The term “cultural competence” is encompassing, and may refer to a client’s ethnic or racial heritage, sexual or gender orientation or disability status, to name a few.

What is cultural competence? While an older definition, Cross’s definition is oft cited. Cross et al. (1989) defines cultural competence as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals, that enable them to work effectively in cross-cultural situations.” Included in this definition is the idea that cultural competence relies on a person’s ability to accept differences, continually assess themselves regarding culture and the dynamics of difference, and the development of cultural knowledge and resources within service models to meet the needs of diverse populations. Many believe that cultural competence is the most important factor in service utilization for diverse populations.

Saldana (2001) describes three important components in developing cultural competence: knowledge, professional skills, and personal attributes. The knowledge
component consists of knowledge of the client’s culture, communication styles, and help seeking behaviors. Professional skills include application of specific techniques that will prove effective with diverse populations, the ability to discuss racial and ethnic issues, and the ability to use resources on behalf of minority clients. Perhaps the most important of these components are the personal attributes of the counselor, which includes a willingness to work with diverse populations and the ability to communicate genuine warmth and empathy. Knapp and VandeCreek (2012) add that clinicians can work more effectively with culturally diverse clients if they are able to be self-reflective and to recognize the impact of their own cultural heritage on their values and assumptions. Culturally competent professionals are aware of and sensitive to their own racial and cultural heritage and respect differences. Being aware that their worldviews, they exercise care when make determinations of normality or abnormality. Differences, then, are not seen as necessarily deviant or pathological (APA, 2003).

In addition to the need to maintain cultural competency, both ethical and legal mandates look at a closely related issue: provision of nondiscriminatory practices. Ethical codes provide an exhaustive list of criteria to promote non-discriminatory practices. The NASW Code of Ethics, for example, stresses the goal of social competence and ability to work with clients of all cultural groups. It urges social workers to understand “culture and its function in human behavior and society, recognizing the strengths that exist in all cultures” and to have an adequate knowledge base from which to understand their clients’ cultures and be able to demonstrate competence in the provision of services that are sensitive to clients’ cultures and to differences among people and cultural groups.

The American Association of Marriage and Family Therapists (AAMFT) Code Of Ethics also stresses diversity issues and the need for nondiscriminatory provision of services: “Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, or sexual orientation.”

The National Association of School Psychologists code states that “practitioners are obligated to pursue knowledge and understanding of the diverse cultural, linguistic, and experiential backgrounds of students, families, and other clients. When knowledge and understanding of diversity characteristics are essential to ensure competent assessment, intervention, or consultation, school psychologists have or obtain the training or supervision necessary to provide effective services, or they make appropriate referrals.”

BBS licensees are may be subject to disciplinary action for “refusing, or aiding or inciting another licensee to refuse to perform licensed services because of the prospective recipient’s race, color, sex, religion, ancestry, disability, marital status, or national origin.” There is an exception to this law that states that mental health providers may refuse to provide services if these would pose a direct threat to the health or safety of others.
This legislation adds “medical condition,” “marital status,” and “sexual orientation” to the list of reasons mental health professional cannot refuse to perform licensed services. This bill also establishes that these requirements do not prohibit a licensee from taking into consideration those characteristics for purposes of diagnosis or treatment. This bill does not require any practitioner to perform a licensed activity for which he or she is not qualified. If a clinician believes that he or she is not professionally able or competent to provide services, an appropriate referral is allowable.

Assessment and Treatment of Cultural Minorities

In 2002, Lehman published the results of a study funded by the Canadian government regarding accuracy in diagnosing cultural minorities. He found that patients in about one-third of the cases he reviewed were given inaccurate diagnoses because the evaluator did not understand the cultural background of the client. Additionally the American Psychological Association (2003) in conjunction with several multicultural task forces presented several findings pertinent to mental health treatment:

- Individual and institutional racism continue to affect the quality of life for ethically diverse clients and this is often reflected in stressors that lead to emotional problems.

- Racial/ethnic minority groups have less access to health care, the nature of services is inadequate; they are more likely to be medically uninsured, and the services provided are often inferior.

- Traditional mental health care is often inappropriate to the cultural values and life experiences of ethically diverse clients.

- The system of care is often monocultural and ethnocentric in the assessment, diagnosis, and treatment of racial/ethnic minority populations.

- Clinicians are not immune from inheriting the biases, stereotypes, and values of the larger society.

- Cultural values, assumptions, and beliefs often affect how psychological distress is expressed among diverse populations, the manner of symptom formation, and help-seeking behavior.

- Culture-specific mental health treatments consistent with the cultural values and life experiences of a particular group may prove more effective than conventional forms of treatments.

In addition to awareness and self-reflection, culturally sensitive diagnosis and treatment providers seek out educational, consultative, and multicultural training experiences. They are involved with culturally diverse groups outside of their work role. Culturally competent therapists evidence therapeutic flexibility in individual, group, and
systemic interventions. They are able to engage in a variety of verbal/nonverbal helping styles and can play many helping roles besides the traditional counselor-therapist roles (APA, 2003).

**DSM-5**

The DSM-5 reflects a more inclusive description of the range of diagnostic issues across the globe, not just the particular constructs or exemplars most commonly encountered in the US, Western Europe, and Canada (Cummings, 2013). The DSM-5 is divided into three sections – Section 1: Introduction (“DSM-5 Basics”); Section II: “Diagnostic Criteria and Codes”; Section III: “Emerging Measures and Models” – and an Appendix, which includes a “Glossary of Cultural Concepts of Distress.” Section III also includes a chapter on cultural formulation, featuring an updated version of the outline introduced in DSM-IV as well as an approach to assessment, using the Cultural Formulation Interview (CFI). The chapter also includes a section discussing “Cultural Concepts of Distress” (pp. 758–759).

The notion of “culture-bound syndromes” has been replaced by three concepts: (1) **cultural syndromes**: “clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts that are recognized locally as coherent patterns of experience” (p. 758); (2) **cultural idioms of distress**: “ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns” (p. 758); and (3) **cultural explanations of distress or perceived causes**: “labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress” (p. 758).

One important aspect of the DSM-5 is that the descriptions found in the main portion of DSM entries alert practitioners to place symptoms in a cultural context. Panic disorder, for example, describes *ataque de nervios*, a syndrome most associated with Spanish-speaking people from the Caribbean although recognized in Latin Americans and Hispanic and Latino Americans and *khya'l cup, another cultural presentation of panic disorder*. An example of what can happen when there is not this familiarity can be found in the Medical Errors section of this document.

It is helpful for clinicians to familiarize themselves with these cultural syndromes in order to aid with diagnosis.

**Informed Consent**

*Questions to consider:*

How would you define “informed consent?”

Why is informed consent important? Therapeutically? Ethically?

Are there ever times when informed consent is not necessary?

Is informed consent a one-time process?
One important issue for mental health professionals is that of informed consent. Informed consent involves providing clients with information necessary to make educated decisions about treatment. The process of "informed consent" is an opportunity for the therapist and client to make sure they understand their shared venture. Informed consent is both a process, and a capability. The NASP Code, for example, define informed consent to mean that "the person giving consent has the legal authority to make a consent decision, a clear understanding of what it is he or she is consenting to, and that his or her consent is freely given and may be withdrawn without prejudice." Knapp and VandeCreek (2012) term informed consent "empowered collaboration." Informed consent is a process of communication and clarification. Professional codes of ethics are generally very similar in the way that they approach the informed consent process.

Providing clients with the information they need to become active participants in the therapy relationship begins with the initial session and continues throughout counseling. It is challenging to balance giving clients too much information and too little. Informed consent promotes active cooperation of clients. Clients sometimes don’t realize they have rights and don’t think about their responsibilities in solving their problems. They seek the expertise of a counselor without realizing that the success of the therapy relationship depends largely in their own investment in the process.

The following case helps to illustrate the importance of the informed consent process:

Anna is a 36-year-old morbidly obese female. Anna has been obese most of her life, and has consulted with a surgeon regarding gastric bypass surgery. The surgeon evaluates Anna, and feels that a gastric bypass would be an appropriate option for her. He asks Anna to have a series of tests, including a psychological evaluation. The evaluator feels that Anna needs more counseling prior to undergoing weight loss surgery, and that the primary focus of this counseling should be in developing coping skills and decreasing binging behavior. Anna is told to seek the services of a counselor skilled in treating eating disorders. This counselor could send the surgeon a note when he or she feels that Anna has the appropriate coping skills to manage the binging.

Anna contacts her insurance company and receives a list of eating disorder specialists. She contacts Sarah Jeffers, a social worker with 15 years of experience in treating eating disorders. In her initial session with Sarah, Anna explains why she is seeking treatment for her binging. Anna clearly states that her ultimate objective is to have gastric bypass surgery. She also provides Sarah with a copy of her psychological evaluation.

Sarah and Anna meet for nine months. Both agree that Anna has made good progress on her binging, but recognize that her weight has not changed. Anna asks when Sarah believes that she will be ready to continue with the surgery process. Sarah
replies that she does not believe in gastric bypass surgery and would not be willing to support her in this and will not provide Anna with a letter for her surgeon.

In the case Sarah did not accurately represent her position on weight loss surgery or provide Anna with information that would have allowed her to seek alternate services.

The California Patient's Guide, a consumer watchdog agency defines informed consent as an individual’s “agreement to a proposed course of treatment based on receiving clear, understandable information about the treatment's potential benefits and risks.” The guide states that patients must be informed about all treatments available for their health conditions, and the risks of receiving no treatment. Some of the issues that the group includes in their discussion of informed consent are: 1) a description of the diagnosis, treatment, risk and benefits, 2) discussion of other options, and 3) clinician’s qualifications to perform treatment.

Professional codes of ethics provide that clients have the right to be presented with enough information to make informed choices about entering and continuing the therapy relationship. The AAMFT Ethical Code, for example, is explicit in defining the informed consent process. It states: “Marriage and family therapists obtain appropriate informed consent to therapy or related procedures as early as feasible in the therapeutic relationship, and use language that is reasonably understandable to clients. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment, processes, and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible."

Informed consent may take various forms, such as a client information brochure or a discussion between client and therapist. Whatever format it takes, informed consent should include the following factors:

- Goals of therapy/psychotherapy services
- Risks and benefits of therapy
- Approximate length of the process
- Alternatives to therapy
- Fees and services, including processes if bills are not paid
- Qualifications and background of the counselor
- Treatment procedures, including emergency procedures
- Third party disclosures
- Choices between paying with and without insurance
There are instances in which provision of mental health services can occur in the absence of client/parent consent. Some examples include when there is an emergent need for services, such as in the course of a psychiatric crisis. With regard to school-based psychological services, it is ethically permissible to provide school-based consultation services regarding a child or adolescent to a student assistance team or teacher without informed parent consent as long as the resulting interventions are under the authority of the teacher and within the scope of typical classroom interventions. Parent consent is not required for a school-based school psychologist to review a student’s educational records, conduct classroom observations, assist in within-classroom interventions and progress monitoring, or to participate in educational screenings conducted as part of a regular program of instruction. Parent consent is required if the consultation about a particular child or adolescent is likely to be extensive or may result in a significant intrusion on student or family privacy beyond what might be expected in the course of ordinary school activities. Parents must also be notified prior to the administration of school- or classroom-wide screenings for mental health problems (NASP Ethical Code).

While it is important to provide information that allows for informed consent at the beginning of the therapy relationship, informed consent is not a one-time process. Take, for example, the following case:

**Case Study**

Jean Kerigan has been in therapy with licensed professional counselor Loren Sheppard. Jean is a survivor of childhood trauma, and has been participating in supportive/psychoeducational counseling. Loren has just completed EMDR training, and feels that Jean would be an ideal candidate for this medium. She tells Jean that she is going to try a new procedure in which she hears that there are amazing results. Loren is very anxious to support Jean, and they schedule an EMDR session for the following week.

What concerns do you have about this example? Did Loren provide adequate informed consent?

In the example above, informed consent clearly had to be more comprehensive than that which was given, including a description of what EMDR is, the risks and benefits of EMDR, how it will differ from the type of treatment Jean is having currently, and the fact that Loren is newly trained in this type of treatment. If Loren’s treatment is being supervised (and that is new as well), Loren would also need to disclose this.

Another consideration in informed consent involves HIPAA. If the provider needs to be HIPAA compliant (transmission of information to third parties) the informed consent process must also include specific information about access to PHI (protected health information).
Per California law, the informed consent process may be either “formal” (i.e., in writing) or “informal” (by discussion). There are several instances in which a person must be informed in writing through the use of an Informed Consent to Treatment form. These are when a client needs to undergo psychosurgery or electroconvulsive therapy or is a participant in a research study.

**Multiple or Non-Sexual Dual Relationships**

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<thead>
<tr>
<th>Questions to consider:</th>
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<td>Have you ever encountered the possibility of entering a dual/multiple relationship?</td>
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<tr>
<td>Are all multiple relationships harmful?</td>
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<tr>
<td>Why may some dual relationships be harmful to clients?</td>
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The term “boundaries” refers to a set of rules of the professional relationships that set mental health professionals apart from other relationships. Boundaries clarify behaviors that are appropriate in psychotherapy, provide limits and structure, and prevent harm to patients (Knapp and VandeCreek, 2012).

Our ethical codes and state laws are aware of potential conflicts of interest in relationships with clients. There are a number of potential areas that could present potential conflicts of interests, but some of the most commonly occurring ones involve sexual relationships and non-sexual dual relationships. Sexual relationships are extremely harmful and will be discussed in the next section, but it is also important to review issues related to multiple/non-sexual dual relationships.

Standard 1.06C of the NASW ethical code states “Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries.” The NASP guidelines also contain guidelines on dual relationships. The code states: “Dual relationships with clients are avoided. Namely, personal and business relations with clients may cloud one’s judgment. School psychologists are aware of these situations and avoid them whenever possible.” The AAMFT Code states: “Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client’s immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken.”

Some examples of dual/multiple relationships include:
- Counseling a friend, family member or someone known to the therapist
- Providing individual therapy to two members of the same household
- Providing simultaneous individual and group therapy
- Entering a business relationship with a client

The California Department of Consumer Affairs publication *Professional Therapy Never Includes Sex* describes several types of multiple relationships that they consider possible “warning signs” of inappropriate behavior and misuse of power:

- Entering a social relationship with a client
- Hiring a patient to do work for the therapist
- Bartering goods or services to pay for therapy
- Supporting the patient’s isolation from social support systems
- Increasing dependency on the therapist.

With regard to bartering for services, bartering is generally addressed specifically in the ethical standards of the professions. The AAMFT Code, for example, states: “Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: (a) the supervisee or client requests it; (b) the relationship is not exploitative; (c) the professional relationship is not distorted; and (d) a clear written contract is established.”

If we compare the first and second lists, it is clear that some multiple relationships are extremely problematic and others are not at all problematic. For example, many therapists see clients in both individual and group therapy. Some relationships, however, are both avoidable and potentially problematic. Consider the following case:

**Case Study**

_Geri, clinical social worker in private practice, receives a call from Mary, an old college friend. Mary has recently discovered that her daughter, Kim, has been cutting herself, and Mary is very concerned. Kim has refused all treatment, but says she is willing to talk with Geri, whom she knows and trusts. Geri is not entirely comfortable with this, but feels that the potential benefits of treating Kim would outweigh any of the issues related to dual relationships. Geri sets up a consultation, and will reassess her stand following the meeting with Kim. Did Geri make the right decision? Why or why not?_

There are many potential issues with Geri’s agreement to see Kim, even for only an assessment. Pope and Vasquez (2010) discuss the difficulties inherent in dual relationships. On the whole, dual relationships jeopardize professional judgment, clients’ welfare, and the process of therapy. Pope and Vasquez make the following points:

- Dual relationships erode and distort the professional nature of the therapeutic
relationship, which is secured within a reliable set of boundaries upon which both therapist and client depend.

- Dual relationships create conflicts of interest and thus compromise the disinterest necessary for sound professional judgment. Management of transference and countertransference becomes impossible.
- There is unequal footing between therapist and client, making a truly egalitarian relationship impossible.
- The nature of therapy would change.
- This could affect future needs of the client. In particular, the therapist could be compelled (by court order) to provide testimony on the client’s diagnosis, treatment or prognosis.

In addition to the reasons discussed above, there are some that believe that nonsexual dual relationships have the potential to develop into more intimate sexual contact. Although this is certainly not always the case it is important to consider the possible difficulties with a therapy relationship if the potential for conflict of interest may occur. Additionally it is also important to consider these issues with regard to rural social work. For a comprehensive discussion of this topic see Daley & Hickman (2011).

**Consequences to the Therapist of Boundary Violations**

In addition to consequences to clients, boundary violations have the potential to affect therapists as well. Fry (2008) describes the following consequences to therapists:

- a) Less personal time with family and friends
- b) Less job satisfaction
- c) Co-worker frustrations
- d) Burnout
- e) Compassion fatigue

Fry also lists “extreme” consequences of boundary violations:

- a) Loss of job
- b) Loss of license
- c) Loss of professional identity
- d) Loss of peers
- e) Loss of professional relationships

**Physical Contact with Clients**

In addition to the issues connected to dual relationships, a related concern is that of physical touch in treatment. The NASW Code of Ethics provides some clear guidelines on the issue of nonsexual touch. The guidelines state: “Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients).” Social workers who engage in appropriate physical contact with clients are responsible
for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

In reviewing the ethics code, it is clear that physical contact with clients is something that the mental health professional should not engage in indiscriminately. It is important to recognize when physical touch could be distressing to a client (such as in the case of prior sexual abuse or in certain cultures where touch is not comfortable) or when it could actually be helpful to the client. Consider the following case:

Keri is a 28-year-old client with a history of long-term sexual abuse by an uncle. She has been in treatment with Catherine, a clinical social worker with 15 years experience in treating abuse issues. Keri trusts Catherine, and wants to work on her fears of physical touch. Catherine consults with a colleague, and both agree that this would be beneficial to the client. Catherine develops a hierarchy of situations in which Keri will tolerate physical touch, culminating with a hug from Catherine. Keri is able to work through the issues and feels a great deal of relief.

In the case described above Catherine had a clear therapeutic goal and there was appropriate consultation.

Questions to consider:
Have you ever encountered a situation in which a client reported having a sexual relationship with a former therapist? How did you handle this situation?
Why do you believe it is harmful for a therapist and a client to engage in sexual intimacies?

The California Department of Consumer Affairs publication Professional Therapy Never Includes Sex begins with the statement: “Professional psychotherapy never includes sex. It also never includes verbal sexual advances or any other kind of sexual contact or behavior. Sexual contact of any kind between a therapist and a patient is unethical and illegal in the state of California. Additionally, with regard to former patients, sexual contact within two years after termination of therapy is also illegal and unethical. Sexual contact between a therapist and a patient can also be harmful to the patient. Harm may arise from the therapist’s exploitation of the patient to fulfill his or her own needs or desires, and from the therapist’s loss of the objectivity necessary for effective therapy. All therapists are trained and educated to know that this kind of behavior is inappropriate and can result in the revocation of their professional license.”

Sexual Relationships with Clients

As the passage above suggests, the issue of sexual relationships between a client and a therapist is a very important one that can result in a great deal of harm to both parties. California laws, as well as of our professional codes of conduct, have mandates that specifically prohibit sexual intimacies between clients and therapists. Let us again turn to the NASW Code of Ethics. Standard 1.09 (Sexual Relationships) states:
a.) Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced.

b.) Social workers should not engage in sexual activities or sexual contact with clients’ relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients’ relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients’ relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.

c.) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

d.) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

Despite these strong ethical mandates, estimates of sexual relationships between therapists and clients place these in the area of .9-.3.6 percent for male therapists and .2-.5 percent for female therapists. The most important predictor of whether a client will become sexually involved with a therapist is prior sexual involvement on the part of the therapist (Pope & Vasquez, 1991). Interestingly there is also evidence that sexual attraction to clients is a common occurrence with 82 percent of therapists reporting that this has occurred for them at some point in their treatment (Pope & Vasquez, 1991). Consider the following case:

Mark is an attractive graduate social work intern in a college counseling center. During the course of his internship, he meets a number of attractive students, but sets excellent boundaries. One of the students he counsels, Lori is particularly aggressive in her pursuit of Mark. Although Mark is attracted to her, he is able to resist any urge to act on the attraction, and uses the transference/countertransference in a therapeutic way. Lori and Mark discuss this sexual pull over the course of the semester, and are able to relate Lori’s sexual transference to a history of inappropriate sexual boundaries in her family of origin. Lori does well in treatment, and makes a number of gains.
Mark completes his internship at the counseling center and goes on to work at a local social services agency. Approximately two years following the termination of treatment, Mark encounters Lori at a concert. Lori stresses how well she has been doing in the two years since they have seen one another, and again makes her interest known. Les invites her to dinner the next evening. He feels that a sufficient amount of time has elapsed since the termination of his treatment with Lori, and that the two no longer have a professional relationship.

Certainly to many reading this case study, Mark's legal and ethical obligations are clear. To many therapists in this situation, however, professional judgment is clouded, and there are certainly gray areas the state law and ethics codes.

Kenneth Pope (see references) a mental health ethicist who writes about many topics but has a particular interest in the area of sexual intimacies between therapists and clients recently conducted a national survey of 1,320 mental health professionals. He looked specifically at sexual relationships that had occurred between therapist and client following termination of treatment. He found that half the respondents reported assessing or treating at least one patient who had been sexually intimate with a prior therapist; a total of 958 sexual intimacy cases were reported. Most cases involved female patients. He also assessed perceptions of harm arising as a result of these intimacies and found that harm occurred in at least 80% of the instances in which therapists engaged in sex with a patient after termination.

The California Business and Professional Code and the Civil Code (Section 43.93) discuss sexual relationships between clients by therapists. In California, it is illegal for a psychotherapist to engage in sexual contact with a patient or former patient under any of the following circumstances: a. during therapy; b. within two years of termination of therapy; and c. by means of therapeutic deception. Psychotherapist-patient sexual contact by means of therapeutic deception is illegal. Any therapist in California who becomes aware, from a patient, that the patient had a sexual relationship with a psychotherapist during the course of treatment, has the legal obligation to give the patient the brochure entitled, "Professional Therapy Never Includes Sex", and to discuss the brochure with the patient.

Further, according to California laws: Any act of sexual contact, sexual abuse, sexual exploitation, sexual misconduct or sexual relations by a therapist with a patient is unprofessional, illegal, as well as unethical as set forth in Business and Professions Code sections 726, 729, 2960(o), 4982(k) and 4992.3(k). “Sexual contact” means the touching of an intimate part of another person, including sexual intercourse. “Touching” means physical contact with another person either through the person’s clothes or directly with the person’s skin. “Intimate part” means the sexual organ, anus, groin or buttocks of any person and the breast of a female. Sexual exploitation can include sexual intercourse, sodomy, oral copulation, or any other sexual contact between a therapist and a patient or a former patient under certain circumstances. Sexual misconduct includes a much broader range of activity, which may include fondling, kissing, spanking, nudity, verbal suggestions, innuendo or advances. This kind of sexual behavior by a therapist with a patient is unethical, unprofessional and illegal.
The Department of Consumer Affairs publication lists a number of “warning signs” of possible sexual inappropriateness. Sexual misconduct with a client is usually a progressive process. Simon (1995) calls this “the road much traveled” or the “slippery slope.” The awareness is equally important for mental health professionals as well as clients.

**Warning Signs of Sexual Inappropriateness:**

- Telling sexual jokes or stories
- “Making eyes at” or giving seductive looks to the patient
- Discussing the therapist’s sex life or relationships excessively
- Sitting too close, initiating hugging, holding the patient or lying next to the patient
- “Special” treatment by a therapist, such as inviting a patient to lunch, dinner or other social activities
- Dating
- Changing any of the office’s business practices (for example, scheduling late appointments so no one is around, having sessions away from the office, etc.)
- Confiding in a patient (for example, about the therapist’s love life, work problems, etc.)
- Telling a patient that he or she is special, or that the therapist loves him or her
- Relying on a patient for personal and emotional support
- Giving or receiving significant gifts
- Providing or using alcohol (or drugs) during sessions

McNulty, Ogden & Warren (2013) recently conducted a qualitative study of therapist-client sexual relations. They interviewed practitioners about their relationships with clients and former clients. The results highlighted two key themes relating to (i) therapists’ efforts to neutralize the power imbalances between themselves and the clients by minimizing the clients’ mental health problems, stressing the conventionality of the relationships and not testing the appropriateness of the relationship with their supervisors, and (ii) a shifting identity of the therapist between hero, victim, perpetrator, which permeated their accounts as the relationship moved from success to failure. In order for a sexual boundary violation to occur, the therapist generates a sense of equivalent status between themselves and the client. As the relationships failed, the therapists’ accounts of the clients shifted and the inequality of the relationship re-emerged.

**Consequences to the Therapist of Sexual Boundary Violations**

Certainly therapists are human and do make mistakes. Sexual boundary violations are extremely detrimental professionally. Sexual intimacy with clients is a cause for revocation of licensure.

**Consequences to the Patient of Sexual Boundary Violations**

It is well established that sexual boundary violations harm the patient. Simon
(1995) describes the types of harm that may occur. In addition to direct causation such as relapse or worsening of symptoms there are more indirect consequences such as loss of trust and damage to self-esteem.

These consequences include:

- Disengagement from services
- Depression
- Emotional turmoil
- Cognitive distortion
- Shame, fear or rage
- Guilt and self-blame
- Isolation and emptiness
- Identity confusion
- Emotional lability
- Mistrust of authority
- Self-harm behaviors

Clearly these negative aspects of sexual boundary violations are important. It is key that mental health providers maintain a strong therapeutic frame and consider the possible consequences of their actions. Should they have any questions they may consult with colleagues or supervisors.

Treatment Termination and Client Abandonment

**Questions to consider:**

*Have you ever found yourself in a client situation in which you were unable to continue working with a client? What did you do?*

*How do you typically terminate treatment?*

*What steps do you take if clients terminate treatment prematurely?*

Another important ethical concern involves proper termination of treatment and client abandonment. In an ideal world, client termination would be planned, and discussed by both therapist and client. In many instances, however, termination occurs prematurely. There are also instances in which clinicians feel that they can no longer work with clients. There is no mandate that requires continued treatment beyond what the clinician feels is beneficial, and in fact, ethical codes require this type of evaluation. The NASW Code, for example, states “Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients’ needs or interests.” While it is sometimes challenging, termination should be a planned process.
Consider the following cases:

**Case Vignette 1**

Sara is a 22-year-old client currently in treatment with Carla Stern, MFT. Carla has been treating Sara, diagnosed with bulimia, for one year. Sara was recently hospitalized for what appears to be a manic episode. She leaves Carla a phone message from the hospital detailing the hospitalization, and signs a release form to allow the hospital to coordinate care. Carla does not return messages left by the hospital treatment team, nor does she return Sara’s phone calls when Sara is discharged from the hospital. Sara is very upset, and refuses to see another therapist.

**Case Vignette 2**

Sierra is a 22-year-old client who has been in treatment with Mark Lewis, MFT, for one and one half years. She has become increasingly more self-injurious. Mark is concerned about her ability to maintain her safety, and his competence to effectively treat Sierra during this time. He tells Sierra that he feels hospitalization may be needed, and asks her to set up an assessment. When Sierra initially refuses, he tells her that the assessment for hospitalization is a condition of his continued ability to treat her, and that if the evaluator feels she meets criteria for hospitalization, she must comply with that recommendation. When Sierra continues to self-injure even while hospitalized, Mark initiates contact with the hospital, and terminates treatment during an hour-long phone session. The hospital therapist assures him that Sierra will receive an appropriate referral when discharged.

**What did the therapists in these cases do correctly? Incorrectly?**

These cases illustrate many of the considerations in treatment termination, and the possible results of client “abandonment.” There are a number of examples of client circumstances that are potentially difficult:

- When a client accrues a large bill and cannot pay for services
- When a client who has previously paid in full for services now requires a sliding scale
- When there is a role change (e.g., an agency therapist is promoted to a non-clinical role)
- When the therapist does not see continued need for treatment
- When there is a lack of treatment progress
- When there is a threat to the clinician
- When a client’s issues exceed the clinician’s scope of competence

Another important question is when is a client considered a client? The answer is, it depends. It is up to the therapist to establish that boundary. For example, if a therapy
provides a consultation or treatment plan in an email prior to a face-to-face meeting, he or she is already stepping into a therapeutic role. It is often helpful to clarify that the initial in-person evaluation is the chance for both clinician and client to assess whether they would be a good fit, and will work well together. If after the initial assessment the therapist believes the problem to be beyond the scope of their competence, a referral is allowable.

Termination is generally considered to be a complex, but important part of therapy, triggering potential feelings of loss for both clinician and client. Mutually agreeable termination is the “ideal” situation. Roe et al. (2006) found that clients reported initiating these discussions about two-thirds of the time. The most common reasons given for termination were accomplishment of goals, situational/external factors, and dissatisfaction with psychotherapy. The data does not fully detail information relative to possible abandonment. Rose et al. found that 37% felt that the therapy ended earlier than it should have but does not discuss how termination was completed in detail (by the therapist, by the patient, reasons across each group). There is also no distinction made between premature termination (e.g., due to financial constraints) and abandonment (e.g., case vignette 1).

Younggren & Gottlieb (2008) and Younggren (2011) define termination as “the ethically and clinically appropriate process by which a professional relationship has ended.” These authors state that “successful termination is determined by mutual agreement among the parties involved that the goals of psychotherapy have been accomplished and/or no longer require attention. In successful termination, the consumer is a full participant, understands the decision, agrees with the reasons for ending psychotherapy, and is satisfied with the outcome.” Premature termination, however, is the ending of treatment without having adequately resolved the problems that were the initial impetus for therapy. This occurs frequently in practice, such as when a client gets a new insurance plan and a provider is not on that panel or a client has another financial impediment to ongoing therapy services. Abandonment, in contrast, is an inappropriate premature termination and/or when a patient’s ongoing treatment needs are not adequately addressed by the psychotherapist, either when treatment ends or during the course of treatment due to unavailability (Vasquez et al., 2008, p. 654). Abandonment is both clinically contraindicated and unethical.

Client abandonment is addressed in all the ethical codes of mental health professions with similar mandates. An illustration can be found in the ACA code, which states that: 1) Counselors do not abandon or neglect clients in counseling. Counselors assist in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacations, illness, and following termination, 2) If counselors determine an inability to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors should discontinue the relationship. 3) Counselors terminate a counseling relationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit,
or is being harmed by continued counseling. Counselors may terminate counseling when in jeopardy of harm by the client, or another person with whom the client has a relationship, or when clients do not pay fees as agreed upon. Counselors provide pre-termination counseling and recommend other service providers when necessary, and 4) When counselors transfer or refer clients to other practitioners, they ensure that appropriate clinical and administrative processes are completed and open communication is maintained with both clients and practitioners.

Fisher (2011) recommends that therapists discuss termination at three stages of treatment: the intake, during treatment, when actually ending the treatment. The responsibility for these discussions lies with the clinician. Appropriate termination helps to avoid the betrayal of trust and abuse of power, prevents harm, and conveys caring which is critical to ethical treatment.

In addition it is important to recognize that failure to properly withdraw from a professional therapy relationship may expose the therapist to liability.

While it is not possible to foresee all the possible scenarios involved in treatment termination, there area number of recommendations that are helpful for ethical practice:

- Talk about termination in the informed consent process or written document
- Document progress, lack of progress, and considerations for termination
- Plan for drop-outs
- When in doubt, consult with colleagues and document the consultation

In addition, it is beneficial to send clients a formal termination letter, even if the client initiated the termination. There are many examples of such letters online, but clinicians can also develop one on their own, being sure to personalize the letter to each patient (although avoiding specific references to client details), clarifying that the relationship is ending, providing appropriate notification (such as 30 days), briefly stating the reason for the termination, and being clear about recommendations for continued treatment if you believe that it is warranted (Mago, 2013).

**Mental Health Parity**

For many years, insurance companies have set higher co-payments, deductibles, and limits on mental health and addiction treatment than for treatment of physical illnesses such as cancer, heart disease or diabetes. This inequality between physical and mental health benefits has left many patients and their families without proper treatment, and has contributed to the stigma of mental health by fostering the belief that mental health issues are less problematic than physical ones.

In 2008, Congress enacted The Mental Health Parity Act (The Wellstone-Domenici Mental Health Parity Plan), which strove to resolve the inequitable practice of
insurance discrimination. Under the new Federal law, health insurance companies offering mental health benefits will be required to provide equal coverage of mental and physical illnesses. The law, which is formally known as the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 becomes effective on January 1, 2010. The law is projected to provide parity-protection to 113 million people across the country, including 82 million individuals enrolled in self-funded insurance plans.

The Wellstone-Domenici Mental Health Parity Plan is broader in scope than that of previous federal parity legislation. It requires health insurers to guarantee that the mental health and substance use benefits they offer are consistent with coverage offered for physical disorders or diseases. Mental health and substance use disorder benefits are defined to mean benefits with respect to services for mental health conditions and substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. Equity coverage applies to deductibles, co-payments, coinsurance, and out-of-pocket expenses, and to all treatment limitations, including frequency of treatment, number of visits, days of coverage, or other similar limits. The parity act applies to group health plans of 51 or more employees. The California State mental health parity law will continue to apply to health plans of employers with 50 or fewer employees.

According to the American Psychological Association, 2008:

- The Wellstone-Domenici Mental Health Parity Plan not does not specify what psychological conditions must be covered under specific insurance plans, but whatever is covered must be at parity with medical coverage. Generally the conditions covered are specified in the coverage details of a specific plan. If a state parity law requires broader coverage, this will apply.

- This Wellstone-Domenici Mental Health Parity Plan parity continues to require parity coverage for annual and lifetime dollar limits.

- The Mental Health Parity bill ends the confusing process of knowing what constitutes “medically necessary coverage.” Health insurance plans must make mental health/substance use disorder medical necessity criteria available to current or potential participants, beneficiaries or providers upon request. It requires disclosure of the criteria for medical necessity determinations (and reasons for denials of coverage).

- The Mental Health Parity Plan also offers consumer options for out-of-network benefits, potentially allowing greater freedom of choice for consumers. As with other facets of this plan, if a plan offers out-of-network benefits for medical/surgical care, it must also offer out-of-network coverage for mental health and addiction treatment and provide services at parity.
• The legislation extends the parity requirement to any substance-use disorder covered by a health plan. If a state parity law excludes substance use disorders from the parity requirement this would be preempted under the new federal plan. Accordingly, if a health plan offers benefits for substance use treatment, it must be at parity with medical and surgical benefits.

California has expanded upon the Federal law with its own statewide parity provisions. Like the Federal plan, California’s parity law eliminates mental health benefit limits and cost-sharing requirements that are less comprehensive than those for physical conditions. California’s law requires private health plans to eliminate mental health-specific benefit limits and cost-sharing requirements, such as higher co-payments and deductibles and limits on numbers of covered benefits which have traditionally made mental health benefits less comprehensive than other health benefits. The law applies to outpatient mental health services as well as inpatient and partial hospital services.

California’s statute mandates that health insurance plans offered in the state provide coverage for a list of nine mental health conditions: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa. The state law also has broader scope than the federal parity statutes, covering all group insurance plans as well as individual insurance plans.

Although the mental health parity law applies only to private health insurance, comparable benefits are available under state sponsored programs such as Medical. At the present time, the law does not apply to Medicare, or self-insured health plans.
Appendix Chapter 1

Social Work Competency Areas and Practice Behaviors

As recommended by the Council on Social Work Education

Each competency area has performance outcomes - practice behaviors of knowledge, values, and skills needed for generalist practice. Curriculum is designed so that students, upon completion of the major, will be able to demonstrate the integration and application of the competencies in practice with individuals, families, groups, organizations, and communities.

Competency 1: Identify as a social worker and conduct self accordingly

Practice Behaviors
Advocate for client access to the services of social work
Practice personal reflection and self-correction to assure continual professional development
Attend to professional roles and boundaries
Demonstrate professional demeanor in behavior, appearance, and communication
Engage in career-long learning
Use supervision and consultation

Competency 2: Apply social work ethical principles to guide professional practice.

- Practice Behaviors
  - Recognize and manage personal values in a way that allows professional values to guide practice
  - Make ethical decisions by applying standards of the National Association of Social Workers Code of Ethics and, as applicable, of the International Federation of Social Workers/International Association of Schools of Social Work Ethics in Social Work, Statement of Principles
  - Tolerate ambiguity in resolving ethical conflicts
  - Apply strategies of ethical reasoning to arrive at principled decisions

Competency 3: Apply critical thinking to inform and communicate professional judgments

e) Practical Behaviors
f) Distinguish, appraise, and integrate multiple sources of knowledge, including research-based knowledge, and practice wisdom
g) Analyze models of assessment, prevention, intervention, and evaluation
h) Demonstrate effective oral and written communication in working with individuals, families, groups, organizations, communities and colleagues.

Competency 4: Engage diversity and difference in practice

- Practical Behaviors:
  - Recognize the extent to which a culture's structures and values may oppress, marginalize, alienate, or create or enhance privilege and power
  - Gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups
  - Recognize and communicate their understanding of the importance of difference in shaping life experiences
  - View themselves as learners and engage those with whom they work as informants.

Competency 5: Advance human rights and social and economic justice

f) Practical Behaviors:

  g) Understand the forms and mechanisms of oppression and discrimination
  h) Advocate for human rights and social and economic justice
  i) Engage in practices that advance social and economic justice.

Competency 6: Engage in research-informed practice and practice-informed research

- Practical Behaviors:
  - Use practical experience to inform scientific inquiry
  - Use research evidence to inform practice

Competency 7: Apply knowledge of human behavior and the social environment

1. Practical Behaviors:

   2. Utilize conceptual frameworks to guide the processes of assessment, intervention, and evaluation
   3. Critique and apply knowledge to understand person and environment

Competency 8: Engage in policy practice to advance social and economic well-being and to delivery effective social work services
• Practical Behaviors:
  • Analyze, formulate, and advocate for policies that advance social well-being
  • Collaborate with colleagues and clients for effective policy action

Competency 9: Respond to contexts that shape practice

• Informed, resourceful, and proactive in responding to evolving organizational, community, and societal contexts at all levels of practice.
• Recognize that the context of practice is dynamic and use skill to respond proactively
• Practical Behaviors:
  • Continuously discover, appraise and attend to changing locales, populations, scientific and technological developments, and emerging societal trends to provide relevant services
  • Provide leadership in promoting sustainable changes in service delivery and practice to improve the quality of social services

Competency 10 (a)-(d): Engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities

• Practical Behaviors: 10(a) Engagement
  • Substantively and affectively prepare for action with individuals, families, groups, organizations, and communities
  • Use empathy and other interpersonal skills
  • Develop a mutually agreed-on focus of work and desired outcomes
• Practice Behaviors 10(b) Assessment
  • Collect, organize, and interpret client data
  • Assess client strengths and limitations
  • Develop mutually agreed-on intervention goals and objectives
  • Select appropriate intervention strategies
• Practice Behaviors: 10(c) Intervention
  • Initiate actions to achieve organizational goals
  • Implement prevention interventions that enhance client capacities
  • Help clients resolve problems
  • Negotiate, mediate, and advocate for clients
  • Facilitate transitions and endings
• Practice Behaviors: 10(d) Evaluation
Critically analyze, monitor and evaluate interventions
Issues in Domestic Violence: Legal and Ethical Issues
Chapter 2

Introduction

Case Vignette

Carrie is a 38-year-old mother of two preteen children. She has been dating Jack for the past year. When they initially met, she felt that she had finally met the man of her dreams, but now it seems like a constant nightmare. Shortly after the start of the relationship, Jack became physically abusive. Her children have recently witnessed the violence, and her youngest has urged her to call the police. Carrie is fearful of police involvement, however, many of the fears centering around whether her children will be removed from the household.

Domestic violence is a pattern of coercive tactics perpetrated by one person against an adult intimate partner, with the goal of establishing and maintaining power and control. Domestic violence includes physical, psychological, sexual, economic, and emotional abuse. Domestic violence occurs across a spectrum of intimate relationships, including married couples, dating couples, couples who live together, people with children in common, same-sex partners, people who were formerly in a relationship with the person abusing them, and teen dating relationships.

Carrie’s story is not an isolated one. Given the prevalence of intimate partner violence mental health clinicians will likely encounter a survivor in his or her practice. An estimated 5.3 million cases of intimate partner violence are reported each year (CDC, 2003). These incidents result in 486,000 emergency room visits and 18.5 million therapy sessions each year (CDC, 2003). While these numbers may seem high, and they certainly are, they are gross underestimates. According to 2006 Bureau of Justice statistics, less than one-fifth of victims reporting an injury from intimate partner violence sought medical treatment following the injury. Similarly, many domestic violence victims do not report incidents of abuse to law enforcement due to perceived risks of removal of children, dual arrest policies, homelessness, embarrassment or deportation.

Mental health clinicians may be placed in the role of helping to facilitate such reports. They may serve as a lifeline for patients, providing them with information on resources, advocacy and helping them negotiate the legal justice system. While clinicians cannot be experts on all fronts, it is important to have and understanding of the systems in which victims may need to operate. Additionally it is critical that clinicians be aware of their ethical obligations to domestic violence victims and their children.

This is not always easy. According to the American Psychological Association Task Force on Violence and the Family, the legal system is fraught with numerous problems. The report states: “Most victims of family violence will have some contact with the legal system that is not well designed to handle such cases. In addition, inequities in
the application of the law, racial and class bias, and inadequate investigations have harmed rather than helped many families. The low priority given to funding for implementation of child protection laws results in a legal system that frequently fails to work. Many battered women find themselves in dangerous positions because the courts often do not give credence or sufficient weight to a history of partner abuse in making decisions about child custody and visitation. Racial bias often influences the court’s decision about whether to order treatment or to imprison offenders.”

It is important that mental health professionals find ways to negotiate sometimes faulty systems. The first step is in understanding the victim needs and professional obligations.

This course will provide an overview of risks, a discussion of why survivors are reluctant to disclose abuse, the legal resources available to clients and ethical obligations. It will also contain an appendix with helpful information, including a summary of state laws on mandatory arrest and a sample safety plan.

The terms “domestic violence” and “intimate partner violence” will be used interchangeably in this training material.

Educational Objectives

- Discuss the scope of the problem, including intimate partner homicide, lethality assessment and nonfatal injuries
- Discuss reasons why victims often fail to report intimate partner violence
- Define “mandatory arrest” and “dual arrest” and describe the implications of each
- Describe issues related to empowerment and advocacy
- Discuss navigating the various systems related to domestic violence
- Discuss ethical and legal issues related to domestic violence

Scope of the Problem

Prior to looking at the legal aspects of intimate partner violence, it is helpful to look at the history in the impact of domestic violence and its connection to the criminal justice system. While domestic violence is certainly not new, it is only recently that it has been considered a violation of the law. Prior to about the 1970s (and sometimes even currently), domestic violence was seen as a "normal" part of marriage or intimate relationships.

A significant factor in the why the criminal justice system has undergone reforms is how dangerous domestic violence is. The statistics cited in the introduction tell only part of the story. Domestic violence presents a number of concerns related to safety. Mental health providers should be careful not to minimize safety concerns, and assessment of safety and risks should be an ongoing component of therapy.
April 4, 2011 – Orlando, Florida. Police arrested a man they said killed two people at an Orlando apartment complex on Sunday night. Officers said 45-year-old Eligio Isalgue shot his estranged wife and her new boyfriend. Isalgue was arrested in the complex’s parking lot. Investigators said they found a gun inside the apartment. Two other people, including Isalgue’s 13-year-old daughter, were in the apartment. The others were not injured. Investigators said the husband and wife had not lived together for about two months.

Intimate partner homicide is defined as a homicide perpetrated against a current or former spouse, cohabitant, or romantic partner by his or her intimate partner. Here is a summary of some key findings (Catalano et al., 2009):

- In 2007 intimate partners committed 14% of all homicides in the U.S. The total estimated number of intimate partner homicide victims was 2,340, including 1,640 females and 700 males.

- Females were killed by intimate partners at twice the rate of males. Females are generally murdered by people they know. In 64% of female homicide cases, females were killed by a family member or intimate partner. 24% of female homicide victims were killed by a spouse or ex-spouse; 21% were killed by a boyfriend or girlfriend; and 19% by another family member.

- Men were more likely than women to be killed by strangers. Among male homicide victims, 16% were murdered by a family member or intimate partner. Of male homicide victims, 2% were killed by a spouse or ex-spouse and 3% were killed by a girlfriend or boyfriend. Over half (54%) were killed by others they knew, and 29% were killed by strangers.

Prior domestic violence is a strong risk factor for intimate partner homicide. Campbell and Glass (2009), who conducted a study of female victims of intimate partner homicide, found that approximately 80% of women had been a victim of physical and/or sexual intimate partner violence or stalking prior to their murder and 42% were seen in the healthcare system the year before they were killed. While the women themselves are not always good at assessing their own risk, Campbell and Glass state that healthcare professionals, including those in the mental health fields, can be a resource for identifying women who are at risk.

Currently about 20 states have fatality review teams, which comprehensively look at each death. These teams promote prevention and track patterns of homicides and suicides resulting from intimate partner homicide.

Collectively these review teams have found some common warning signs of intimate partner homicide. These include (Campbell et al., 2003):
A prior history of domestic violence and injuries  
Attempts to break away from the abusive partner (such as a protective order, pending divorce, or moving out of the house)  
Stalking or threatening behaviors  
Previous police involvement  
History of mental illness  
History of drug or alcohol abuse (abusive partner or victim)

Assessing Safety

Safety planning is an important component of treatment. Experts on trauma work such as Herman (1997) and Bloom (1997) state that creating safety for trauma survivors is key to recovery. With survivors of domestic violence, this often involves assessing lethality and developing a safety plan. This training material will discuss safety planning later in this chapter. Mental health professionals can use the warning signs of intimate partner homicide in their safety assessment. Additionally safety assessments involve asking clients about:

- Increases in frequency of violence  
- Means of violence (physical violence, presence of guns)  
- Threats of violence  
- Presence of a child that is not the abuser’s  
- Control  
- Threats of suicide  
- Stalking or spying behavior

Other Losses

Case Vignette

A case recently in the news in New York is that of the death of Mary Kennedy, who committed suicide. Her death came on the heels of husband Bobby Kennedy filing for divorce. Bobby Kennedy alleges that he was the victim of domestic violence. Mary’s family alleges that she was a victim.

In addition to homicide of victims of intimate partner violence, there are also other losses. Suicide attempts/completed suicide is another loss associated with domestic violence. Suicide.org estimates one out of every four women who are the victims of domestic violence attempt suicide.

Non-fatal Injuries

While the discussion of intimate partner homicide provides a frightening picture, in terms of sheer numbers, the number of men and women who suffer non-fatal injuries is significantly higher. In 2008 females age 12 or older experienced about 552,000 nonfatal violent victimizations (rape/sexual assault, robbery, or aggravated or simple
assault) by an intimate partner (a current or former spouse, boyfriend or girlfriend). In the same year, men experienced 101,000 nonfatal violent victimizations by an intimate partner. About two-thirds of reported victimizations occur at home. After the incident, less than one-fifth of victims seek medical care (Catalano et al., 2009).

**Reporting Intimate Partner Violence**

Many victims of domestic violence fail to report abuse to the police. Research has shown gender differences in reporting rates, as well as some of the reasons that victims choose not to make a police report. Males victims of domestic abuse are actually more likely to report violent conflicts. In 2008, 72% of the intimate partner violence against males and 49% of the intimate partner violence against females was reported to police. Stalking victimization was equally likely to be reported to police whether the victim was male or female. Thirty-seven percent of male and 41% of female victimizations were reported to the police by the victim or another person aware of the crime (Catalano et al., 2009).

A recent study from the Bureau of Justice statistics found that the major reasons for not reporting abuse to police were: fear of reprisal (15%), belief that police cannot help (6%), and a feeling that violence is “private” (28%). Additionally many victims of intimate partner violence are extremely isolated from sources of support, and lack the support networks to leave abusive environments. They may be faced with the prospect of homelessness or family separation.

This distrust of the legal system also extends to healthcare professionals. This may be particularly true when children are involved or children witness or are victims of family violence. One source of controversy are “failure to protect” statutes. These statutes may be enforced if victims choose to remain with abusers as they place children in harm’s way. In some states, children can be removed from the family in this situation.

Many victims of domestic violence also hide the abuse from health care providers. What is unfortunate is that by doing so they may be cutting themselves off from potential resources and sources of help. It is important that mental health professionals be aware of signs of domestic violence and includes questions about the possibility of domestic violence in their screenings. It is important to ask these questions outside the presence of the potentially abusive partner.

**Mandatory and Dual Arrest Policies**

In understanding domestic violence and the law it is important to understand the legal context of domestic violence. The U.S. Department of Justice defines domestic abuse or violence as, "a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner."
Since the 1970s, many states have implemented so called “warrantless arrest policies” in an effort to deter domestic violence. While these laws have been helpful in increasing rates of arrest, prosecution, and conviction of perpetrators of domestic violence (National Research Council, 2004), they have led to some problems. State laws vary State laws with regard to circumstances under which warrantless arrests can be made. For example, some stipulate that arrests can be made in cases of felonies, within a certain number of hours of the incident, and/or if the persons involved are married, blood-related, living together or have a child together. A listing of these policies can be found in the appendix of this training material.

**Mandatory arrest policies** mean the police officers are required by law to make arrests based on probable cause that domestic violence was committed. Some states that have mandatory arrest provisions include: Alaska, Arizona, Colorado, Connecticut, Iowa, Kansas, Louisiana, and the District of Columbia. **Preferred arrest policies** are less strict; they encourage but do not mandate arrest as the favored action when probable cause exists. States with preferred arrest provisions include: Arkansas, California, Massachusetts, Montana, North Dakota and Tennessee. **Discretionary arrest Policies** allow greatest leniency when confronted with domestic violence. The statutes stipulate that the officer "may" arrest under certain circumstances where probable cause is evident. Those states with discretionary arrest provisions include: Michigan, Minnesota, Nebraska, New Hampshire, New Mexico, North Carolina, Oklahoma, Pennsylvania, Texas, Vermont, West Virginia and Wyoming.

With these policies, an important (but subjective) determination is the idea of “primary aggressor.” Responding officers often have to sort out varying stories of what occurred. In situations where there is a lack of clarity, officers make a dual arrest. In this instance, both victim and perpetrator are arrested, and the court makes the determination. These policies have come under fire by domestic violence advocates, such as Eleanor Pence, developer of the Duluth Model of intervention. She states that contemporary domestic violence intervention, far too often, is “one-size-fits-all,” and can allow some chronic violent abusers to avoid proper punitive sanctions for their long-term violent behavior.

Buel and Hirst (2009) believe that healthcare professionals can be instrumental in helping victims to advocate for themselves when threatened with dual arrest. They can serve as “translators” to help victims of domestic violence to voice what occurred. While this role is an important one, the overall feeling is that dual arrest policies can be detrimental to victims of intimate partner abuse.

**Advocacy**

As Buel and Hirst’s (2009) comments suggest, one role that mental health professionals can play in working with domestic violence is advocacy. Victims of intimate partner violence generally feel disempowered and overwhelmed by the many...
systems and legalities associated with trauma. They may be struggling to create physical and emotional safety.

What is empowerment? Wilson and Martin (2006) define the word “empower” as “increasing the control people have over their lives.” They include components of feeling powerful, competent and worthy of self-esteem. These authors also state that there needs to be a modification of the structural conditions in order to reallocate power.

The Advocacy Wheel for domestic violence (The Missouri Coalition Against Domestic Violence, n.d.) follows. Based on the Duluth Wheels, this graphic provides a schema that describes the role of the clinician-advocate. The central goal of the wheel is to help promote empowerment for victims of domestic violence.

While clinicians will have differing roles with regard to advocacy, this wheel is broad enough to cover many of these. A synopsis and explanation of each follows:

Confidentiality: As a first step, the clinician must establish confidentiality. Discussing the possibility of victimization must occur in private. A victim of domestic abuse will not typically disclose a history of violence in the presence of her perpetrator or other family members. If she discloses the violence in his presence, it is likely she will...
suffer retaliation. When there may be limits to confidentiality (discussion will follow), these must be verbalized at the outset. It is helpful to emphasize that the goal of any intervention is providing help.

One area that can be particularly tricky is balancing the role of advocating from a victim of abuse and the mandate to report child abuse.

**Case Vignettes**

*Maureen Quinto, a licensed social worker, is employed at a community mental health center. She completed an intake with Mary, a new client seeking help for depression. Mary reported to Maureen that her husband would often beat her and the children. Maureen complied with agency procedures, and reported the child abuse. She received a distraught and angry phone call from Mary, stating that her children had been removed from the house.*

*Trudi Hayes, a licensed social worker, is employed at a community mental health center. She meets with a new client, Maribeth. Prior to the intake, she discusses confidentiality, including the limits around child abuse reporting. Maribeth states that she is frightened to tell her what has been happening at home because “I don’t want to lose my kids.” Trudi explains that if a parent initiates a call to Child Protective Services, they are less likely to take the children, stressing that there are resources that can help her. She does not make any guarantees. Maribeth tearfully describes how her husband Tom beats her and the kids. Together they call Child Protective Services, who supports Maribeth in her efforts to take the children to a domestic violence shelter.*

These two cases illustrate the importance of managing confidentiality issues in a way that is sensitive and also affirms the role of the non-abusing parent as an integral role.

*Validation:* Validating that violence perpetrated against the victim is true. Victims of domestic violence may be fearful that they will not be believed if they report abuse. In many households where there is domestic violence, and abusive partner can look very “normal” or be considered by others to be an “upstanding citizen.”

*Acknowledge the Injustice:* Victims of domestic violence often feel that abuse is their fault. Be aware of blaming statements and respond appropriately. There is often a great deal of self-doubt and blame.

*Autonomy:* Empowering advocacy is based on the core belief that victims of domestic violence have the right to control their own lives. In the process of victimization, control has been taken away from them. Clinicians should provide victims with autonomy by guiding, but allowing victims to make their own decisions.
Safety Planning: What are the victim's options? Safety is critical. According to the American Psychological Task Force on Violence and the Family (1996) (as summarized by Wilson & Martin, 2006) the following strategies will help ensure safety:

- Calling the police
- Calling a shelter
- Leaving the home or scene
- Superficially complying with the abuser’s demands
- Talking to friends
- Hiding
- Avoiding the abuser
- Seeking professional help
- Avoiding conflict and keeping the peace

It is also important to remember that the victim is often the ultimate expert on how an abuser will respond. For example, leaving the house may not be an option because it will further incense the abuser. According to Wilson and Martin (2006), two important questions to ask are: “What are some of the cues or behaviors that are present before a violent incident occurs?” and “What have you done in the past to successfully protect yourself and your children.”

Clinicians can also use the sample safety plan (contained in the appendix), a detailed roadmap for victims. It is important to discuss safety procedures, and review them frequently.

Promote Access To Community Services: Know the resources in your community. If you are able to do so, provide victims with a written list that they can refer to.

Navigating the Systems

A key component in working with domestic victims is in helping them to navigate the various systems they encounter. In addition to the mental health system, some of these systems include: legal, medical, social service, and child protective. When making a referral to any of these systems it is helpful to provide victims with a sense of what they can expect.

Offices for the Prevention of Domestic Violence

These systems support local and state domestic violence efforts. While many of their efforts have to do with grants and funding, they can be a resource for learning about availability of domestic violence training and a clearinghouse of other services.

The California Partnership to End Domestic Violence may be reached between
the hours of 9:00 am – 5:00 pm at 800-524-4765. They can provide clinicians and clients with hotline numbers for local domestic violence programs. These programs include shelters in various counties, contacts at the Family Law Violence Center, Culturally sensitive assistance (e.g., Narika, a program for South Asian women and Shalom Bayit, a program for Jewish women), as well as services for women and families in rural areas.

**Victim/Witness Services**

California Victim Witness Assistance Centers and trained Victim Witness Advocates are available throughout the state to assist victims of crimes. Victim/Witness Assistance Centers are available in each of California’s 58 counties, plus the City of Los Angeles. For further information, please see [http://calvictimassistance.com/victim-assistance-centers/](http://calvictimassistance.com/victim-assistance-centers/)

**Offices of Victim Services**

Offices of Victims Services can be invaluable in supporting victims. Victims Services compensates victims of crime for unreimbursed out-of-pocket expenses, which can include expenses for mental health counseling (including counseling for children and relatives). These systems provide funding to victims of spousal abuse, sexual assault and child abuse. In some states these program includes other victims of violent crime.

In addition to victim compensation, most offices of victim services provide advocates help victims of violent crime by notifying them of their rights and by providing information and assistance. These advocates:

- Provide information to the victim about the criminal case and criminal justice system
- Act as a liaison between victims and court personnel
- Escort victims and their family members to court proceedings
- Advocate for victims during court proceedings
- Provide victims with social service referrals
- Assist victims and their family members in preparing and delivering a victim impact statement

**Batterers Intervention Programs**

Since 1994, California law has required defendants who are convicted and granted probation in domestic violence cases to complete a certified batterer intervention program (BIP). In addition, recognizing the severity of the problem of intimate-partner violence and the unique challenges these cases present, many superior courts in California have adopted specialized procedures for handling domestic violence cases such as using dedicated calendars and holding periodic review hearings with offenders.
Criminal And Civil Courts

This system is the legal arm of domestic violence. Many states have dedicated domestic violence courts that act on criminal complaints pertaining to domestic violence. This ensures consistent responses to domestic violence. Domestic violence is no longer treated as a simple battery. Consequently, our system imposes enhanced and specialized sentences for these offenses.

One important function of civil courts involves the issuance of protective orders. An order of protection (also called a restraining order) is an official document that outlines provisions that limit contact between an abusive partner and the victim. There are generally two types of protective orders: protection from abuse (PFA) and protection from harassment (PFH).

In California, victims of domestic violence must complete the Request for Domestic Violence Restraining Order (DV-100) and the California Law Enforcement Telecommunications System (CLETS) Information Form. The DV-100 asks for information on the abuser, relationship between victim and abuser and previous court cases. California restraining laws are among the most comprehensive in the nation. Victims can request:

- Personal Conduct Orders – prevents abusers from being harassed attacked, threatened, or assaulted and /or prohibits any type of contact
- Stay-Away Order – prohibits abusers from coming within a certain radius of the victim
- Move-Out Order – requesting that the court require the abuser to move to another residence
- Guns or Other Firearms and Ammunition – may be taken away if owned by the abuser
- Record Unlawful Communications - allowing the victim to record communications made by the abuser in violation of legal orders
- Animals: Possession and Stay-Away Order
- Child Custody, Visitation and Support provisions
- Debt payment – ordering the abuser to continue paying accrued debt
- Property Restraint – ordering that the abuser not borrow against, sell, hide, or get rid of or destroy any possessions or property

While it is not mandatory that the victim bring any “proof” with her to court, it is generally helpful. Proof of abuse or harassment may include:

- Photographs of injuries (and if possible the person who took the photographs)
- Threatening notes, email, phone messages.
- A witness who saw or overheard the abuse, even though in some courts only the parties are allowed to testify.
A victim advocate may be helpful to provide additional support.

Once a protection order has been issued, its effectiveness in ensuring the continuing safety of the protected person depends in large measure on the enforcement of that order. Enforcement must occur smoothly and routinely in order to work as a deterrent to continued domestic violence. States and municipalities establish rules around the enforcement of protective orders. The Federal Violence Against Women Act (VAWA) makes protection orders enforceable against state lines. If a victim believes that an order of protection has been violated, he or she should call police immediately. In many states, violators of protective orders are immediately arrested and jailed.

Family Courts

Intimate partner violence is a common issue in custody, visitation, and divorce cases. Family courts often assess the impact of family violence with regard to these types of court cases. Since custody and visitation cases often involve mental health issues, expert testimony from mental health providers may be required.

Departments of Health

These systems include direct medical services. Rape crisis centers are also housed within departments of health. These systems generally also provide direct crisis counseling.

Adult Protective Services (APS)

Each county has an APS agency to help elder adults (65 years and older) and dependent adults (18-64 who are disabled), when these adults are unable to meet their own needs, or are victims of abuse, neglect or exploitation.

Child Protective Services (CPS)

While most clinicians know the term “child protective services”, it is often not until a client is involved in this system that CPS functions are truly understood. Many women who have been abused by an intimate partner are also involved with CPS, and by extension, treating clinicians will be involved as well. In defining CPS, the Family Violence Prevention Fund states: “The child protection system is a bureaucratic government institution responsible for ensuring that various laws, regulations and policies regarding the protection of children are enforced.”

While state laws vary with regard to what is reportable to CPS, in many states clinicians are mandated to report to CPS any reasonable suspicion of child abuse or neglect.

Most women fear the possibility of a report being filed with CPS. While there are cases in which children are removed from an abusive household, more often efforts are made
to keep children with a non-abusing parent. This may mean that a parent is referred to a shelter or short-term housing. CPS often also runs support groups and can refer women to additional resources. The following types of services are available:

*Family support services* are community-based services that assist and support parents in their role as caregivers. Family support services promote parental competence and healthy child development by helping parents enhance their strengths and resolve problems that can lead to child maltreatment, developmental delays, and family disruption.

*Family preservation services* are short-term, family-focused, and community-based services designed to help families cope with significant stresses or problems that interfere with their ability to nurture their children. The goal of family preservation services is to maintain children with their families or to reunify them, whenever it can be done safely.

**Ethical Considerations: Confidentiality**

**Case Vignette**

*Diane Markin is working with Patricia, a registered nurse, who has recently separated from her husband Gerald. Patricia has two daughters, ages 8 and 10. Gerald sees his daughters on weekends. Gerald has been abusive to Patricia in the past, but she denies any current incidents. Patricia has worked hard to increase her autonomy, and has stated that she will not condone any type of abuse to herself or her daughters. Following the separation, Patricia purchased a handgun and has taken shooting lessons. Patricia phones Diane for an emergency session. She tells Diane that her older daughter came home from a weekend visit with bruises, stating that her father had hit her because of her “foul mouth.” Patricia is incensed, stating that she plans to “kill that son of a bitch.”*

*What are Diane’s obligations here? Should she report Gerald to child protective services? Does she have a duty to warn Gerald about the threat to his safety?*

Mental health professionals are confronted with a wide range of ethical and legal issues concerning in their treatment of victims of domestic violence. As the case above illustrates, many ethical issues arise as a result of balancing the roles of therapist, advocate, and mandated reporter. Mental health functions frequently intersect with other disciplines, which can lead to conflicts in maintaining confidentiality. For example, a common issue that arises in treatment of domestic violence victims is the need to interact with the various systems discussed in this material, such as the criminal justice system, child protective services, etc. The case vignette provided an example of potential disclosure of confidential therapy discussions to child protective services. Questions may arise regarding whether clinicians can maintain the confidentiality of patient information or whether they must comply with police or court requests for access.
to health records or reports. Another common issue is whether mental health professionals should breach confidentiality in relation to patients they consider at risk of harming themselves or others. This section will discuss several of these issues. It is important, however, to be aware of the specific guidelines of the state in which you practice.

To begin, let’s look at the obligation to maintain confidentiality, a standard shared by all professional codes. An example of this guideline is contained in National Association of Social Workers (NASW) standard 1.07, which states: “Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.”

That does not mean, however, that social workers, psychologists, and counselors cannot share confidential information. When an appropriate authorization is in place, and clients consent to sharing information, this is allowable. Examples that may apply to domestic violence cases are: interacting on the patient’s behalf to obtain housing, sharing information with courts to support an order of protection, or coordinating with a child’s school teacher or counselor.

Compelling Reasons to Break Confidentiality

In addition, professional codes of ethics allow disclosure of confidential information when there are “compelling professional reasons.” These reasons include “serious, foreseeable, and imminent harm to a client or other identifiable person.” This is a broad dictate, and can include (but is certainly not limited to) harm to a minor child, harm to an elder, harm to oneself, or harm to others. Should a clinician be required to break confidentiality, he or she should disclose “the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed” and when possible, inform clients of the disclosure in advance.

While the confidentiality standards discussed in the previous paragraph are ethical mandates, a closely related legal function is the clinician’s role as a mandated reporter. Simply put, being a mandated reporter means that an individual is required to report suspected cases of abuse. All states have passed some form of mandatory child abuse and neglect reporting law in order to qualify for funding under the Child Abuse Prevention and Treatment Act (CAPTA). In addition to child abuse reporting laws, many states also have laws pertaining to mandatory reporting of elder abuse (for more about older adults and domestic violence please see “Issues in Domestic Violence: Special Populations.”) The laws apply to mental health providers working both in private practice and institutional settings.

One common question is how certain about clinicians need to be in order to make a report of abuse. Although this is something that each clinician needs to decide
for his or herself, Pass (2007) observes that if a clinician witnesses only behavioral symptoms of child abuse (e.g., sudden changes in behavior or school performance, hypervigilance, concentration problems) it is best for the clinician to document their observations and continue to assess the situation. When a professional observes physical symptoms (e.g., bruises or other marks) it is best to consult with a colleague and also to speak with a parent or guardian. When a clinician notices a combination of physical and behavioral symptoms, however, an immediate report is indicated. On a therapeutic level it is important to consider the potential consequences of reporting, and thoroughly assess the situation. There is no timeframe; a 2-3 week assessment is ok if the child is not in immediate danger.

In addition to issues regarding suspected child abuse, clinicians are ethically bound to disclose information in situations in which they believe a client will harm themselves or another identifiable person. With the link between domestic violence and suicidal thoughts/ attempts (see Devries et al., 2011) it is important to keep in mind that a clinician may need to seek help for a client, even if it means breaking confidentiality. Additionally they may be compelled to seek help for an intended victim, even if that victim is an abusive partner. The treating professional's duty to warn is discussed in a subsequent section.

Confidentiality and Privilege

Case Vignette

Carla Varnis, a clinical social worker, is working with Pamela. Pamela has been a victim of domestic abuse. Carla receives subpoena for medical records from Pamela’s husband’s attorney. Pamela’s husband has filed for custody, stating that Pamela is “crazy” and “unfit to be a parent.” Carla recognizes that her therapy notes likely do have some information about Pamela’s past mental health history that could be prejudicial. What should she do?

As this case illustrates, the intersection of the court system and mental health system can prove to be challenging. In some cases, such as when a clinician is providing information that a client has requested that a court representative receive, it is simple. For example, if a client requests that her own lawyer receive a summary of therapy sessions, such information can be provided by having the client sign a release form authorizing this disclosure. This is covered by NASW ethical standard 1.07b “Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client” and by similar standards with the other professions. It is still important, however, to explain to the client the potential consequences of the disclosure prior to releasing the records to a third party. NASW ethical standard 1.07d states “Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made.” The standard goes on to clarify that clinicians should still educate the client about the potential effects of disclosures “on the basis of a legal requirement or client consent.”
A question that frequently arises is the distinction between confidentiality, an ethical and legal requirement, and privilege, a legal term. Psychotherapists have an ethical and legal requirement to maintain the confidentiality of disclosures made by clients during the course of treatment.

In the case of the vignette presented at the outset of this section, in which an attorney subpoenas treatment records a clear conflict exists for the clinician. The therapist in the vignette, Carla, has several duties to Gloria, one of which is to maintain the confidentiality of their communications. In order to do so, Carla must assert psychotherapist-patient privilege. By asserting privilege, Carla is communicating to the court that she recognizes her duty to respond to the subpoena asking her to provide information to the Court (which is a legal obligation), but that she has a competing duty to the patient to keep her therapy disclosures confidential. Further by invoking privilege Carla is asserting the belief that her duty to maintain patient confidentiality outweighs the duty to provide information that could be used as evidence. Asserting privilege acts as a request to the court to be exempted from the duty to provide this confidential information (Clinical Lawyer, n.d.)."

While the opposing lawyer can continue to fight to see Gloria’s records, most courts err on the side of privilege. It is helpful to speak to legal experts from the state licensing board that governs your profession.

*Treating Professional’s Duty to Warn*

Another ethical issue is the treating professional’s duty to warn. Let’s return now to the case vignette that introduced this section:

*Diane Markin is working with Patricia, a registered nurse, who has recently separated from her husband Gerald. Patricia has two daughters, ages 8 and 10. Gerald sees his daughters on weekends. Gerald has been abusive to Patricia in the past, but she denies any current incidents. Patricia has worked hard to increase her autonomy, and has stated that she will not condone any type of abuse to herself or her daughters. Following the separation, Patricia purchased a handgun and has taken shooting lessons. Patricia phones Diane for an emergency session. She tells Diane that her older daughter came home from a weekend visit with bruises, stating that her father had hit her because of her “foul mouth.” Patricia is incensed, stating that she plans to “kill that son of a bitch.”*

*What are Diane’s obligations here? Should she report Gerald to child protective services? Does she have a duty to warn Gerald about the threat to his safety?*

There are clearly a number of issues involved in this case, including therapeutic, ethical and legal concerns. Let’s take each of these duties separately. From a therapeutic standpoint, Diane has a duty to provide a safe environment in which Patricia can work through her feelings about her relationship with Gerald. Such safety is
especially critical to allow victims of domestic violence to heal from their traumas and to move forward with their lives. According to the Advocacy Wheel depicted earlier it is critical to respect confidentiality, promote safety and validate the victim’s experiences. Given these important concerns, it is important that any decision that would involve breaking confidentiality be fully considered.

Ethically, Diane could, if she feels it is indicated, make a disclosure based on the limited details of the case. While Diane could disclose information for the reason of protecting Gerald, it would clearly come into conflict with his ability to act in a therapeutic manner.

As discussed in the previous section of this document Tarasoff v. Regents of the University of California (1976) is the case that established the duty to warn in California and iterations of the “duty to warn/duty to protect” laws have been passed in most states across the country. The idea behind these laws is that by accepting responsibility for the care of a client in need of mental health treatment, the clinicians may owe a duty to protect third parties from harm threatened by the client. The Tarasoff ruling states: “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” (Tarasoff, 1976, p. 340). In California, Diane has a mandatory duty to warn.

There is no “one-size fits-all approach.”. According to the NASW publication Social Workers and State Duty to Warn Laws, some of the key issues to review in a case involving a possible duty to warn are:

- Whether the client is the individual who represents a threat to self or others
- Who has disclosed the threat and under what circumstances
- How much time has passed since the threat was made
- Whether the client possesses the means and capacity to carry out the threat
- Whether the duty to warn has been established as a mandatory requirement in state law
- Whether the threat of harm is to a specific individual or represents a general threat to the public at large
- Whether the criteria for involuntary commitment may apply
- Whether the state permits disclosure of a threat even if it is not mandatory
- Who needs to be warned to effectively discharge the duty to warn (e.g. Law enforcement, the intended target, the department of motor vehicles, a treating physician, a responsible family member).

Sample conversation with Patricia

After allowing Patricia time to talk about feelings:

Dr. Markin: I am concerned about some things that you said earlier. You said that you wanted to “kill that son of a bitch.” Do you still feel that way?
Patricia: I don’t want to see my daughter being abused the same way I was.

Dr. Markin: That’s understandable. But meeting violence with violence is not the answer. If you went to prison, your daughters would have no one to care for them.

Patricia: I know that. I just feel so powerless.

Dr. Markin: I think that one thing that may help is to make a call together to Child Protective Services. They will help us to make sure that both you and the girls stay safe.

Patricia: I know you’re right. I’m angry, that’s all. Let’s make the phone call.

In this situation, Diane used clinical judgment to diffuse a potentially dangerous situation. Had Patricia been less cooperative and he felt that a credible threat still existed, enlisting the support of the authorities may have been necessary.

Summary

This training material discussed many of the legal and ethical issues related to supporting victims of domestic abuse. While clinicians cannot be “experts” on all facets of domestic violence competent care is grounded in the ethics and standards of the profession. Mental Health professionals need to be aware of ethical and legal standards and they also need to develop and maintain the professional skills necessary to work with victims and families affected by domestic violence.
Chapter 2 Appendix

Domestic Violence Safety Plan

Victims of domestic violence need to plan in advance for safety. The following considerations are important ones, and can be discussed in a therapy session.

Things to think about and have ready:

1. Important phone numbers. These may include hotlines, clergy, school contacts, friends and the local domestic violence resources and shelters.
2. Friends or neighbors that could seek help on your behalf. Ask them to call the police if they hear angry or violent noises. If you have children, teach them how to dial 911. Make up a code word that you can use when you need help.
3. Safe exit from home. Practice ways to get out quickly if need be.
4. Safer places within home. Think about places where victims can go to be away from the abuser.
5. Remove all weapons from the house if possible.
6. Even if clients are not open to the idea of leaving, it is still important to, have them consider where they could go. An “exit strategy” is also helpful. This strategy may involve a way to leave the house, such as walking the dog or going to the store. It is also helpful to have a bag of everyday items packed, but well hidden.
7. Encourage clients to go over their safety plan often.

Other considerations:

1. Have clients think of three or four places they could go if they leave home.
2. Have clients think about people who might help if they left. These may include people who could keep a bag for them, who could loan them money, or who could help with children. It is also important to make plans for pets.
3. Clients may consider getting a prepaid cell phone to pack in a bag.
4. Clients may consider opening a bank account or getting a credit card in their name only.
5. Clients should consider issues regarding children. There may be times when it is safer to leave without children.

Things to take

☐ Order of protection
☐ Money
☐ Keys to car, house, work
☐ Extra clothes
☐ Medicine
☐ Important papers
☐ Birth certificates
☐ Social security cards
☐ School and medical records
☐ Bankbooks, credit cards
☐ Driver's license
☐ Car registration
☐ Welfare identification
The Health Insurance Portability and Accountability Act (HIPAA)  
Chapter 3

Introduction

Case Study 1

Barbara is a 55-year-old woman with chronic depression who has been seeing Dr. Hart in weekly therapy for the past year. Dr. Hart has seen some improvement in Barbara’s symptoms, but as much of her depression is related to childhood issues and has been longstanding, Dr. Hart has continued to see Barbara weekly. Barbara’s husband has recently changed jobs, and Dr. Hart is now billing her new healthcare plan. Dr. Hart receives an explanation of benefits denying coverage for Barbara’s treatment and with the explanation code “preexisting condition.” Distraught and unable to pay for services without insurance, Barbara leaves treatment.

Prior to 1996, scenarios such as the one detailed above were all too common. Insurance companies often denied consumers coverage for needed treatment if a mental health or medical condition preceded the coverage date for the insurance plan, or insurance carriers imposed lengthy waiting periods on coverage. The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996 and focused on protecting employees and their families from insurance practices such as these. The initial version of HIPAA focused primarily on health care coverage, specifically ensuring that employees are not in danger of not having coverage if they lose or change their jobs.

In 2003, the Federal government expanded the scope of HIPAA to include Privacy and Security standards. Although maintaining client privacy and confidentiality has always been a hallmark of mental health treatment, HIPAA has resulted in practitioners being held accountable for privacy practices under Federal law. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and addresses the security and privacy of health data. This will mean changes to existing procedures for many mental health providers.

These training materials will focus on HIPAA and the implications for mental health practitioners. Additional resources are provided in at the end of the training material. Ethical standards of the professions mandate that clinicians remain aware of state and federal regulatory standards. The Marriage and Family Therapist Ethical Code, for example, states: “Marriage and family therapists maintain adequate knowledge of and adhere to applicable laws, ethics, and professional standards.” This training material will
provide an overview of HIPAA. Resources for further study are also contained in the references section of this document.

Educational Objectives

- Discuss established ethical and legal requirements contained in the Define HIPAA and list its components
- Discuss portability of health plans
- Define Protected Health Information (PHI)
- Discuss incidental uses of health information and reasonable safeguards
- Discuss changes to the informed consent procedure, including the Notice of Privacy Practices
- Distinguish between psychotherapy notes and the clinical record
- Describe patient access to information
- Discuss HIPAA implications for forensic services
- Describe the HIPAA Security Rule

Components of HIPAA

Although many mental health providers have heard the term “HIPAA” they are uncertain what HIPAA actually entails or whether HIPAA rules apply to them. HIPAA is the acronym for the Health Insurance Portability and Accountability Act. HIPAA has several components:

- Portability standards that ensure the continuity of healthcare
- Privacy standards that govern the disclosure of protected health information
- Security standards that protect the development and maintenance of health information

Health Care Portability

As initially enacted in 1996, HIPAA was devised to ensure portability of employee health coverage. HIPAA:

1. Limits the ability of a new employer plan to exclude coverage for preexisting conditions
2. Provides individuals with the opportunity to enroll in a group health plan if they lose other coverage or experience certain life events
3. Prohibits discrimination against employees and their dependent family members based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information
One of the most important protections under HIPAA is that it helps those with preexisting conditions get health coverage. Previously some group health plans limited or denied coverage if a new employee had such a condition before enrolling in the plan. Under HIPAA such denials are not allowed. If a plan generally provides coverage but denies benefits to an individual because they had a condition before coverage began, this is a HIPAA violation.

Under HIPAA, a plan is allowed to look back only 6 months for a condition that was present before the start of coverage in a group health plan. The law says that a preexisting condition exclusion can be imposed on a condition only if medical advice, diagnosis, care, or treatment was recommended or received during the 6 months prior to that individual’s enrollment date in the plan. Take, for example, if a person that was diagnosed in the past with anxiety but did not receive treatment for the anxiety in the 6 months before they enrolled in the plan. Because there had been no treatment, the anxiety cannot be subject to a preexisting condition exclusion.

HIPAA limits the preexisting condition exclusion period for most people to 12 months, although some plans may have a shorter time period or none at all. In addition, many plans allow people who have had prior health coverage to reduce the exclusion period even further. This is called a “creditable coverage” provision. Despite the fancy moniker, this simply means that a person was enrolled in another health plan prior to becoming enrolled in the new plan. Most health coverage can be used to establish creditable coverage, including participation in a group health plan, COBRA continuation coverage, Medicare and Medicaid, as well as coverage through an individual health insurance policy. It is advisable that individuals try to avoid a significant break in coverage (63 days) if they want to be able to count their previous coverage. Most of the time employers will provide an individual with a certificate of creditable coverage after termination of employment or individuals can request this should the new plan deny coverage based on a preexisting condition clause.

Case Study 1 (continued)

Dr. Hart, concerned by Barbara’s abrupt termination of treatment further researches HIPAA guidelines. He asks Barbara’s husband to request a certificate of coverage from his previous employer, and Barbara’s husband submits this to the new health care plan. This allows Barbara’s previous claims to be covered and she resumes treatment.

Protected Health Information

Prior to looking at the HIPAA privacy and security standards it is important to define the term protected health information (PHI). Protected health information is any information about health status, provision of health care, or payment for health care that can be connected to a person. This broadly includes any part of a client’s medical record or payment history. HIPAA standards apply only to PHI.
According to the 1996 HIPAA guidelines, protected health information includes:

- Any information about a person’s past, present or future mental health status
- Names
- All client address information other than their state of residence
- Dates (except year) related to an individual, including birth date, admission date, discharge date
- Client phone or fax numbers
- E-mail address
- Social Security numbers
- Client photographs

HIPAA Privacy Standards

A key component of HIPAA is the Privacy Rule. The HIPAA Privacy Rule creates national standards to protect individuals’ medical records and other personal health information.

1. It sets boundaries on the use and release of health records.

2. It enables clients to find out how information may be used, and about certain disclosures of their information that have been made.

3. It gives patients the right to examine and obtain a copy of their health records and to request corrections if data is incorrect.

4. It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.

5. It enforces civil and criminal penalties if there is a violation of clients’ privacy rights

Although this may sound daunting, it actually the requirements for most mental health providers are fairly straightforward. The Privacy Rule requires activities, such as:

a. Notifying clients about their privacy rights and how their information can be used. Providers are required to notify clients about Privacy Practices during their first session (notice of privacy practices)

b. Adopting and implementing privacy procedures

c. Training any employees that work for them (such as billing specialists and administrative personnel) so that they understand the privacy procedures.

d. Designating an individual to be responsible for seeing that the privacy procedures
are followed

e. Securing client records containing individually identifiable health information so that they are not readily available to those who do not need them

Who is a “Covered Entity”?

If you are an individual mental health provider or work for a hospital, health plan or health care clearinghouse that transmits information electronically you are affected by HIPAA. HIPAA provisions call these individuals or institutions “covered entities.”

The term “covered entity,” includes any mental health provider who submit billing information to managed care companies or other third parties. Currently HIPAA does not apply to providers who bill clients directly, receive out-of-pocket payments, or ask clients to submit reimbursement requests to third parties on their own. Please note that if there is even a single electronic transmission to an insurance carrier or other third party, the HIPAA requirement states that you must immediately become compliant with all guidelines. Those providers who do bill insurance companies may have noted that there has been a trend away from paper submission of billing information. It is important, then, that all mental health professionals be familiar with HIPAA and, if indicated, take steps to become compliant with the guidelines.

Since the Privacy Rule became effective in 2003, many mental health professionals have integrated these regulatory requirements into their existing procedures. These regulations may change procedures related to informed consent, therapy notes, forensics, and psychological testing. Each of these areas will be considered later in this training module.

Case Study 2

Dr. Carter is a psychologist who runs a practice in which clients pay directly for psychotherapy and testing services. He routinely provides clients with receipts and many of them submit their expenses to insurance companies. Many of his clients have mentioned that they then submit requests for reimbursement online. Dr. Carter wonders whether he needs to conform with HIPAA guidelines.

At the present time, Dr. Carter is not considered a “covered entity” under HIPAA guidelines and does not need to change his already ethical practices for ensuring confidentiality and security of records. This may change in the future should the definition of who is affected by HIPAA broaden, or if Dr. Carter changes his billing practices to include any electronic transmission of information. In that case, HIPAA guidelines require immediate compliance with all privacy and security standards.

Incidental Uses of Health Information
Many practices play an important role in ensuring that clients receive effective mental health care, and the goal of HIPAA is not to hamper the providers' ability to communicate with clients, to engage in treatment planning or to coordinate care with other professionals. HIPAA policies recognize that there may be instances in which protected health information may be disclosed inadvertently. This is called “incidental disclosure” of protected health information. Many health care providers, for example, have been in a position in which someone other than the client has overheard portions of a provider's conversation with a client. There may also be the need to share some aspect of a client’s information with someone not directly involved in the patient’s clinical care, such as the fact that a person doing the provider’s billing will need access to a diagnostic code. The Privacy Rule permits these incidental disclosures of health information when the provider takes reasonable safeguards to protect an individual's privacy. Examples of reasonable safeguards include:

- Speaking quietly when discussing a client’s condition with family members in a public area;
- Avoiding using clients’ names in public hallways and elevators
- Using passwords on computer files containing personal information.

**Case Study 3**

Jane is the director of a Partial Hospital Program. The program is based in a hospital that submits information electronically, thus falling under HIPAA provisions. In the PHP, clients are assigned to various therapy groups, including drug and alcohol-specific programming. Jane places a whiteboard with clients’ names at the front of the main therapy room, and color-codes the groups a client is to participate in. Is this a HIPAA violation? If so, how can Jane change this procedure?

This example is a good one to look at the ambiguities that may be evident in applying HIPAA guidelines. Although the whiteboard displaying information may be considered an “incidental disclosure,” the key question to answer here is whether the PHP has taken adequate precautions to safeguard the client’s confidentiality. In this situation, other clients are privy to who is struggling with addiction issues. In this situation, minimal changes in procedure, such as handing each client a sheet specifying the groups that they should attend, could serve as a safeguard.

The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information.

It is also important to note that HIPAA does not restrict providers from communicating with one another. For example, a psychologist or social worker can discuss information with a client’s psychiatrist or with other members of a client’s treatment team. In fact, disclosures for treatment are explicitly exempted from the minimum necessary requirements. Uses of protected health information for treatment are not exempt from the minimum necessary standards, however. The Privacy Rule
does provide substantial discretion with respect to how providers implement the minimum necessary standards.

**Notice of Privacy Practices**

One change that has occurred as a result of HIPAA is the need for individual providers and hospitals that are covered under HIPAA to provide clients with a Notice of Privacy Practices. This document details client rights involving release of information. The Notice of Privacy Practices should be incorporated into the informed consent process, and the provider must obtain a signature showing that the Privacy Notice was received. If for any reason a client refuses to sign the Privacy Notice, a note indicating that the form was offered and that the client refused to sign is sufficient. If the client is a minor, the parent is required to sign the notice of Privacy Practices.

An issue that complicates providing a Notice of Privacy Practices as well as other HIPAA policies involves the interaction between state law and HIPAA. In general, HIPAA preempts state law that is “contrary” to the federal rule. A provision of state law is contrary to HIPAA if:

- the provider would find it impossible to comply with both the state and federal law provisions
- the provision of state law would be an obstacle to the accomplishment and execution of the goals of HIPAA

Many providers, then, ask the question “Can I comply with both state law and HIPAA?” The answer is generally that they can. It is helpful to look at which presents a stronger standard: state law or HIPAA. For example, if state law gives a provider 10 days to respond to a patient’s request for a copy of his medical records, and HIPAA allows 30 days, you can comply with both state and federal law by responding within 10 days.

As evident from the above discussion, the content of the Privacy Practices notice will vary. In general, this document details routine uses and disclosures of protected health information as well as an individual’s rights and the provider or hospital’s duties with respect to protected health information. The discussion below will describe some issues common to mental health care. It is not intended to provide an exhaustive list of what can be included but some general guidelines.

- **Treatment Issues:** Many mental health providers disclose PHI to provide, coordinate, or manage health care and any related services. This includes the coordination or management of PHI with a third party. For example, PHI may be provided to a health provider to whom a client has been referred to ensure that the provider has the necessary PHI to diagnose or treat them. Clients must be made aware that such disclosures will occur.
- Payment: PHI is often used to obtain payment for mental health services. This may include speaking to representatives of health insurance plans before it approves or pays for the health care services. Depending on the client’s level of care, more or less PHI may be provided for coverage decisions. Routine requests by insurance companies include information about diagnosis, dates of service, and type of service provided (e.g., individual or family therapy.)

- Exceptions to Confidentiality: This is both an ethical and HIPAA mandate. The Notice of Privacy Practices should include information about instances when providers may need to disclose protected health information and do not specifically need to inform clients about these. These vary by state law but may include disclosing PHI when there is a threat to self or others or when the professional is ordered to do so by law.

- Sensitive Health Information: This mandate involves how details about psychological information is disseminated, such as removing patient identifiers when able to do so, as well as treatment of particularly sensitive information such as HIV/AIDS information, disability status, alcohol and drug information. The Notice of Privacy Practices must detail steps that are taken to protect this information.

- Right of Access: The Notice of Privacy Practices should also describe how patient access to medical records. The following section on psychotherapy notes will provide additional information on what is considered a medical record. It is important to know state laws with regard to access (these can sometimes be more inclusive than HIPAA guidelines). Providers should include a statement indicating “ownership” of medical records. Clients should be informed of their right to access their medical record and to amend or correct errors in medical records.

The primary criticism of the Privacy Practices is the sheer amount of information that is covered in these documents. Many clients do not read these documents and a verbal explanation of confidentiality continues to be helpful. There are many excellent examples of Privacy Practices Notices available online and through the APA Practice Organization.

**Patient Access to Records**

The HIPAA Privacy Rules allow clients to view their medical records. Previously access was dependent on state laws, however, HIPAA sets Federal standards for such access. HIPAA allows clients to view copies of records only and does not require that practitioners provide clients with the original chart. It does not require that a practitioner be given written notice of the request for medical records, but providers can establish
such standards if the client is apprised of this in the Notice of Privacy Practices.

The Privacy Rules recognize that there are situations in which access to records would be contraindicated. An individual’s request to access PHI can be denied for the following reasons:

- If access is reasonably likely to endanger the life or physical safety of the individual or another person

- The PHI refers to another person (except for a health care provider) and access is reasonably likely to cause substantial harm to that person; or

- If PHI is created during research, the access to PHI may be temporarily suspended if the individual is notified in advance

- If the PHI was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would reveal the source of the information

As will be described in the following section, the Privacy Rule does not require that clients have access to psychotherapy notes. Although rules about access to psychotherapy notes do vary from state to state, in general it is assumed that such notes belong to the provider, and that a provider may restrict access to them. Some states may require that a summary of such notes be provided if clients request them. It is always advisable to know the rules of the particular state in which you practice.

Under the HIPAA privacy regulation, providers are faced with deadlines for responding to requests for medical records, and the regulation establishes a procedure for reviewing denials of these requests. Providers are allowed to charge reasonable fees for copying and postage. The practitioner has 30 days to reply to the request. HIPAA does not include a record retention period. It does specify, however, that clients can request an accounting or report of who has accessed their records for six years prior to the date of the request.

The HIPAA guidelines generally apply to requests that originate from the client. Clients may designate a friend or relative to receive information related to care and treatment. Permission should be given in writing and filed with the care provider or facility. This is important in the case of elderly or impaired clients.

HIPAA provides parents with the right to access their minor child’s medical records. There are some exceptions to allowing access:

- When the minor is the one who consents to care and the consent of the parent is not required under State or other applicable law.

- When the minor obtains care at the direction of a court or a person
appointed by the court.

- When, and to the extent that, the parent agrees that the minor and the health care provider may have a confidential relationship.

HIPAA also allows clients to amend information in medical records that they consider inaccurate. Clients must detail any amendment in writing. Providers do have the right to refuse changes to the medical records, but must respond within 60 days verifying the correction or disputing the information. Clients can ask to have it noted in their chart that there is a disagreement on information.

Although this training material is primarily concerned with HIPAA mandates it is also important to consider the clinical implications of a client viewing his or her medical record. A recent review article published in the Journal of the American Medical Association found that there were no adverse consequences associated with allowing patients to review records in medical settings, however, there were more risks for psychiatric patients. In one case series, for instance, a psychotic patient’s paranoia was further entrenched when a minor piece of information, which she regarded as vital to proving her sanity was missing from the record. In a study of psychiatric inpatients, a substantial minority (32%) felt more pessimistic after reading their records. From 12% to 50% of psychiatric patients report becoming upset when they read their medical records (see Ross, MD & Chen-Tan Lin, 2003). In situations in which a practitioner is concerned about client requests to access medical records, it is important for the provider to discuss his or her concerns with the client in advance, and to limit access should the provider determine that this would cause substantial harm. More suggestions will be provided in the section on therapy notes versus the clinical record.

Case Study 4

Lena, a clinical social worker in a hospital setting received a phone call from a former patient of the hospital requesting his records. The patient had previously been treated for bipolar disorder, and made allegations during the course of the conversation that lead Lena to suspect that he was in an active manic state. Concerned about HIPAA regulations with regard to patient access, Lena discussed the case with her supervisor, and together they called to patient to inform him such access would not be possible. They followed up on this conversation with a letter.

Therapy Notes vs. The Clinical Record

A concern that is commonly expressed by mental health professionals is how HIPAA guidelines affect access to psychotherapy notes. It is important for providers to be familiar with state rules governing access to psychotherapy notes. Under HIPAA, psychotherapy notes are defined as "Notes recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a private counseling session." The Privacy Standards provide particular protection for
psychotherapy notes by enabling some types of information in mental health notes to remain confidential, notably the content and process of a therapy session, as well as the provider’s impressions about the client or session. Many providers refer to such notes as process notes.

In addition to providing protections on access to psychotherapy notes, HIPAA specifically states that insurance companies may not predicate coverage on the review of therapy notes. Thus, health plans cannot refuse to provide reimbursement if a patient does not agree to release information covered under the psychotherapy notes provision.

There is another caveat to the psychotherapy notes provision. The HIPAA definition of psychotherapy notes specifically states that such notes must be kept separate from the rest of an individual's record. If the provider keeps therapy notes in a patient's general chart, or if it's not distinguishable as separate from the rest of the record, access to the information doesn't receive specific protections. Many providers have chosen to keep a separate set of more general notes as a “clinical record.”

An important question to consider, then, is what to keep in the clinical record versus the psychotherapy notes. A good rule of thumb is that the clinical record must contain information to meet minimum documentation guidelines. The HIPAA guidelines specifically list the following as being separate from psychotherapy notes:

- modalities and frequencies of treatment furnished
- dates of treatment
- results of clinical tests
- treatment plan
- symptoms
- prognosis
- progress to date

Case Study 5

Robert is a psychologist in private practice. He is working with Mark, a gay male, who is HIV positive. Knowing that this information is sensitive, Robert chooses to keep written documentation related to the HIV diagnosis only in his psychotherapy notes on the patient, rather than in the general medical record he keeps for broader use. When Mark discovered this, he was relieved that this information could not find its way to third parties such as his employer.

Forensic Services

Although HIPAA has caused some confusion among mental health providers that provide forensic services it has not generally had a great impact on forensic services. To understand why that is, it is important to think back to the definition of protected
health information discussed previously in these training materials: any information about health status, provision of health care, or payment for health care that can be connected to a person.” Forensic services are intended to serve a legal purpose, and are not related to an individual’s treatment. Such services are generally unable to be submitted to third party health insurers for payment. In addition, although clients are able to access and amend their medical records, HIPAA specifically exempts “information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding” from client review. This information would continue to be subject to state laws concerning access to forensic information. Providers who engage in both clinical and forensic activities must comply with HIPAA in non-forensic areas of practice.

Although forensic services do not generally fall under HIPAA guidelines, it is still necessary to have clients sign an informed consent agreement.

**HIPAA Security Standards**

The final HIPAA practicality for mental health practitioners concerns the HIPAA Security Rule. This rule establishes standards to help keep client information safe and to protect information from unintended disclosure. For example, in some larger group practices with administrative personnel, computer monitors containing confidential client information may be visible to others. The HIPAA Security Rule requires mental health providers to anticipate threats to, or inappropriate uses of, confidential information.

Unlike the Privacy Rule, which applies to all protected health information the Security Rule applies only to “electronic protected health information” or E PHI. EPHI is protected health information that is transmitted or maintained in electronic form rather and does not include hand-written or orally transmitted information. Examples of EPHI include:

- Health care claims
- Health care payment and remittance advice
- Electronic requests for coordination of benefits
- Electronic treatment request forms

The Security Rule discusses administrative, physical, and technological safeguards. These include access to offices, computers and files needed to keep electronic health care information confidential and secure. Thus it looks at a practitioner or facility’s administrative procedures, the way that data on computers is secured and identified, and how information is transmitted.

The first step in the compliance process involves the provider doing a “risk analysis” of his or her practice. This analysis is a thorough assessment of the potential security risks and vulnerabilities related to EPHI. The analysis entails reviewing established security procedures, and it provides the basis for making appropriate modifications to
these procedures. Many of the changes that a provider may need to make may be simple ones, such as ensuring that rooms in which computers are placed are locked when not in use, making certain that computer files contain passwords known only to those who need to access data. The Security Rules take into account the concept of scalability.” This means that a solo practitioner will not be expected to take the same steps to comply as will a large practice or a health care facility.

**Case Study 6**

Dr. Robb, a psychologist in private practice has just become familiar with the HIPAA Security Rules. He does a risk analysis and takes steps to make changes to administrative procedures. In completing his risk analysis, Dr. Robb notes that his assistant will often take files home to work on billing and will submit payment requests on her home computer. As Dr. Robb cannot ensure the security of offsite transmissions, Dr. Robb asks his assistant to only work on client information and needs in the office.

**Summary**

HIPAA has changed the way that many mental health providers approach a client’s confidential health information. Although confidentiality has always been essential in the practice on mental health, the Federal guidelines increase accountability to ensure such privacy. It is important for practitioners to note:

6. HIPAA standards apply to protected health information: “information about health status, provision of health care, or payment for health care that can be connected to a person.” This broadly includes any part of a client’s medical record or payment history.

7. HIPAA sets boundaries on the use and release of health records.

8. HIPAA patients the right to examine and obtain a copy of their own health records and request corrections.

9. It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.

j) Providers must notify clients about their privacy rights and how their information can be used.

k) Mental health practitioners must adopt and implement privacy procedures
Considerations for the Provision of E-Therapy (Online Psychotherapy)
Chapter 4

Questions to consider:
How do you use online resources in your work with clients?
What are some of the issues that may be problematic in online psychotherapy?

One growing trend that bears mention is online psychotherapy. The same laws as those individuals seeking traditional psychotherapy protect California consumers seeking online psychotherapy and providers of online psychotherapy are bound by the same legal and ethical mandates as those providing more traditional means of therapy. The BBS recently released a Notice to California Consumers Regarding Psychotherapy on the Internet. Practitioners are also encouraged to be familiar with the content of this notice.

The following material will discuss the provision of E-Therapy, including the challenges/benefits of E-Therapy, cultural and linguistic considerations, and regulatory and ethical considerations associated with this medium.

Educational Objectives

- Define E-Therapy
- Discuss research related to its effectiveness
- Describe considerations of providing E-Therapy with ethnic and linguistic minorities
- Describe legal and ethical considerations related to the provision of E-Therapy, including practitioner protections
- List electronic safety measures that practitioners should employ

What is E-Therapy

The provision of behavioral health services delivered interactively from a distance began as early as 1959, at the Nebraska Psychiatric Institute, when a television link was used to provide consultation (Maheu, et al., 2005; Maheu, Whitten, and Allen, 2001). Since the introduction of the use of technology in this manner, other forms of service delivery using electronic media have been developed and used in health care systems throughout the United States and abroad (Brown, 1998; Darkins and Cary, 2000; Maheu, et al., 2005). The development of electronic forms of behavioral health service
delivery has also led to a multitude of terms used to describe this form of treatment. While E-health (also known as ehealth) is believed by many experts to be the preferred term for all clinical services administered via the Internet, E-therapy is among those names (in addition to e-counseling, cybercounseling, cybertherapy, and teledotherapy) commonly used among professionals to describe services administered electronically (Maheu, et al., 2005). Similarly, there are a number of definitions to further explain the components and uses of E-therapy. The definition below serves as the conceptual framework for the information provided in this document:

E-therapy is the use of electronic media and information technologies to provide services for participants in different locations. It is used by skilled and knowledgeable professionals (e.g., counselors, therapists) to address a variety of individual, familial, and social issues. E-therapy can (1) include a range of services, including screening, assessment, primary treatment, and after care; (2) provide more accessible modes of treatment than the traditional ones to those who actively use the recent development of technology (i.e., adolescents and young adults); (3) help people access treatment services who traditionally would not seek services because of barriers related to geography, shame and guilt, stigma, or other issues; and 4) be provided as a sole treatment modality, or in combination with other treatment modalities, like traditional or existing treatments.  

A variety of electronic media is used to conduct E-therapy and can be classified as either text-based or non-text-based. Text-based forms of communication include e-mail, chat rooms, text messaging, and listservs. Forms of communication that are not text-based include telephone and videoconferencing (Maheu, et al., 2005). Each form of communication has its advantages and disadvantages, which should be taken into consideration when determining the best methods for the service population, which may vary by health-related issues. These benefits and challenges are shown in Table 1. In general, services administered via E-therapy are either synchronous or asynchronous. Synchronous communication is most easily facilitated through instant messaging, chat rooms, telephone, and videoconference. Synchronous communication provides immediate feedback, since both the practitioner and client are engaged in conversation during the same time frame (Castelnuovo, Gaggiolo, Matonavani, and Riva, 2003; Elleven and Allen, 2004). However, it should be noted that the quality of the equipment used in providing synchronous E-therapy services is of utmost importance in maintaining the flow of communication (D. Albury, personal communication, Aug. 28, 2006). In particular, older equipment may result in sluggish transfer of information, while

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3 Developed, revised, and finalized by CSAT E-Therapy Expert Panel Work Group Meeting participants, Aug. 28, 2006.
faulty equipment may be disruptive. An additional consideration for the use of synchronous text-based service delivery (i.e., via text messaging and chat rooms) is that it is most useful with clients who have typing skills (G. Stofle, personal communication, Aug. 28, 2006; Suler, 2000). For this reason, a user’s skills in communication and typing should be among the client characteristics considered when making decisions about the appropriateness of specific forms of electronic therapy.

Asynchronous communication allows for correspondence without simultaneous connection (Maheu, et al., 2005). Examples include postal mail, e-mail, facsimile, and voicemail. These forms of contact generally do not allow for immediate feedback or a consistent flow of conversation. As a result, the level of support offered via asynchronous communication is believed to be lower in comparison to synchronous forms of communication (M. Osborne, personal communication, Aug. 28, 2006). However, it is also important to note that asynchronous forms of communication tend to be less expensive, as they generally do not require the same degree of technological capacity as most synchronous forms of interaction. Further, asynchronous forms of communication allow the practitioner to prepare and revise responses to clients, thereby providing more thoughtful feedback (Castelnuovo, et al., 2003; Maheu, et al., 2005; G. Stofle, personal communication, Aug. 28, 2006; Suler, 2000).

When planning E-therapy implementation, it is important to acknowledge the distinction between forms of communication, so that clients’ needs can be readily addressed. For example, practitioners serving significant numbers of persons in crisis should consider the use of synchronous forms of communication, as a delayed response might place distressed clients in danger (Yager, 2002). However, as most service providers address an array of client challenges, having the capacity to use both synchronous and asynchronous forms of communication may be most appropriate (Maheu, et al., 2005; Stofle, 2004).

When is the Use of E-Therapy Appropriate?

E-therapy has the potential to be utilized throughout the continuum of care, for a variety of conditions. In particular, online counseling may be appropriate for psychoeducational purposes, issues requiring short-term treatment, self-help interventions, and cognitive-behavioral approaches (Mallen and Vogel, 2005). Also, persons who have endured trauma and are contending with feelings of anxiety, guilt, fear and shame as a result, are good candidates for E-therapy (J. Hoffmann, personal communication, Aug. 28, 2006; G. Stofle, personal communication, Aug. 28, 2006). In addition, experts have identified specific groups of people for whom E-therapy may be suitable (e.g., International Society for Mental Health Online [ISMHO] Clinical Study Group, 2002; Mallen and Vogel, 2005; J. Shore, personal communication, Aug. 28, 2006; Stofle, 2004). For example, persons located in remote areas (e.g., rural, American Indian/Alaska Native territories) may benefit greatly from the flexibility of services delivered electronically (Brown, 1998; Gibson, Morley, and Romeo-Wolff., 2002). Other underserved populations, including ethnic and racial minorities, women with children, and people from low-income families may also experience improved
access to substance abuse treatment services (Y. Choi, personal communication, Aug. 28, 2006). Adolescents and young adults have also been identified as a population that has the potential to benefit from E-therapy (Skinner, Biscoe, Poland, and Goldberg, 2003). An added advantage of this group is their familiarity with computers and the Internet and their willingness to utilize technology in new ways (Skinner, et al., 2003; J. Wodarsky, personal communication, Aug. 28, 2006). However, according to Stofle (2001), populations inappropriate for online counseling include those with suicidality; borderline personality disorders, difficulty distinguishing reality from nonreality, or conditions that require face-to-face meetings for diagnosis (ISMHO, 2002).

**How Can Treatment Providers Use E-Therapy?**

An additional benefit of E-therapy is its versatility in terms of service delivery. E-therapy can be used to provide education, assessment and diagnosis, direct treatment, and aftercare services. In addition, providers can give and receive training and supervision using electronic forms of communication (Maheu, et al., 2005; Stofle, 2004). Each of the aforementioned uses is discussed in further detail below.

**Referrals**

Persons seeking treatment for substance abuse can obtain referrals via the Internet, e-mail, or telephone from credible resources (Maheu, et al., 2005; Stofle, 2004). A number of web-based directories, often maintained by insurance companies and service providers, give prospective clients practitioner information about available services, treatment specialties, types of insurance accepted, and location (Maheu, et al., 2005). Many of these websites are available for providers to advertise for a fee. However, fraudulent websites have been identified. Therefore, practitioners should thoroughly investigate any website before posting information and/or remitting payment (Maheu, et al., 2005). In addition, service providers must be aware that confirming the identity of a client referred electronically might be difficult. Additional considerations related to confidentiality and identity confirmation are discussed further in the “Legal and Regulatory Issues” section of this document.

**Education**

The Internet has served as a source of information and education for a number of health-related issues through scientific journal articles available online, websites (e.g., WebMD, CyberDocs, and Metanoia), and listservs (Maheu, et al., 2005; Yager, 2002). Practitioners can also use the Internet to help clients feel more comfortable with technology, inform them of the treatment process, and assuage their anxiety about undergoing therapy. In addition, service providers can develop client education programs that are accessible via the World Wide Web. These programs can provide ongoing support, information, and treatment via the Internet. For example, Federal agencies, in their efforts to support substance abuse treatment efforts in communities, have developed several websites that target specific age groups. Specifically, the National Institute on Drug Abuse (NIDA) has developed a website to educate
adolescents ages 11 through 15 years about scientific factors associated with drug abuse (see http://teens.drugabuse.gov/about.asp). Similarly, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has developed a series of interactive, Internet-based tools for college students to inform them of the dangers of alcohol use (see http://collegedrinkingprevention.gov). However, it should be noted that these programs should be immediately followed by treatment if necessary to prolong the effects of the information provided (Maheu, et al., 2005). Additionally, GetFit.SAMHSA.Gov (see http://getfit.samhsa.gov/) is an interactive website that provides information about physical health, mental health, alcohol and illicit drugs.

Assessment and Diagnosis

The Internet may also play a role in assessment and diagnosis. Several web-based screening tools are available for clients to assess their substance use. Many of these sites provide feedback and treatment resources for those who need assistance after taking an assessment (Copeland and Martin, 2004; Stofle, 2004). In addition, web-based questionnaires can be used to assess clients both before and during treatment (Maheu, et al., 2005). This practice establishes a baseline measure of the client’s condition and ongoing measurement of progress. Moreover, some studies suggest that psychological self-assessments conducted via the Internet are comparable to paper-and-pencil assessments (Vallejo, Jordán, Diáz, Comeche, and Ortega, 2007). However, as practitioners are commonly trained to incorporate observed nonverbal cues into their assessment and diagnosis, some experts (e.g., see Fenichel, 2000) argue that diagnosis is difficult without visual, olfactory, and aural cues to assist with the process. Grohol (cited in Ragusea and VandeCreek, 2003) argues that diagnosis is simply impossible online. Unfortunately, the ability to observe certain cues is not possible when administering a questionnaire via the Internet. There is some evidence to suggest that videoconferencing may alleviate some of the concern around the inability to fully view the client, but the findings are somewhat inconclusive to date (Elleven and Allen, 2004). For this reason, many experts agree that an initial in-person meeting should be held for assessment purposes and to determine the appropriateness of E-therapy for the client’s condition (Alleman, 2002; Stofle, 2004).

Direct Care

Substance abuse treatment may also be provided via E-therapy for clients deemed appropriate for service delivery in this fashion. A number of providers in private practice offer treatment, most often via e-mail or chat rooms as the method of delivery (Stofle, 2004). In addition, chemical dependency treatment programs are available online. Many of these programs, such as eGetgoing (www.egetgoing.com), provide Internet-based services, and are recognized by major bodies of accreditation (Stofle, 2004). In addition, Internet-based brief interventions for substance use have yielded promising outcomes (e.g., Copeland and Martin, 2004).

E-therapy may also be used as an adjunct to services provided face-to-face (Maheu et al., 2005). Practitioners may provide opportunities for communication through
e-mail, chat, telephone, or videoconference. It should be noted that E-therapy might not be appropriate for all clients, as it may compromise the development of independence from the service provider. However, for some clients, it may facilitate communication that would not otherwise occur (Day, quoted in Maheu, et al., 2005, p. 360).

After Care

E-therapy may also be used by practitioners to support clients after treatment has been administered. Providers can use direct online contact as part of relapse prevention, particularly when using text-based forms of communication. These interactions serve as a reference for both the provider and client. In addition, self-help groups have resources available through the Internet (Stofle, 2004).

Training and Supervision

Communication conducted via E-therapy can also be used for training and supervision purposes. Text-based sessions provide records that can be reviewed directly (Maheu, et al., 2005). In addition, providers have offered continuing education to clinical staff in remote locations through videoconferencing. This method provides a low-cost, time-effective means for obtaining training and education (Gibson, et al., 2002).

How Effective is E-Therapy?

The array of services delivered via E-therapy provides opportunities for populations that would otherwise go without much-needed care (Brown, 1998; Gibson, et al., 2002; ISMHO, 2002; Mallen and Vogel, 2005; J. Shore, personal communication, Aug. 28, 2006; Stofle, 2004). Determining the degree to which E-therapy is effective should be based on both client perceptions of the care they received and on empirical research demonstrating a reduction in symptoms.

In terms of client perceptions, an informal survey conducted by Metanoia, a nonprofit clearinghouse for mental health websites, yielded the following results:

- Ninety percent of online clients who participated in the survey felt that E-therapy helped them.
- Many participants also felt that they would not have initially sought face-to-face therapy.
- A large percentage of those who sought online therapy later used face-to-face counseling (Alleman, 2002).

These results suggest that clients believe that they have been helped by services delivered through E-therapy.
Although the potential of E-therapy to provide quality services is frequently cited, there is insufficient empirical research to determine the efficacy of online therapy (Alleman, 2002; Barnett, 2005; Copeland and Martin, 2004; Ragusea and VandeCreek, 2003). Experts (e.g., Barnett, 2005) have emphasized the need for more research to thoroughly assess the delivery of mental health services via electronic media, citing methodological difficulties in designing studies to assess different types of online counseling and capturing the effects of practices commonly used with some forms of E-therapy (e.g., the use of emoticons to convey emotions using text). Additional methodological concerns include small sample sizes, high dropout rates, and the lack of standards for comparison (e.g., Barnett, 2005; Copeland & Martin, 2004). These issues are discussed in further detail in the “Evaluation” section of this document.

While some argue that online therapy may be limited in its treatment efficacy due to the lack of nonverbal cues, some research suggests that humans find ways to express nonverbal cues in the absence of conventional “socio-emotional, nonverbal” cues. Further, some research findings suggest that levels of affect can exceed those of face-to-face situations in the absence of traditional nonverbal cues. For example, both children and adults seem to readily disclose much sooner when receiving treatment online versus in-person (Alleman, 2002).

The Efficacy of Specific Approaches

Castelnuovo and colleagues (2003) contend that the Internet can improve treatment delivery in two areas: individual therapy and self-help therapy. “Individual telepsychotherapy,” which is psychotherapy conducted remotely, might be used to access remote populations (Castelnuovo, et al., 2003). Findings from studies investigating the efficacy of individual telepsychotherapy with conditions including panic disorder, public speaking phobias, and agoraphobia have suggested that treatments administered electronically have significantly decreased most symptoms associated with those conditions (e.g., Botella, Banos, Villa, Perpiñá, and Garcia-Palacios, 2000; Bouchard, et al., 2000; Murdoch and Connor-Greene, 2000). In terms of self-help therapy, the effectiveness of online groups is generally high for the treatment of eating disorders and depression. However, it should be noted that the potential for ethical violations is also high, due to limited privacy, varied locations of participants, and the inability to confirm participants’ identities.

Although few studies exist examining the efficacy of Internet-based substance abuse interventions, there is some evidence that providing cognitive behavioral treatment (CBT) electronically may be as effective as face-to-face. For example, Hester and Delaney (1997) found that behavioral self-control training, a CBT intervention designed to help participants change their behavior around drinking, was equally as effective when delivered online (Copeland and Martin, 2004). Further, the reductions in alcohol use were maintained over a 1-year period.

Benefits and Challenges Associated with E-Therapy
Every form of treatment has benefits and challenges associated with its use, and E-therapy is no exception. As was previously mentioned, more research is needed to thoroughly assess the benefits and challenges associated with providing mental health services online. While there are many aspects of E-therapy that may be deemed either positive or negative, the following section focuses on three salient issues for each. Specifically, in terms of benefits, accessibility, cost, and continuity of care are discussed. The challenges discussed include demand for E-therapy, the "digital divide," and confidentiality.

Benefits Associated with E-Therapy

In terms of access to services, research findings have suggested that online counseling may benefit clients who are isolated in rural areas or are underserved by conventional systems (Mallen and Vogel, 2005). That is, treatment providers may have the ability to make themselves more widely available to those in need, as compared to providers administering face-to-face treatment. For example, E-therapy services can be found in “rural clinics, military programs, correctional facilities, community mental health centers, nursing homes, home health care settings, and hospitals.” (Maheu, et al., 2005). More practitioners delivering services electronically will also improve treatment access for underserved populations. Further, practitioners can more readily provide interactive psychoeducational materials during times when traditional services may not be accessible. These online materials can be used to dispel myths about mental health treatment, encourage treatment compliance, promote self-monitoring, and teach relapse strategies (Mallen and Vogel, 2005).

E-therapy is also associated with lower costs for care, particularly for rural programs (Alleman, 2002; Brown, 1998; Gibson, et al., 2002). For example, direct costs associated with E-therapy consultations have been as much as 50 percent less than face-to-face consultations in eastern Oregon’s RodeoNet telepsychiatry program (Brown, 1998). Although the initial costs for equipment may be prohibitive (Darkins and Cary, 2002), reduced travel for clients and practitioners, improved quality of care, and increased levels of monitoring and assistance have all been identified as factors related to the decrease in funds spent to provide care (Maheu, et al., 2005; Gibson, et al., 2002). Lower costs have also been attributed to reduced time spent per appointment for some areas of health care, such as dermatology (Darkins and Cary, 2002). E-therapy may also allow practitioners to maintain consistent contact with clients who relocate or are highly mobile (Mallen, et al, 2005; Yager, 2002). The ability to access providers and clients from multiple locations vastly increases the continuity of care. Research findings suggest that continuity of care is important to the development and maintenance of the client-practitioner relationship. The strength of this relationship is, in turn, associated with client assessments of the quality and effectiveness of the care they receive (Castelnuovo, et al., 2003).

Challenges Associated with E-Therapy

Experts have identified a number of challenges associated with E-therapy. It is
predicted that the overall demand for online treatment service delivery will increase over the next decade (Alleman, 2002; Castelnuovo, et al., 2003; Mallen, et al., 2005). However, according to Alleman (2002), mental health professionals are unprepared for this demand (Alleman, 2002). Further, it is believed that practitioners are reluctant to investigate ways to incorporate E-therapy into their existing methods of service delivery (Mallen, et al., 2005). As a result, the accessibility of services offered through electronic means may not achieve its full potential over time. In addition, the demand for assistance will continue to exceed the availability of services, resulting in continued unmet need.

Another challenge associated with providing E-therapy involves maintaining client-practitioner confidentiality. This is a major concern, as regulations are imposed on the therapist, but not the client. Nothing prevents a client from forwarding correspondence between himself and his therapist to a third party (Alleman, 2002). In addition, the exchange of information conducted over the Internet creates records that can be infiltrated and are not easily deleted (Manhal-Baugus, 2001; Recupero and Rainey, 2005). Further, these records can be infiltrated easily if communication occurs over insecure connections (Maheu, et al, 2005; Terry, 2002). Maintaining the highest possible levels of network security is of paramount importance for practitioners to ensure the privacy of clients (Ragusea and VandeCreek, 2003).

An additional challenge associated with the use of E-therapy concerns disproportionate access to electronic media. Mallen and colleagues (2005) identified “young, affluent, educated, and highly functioning whites as having the greatest access to the technology required” for E-therapy (Sanchez-Page, 2005). This “digital divide” may compromise the ability of E-therapy to reach underserved populations (Sanchez-Page, 2005; A. K. Burlew, personal communication, Aug. 28, 2006). The effects of the “digital divide” also include persons who are not computer-savvy or are fearful of technology.

Summary

- An array of media is used to conduct E-therapy. The advantages and disadvantages of each form of communication should be considered when determining the best methods for a service population. For example, a user’s skill level (e.g., communication, typing, and other media-related skills) should be among the client characteristics considered when making decisions about the appropriateness of specific forms of electronic therapy.
- E-therapy has the potential to be utilized throughout the continuum of care, for a variety of conditions. For example, E-therapy can be used to provide: (1) education; (2) assessment and diagnosis; (3) direct treatment; and (4) aftercare services. In addition, providers can give and receive training and supervision using electronic forms of communication.
- Although the potential of E-therapy to provide quality services has been examined extensively, there is a dearth of research findings to determine its
effectiveness, especially for substance abuse intervention and treatment. Experts have emphasized the need for more research to thoroughly assess the delivery of mental health services via electronic media, citing methodological difficulties with study design.

- Benefits associated with E-therapy include greater accessibility for hard-to-reach and underserved populations, lower costs as compared to face-to-face therapy, and the ability to maintain continuity of care when clients relocate or travel.
- A challenge associated with E-therapy includes the “digital divide,” the term used to characterize disparities in access to computers and the Internet. An additional difficulty associated with E-therapy is maintaining confidential relationships with clients.

Cultural and Linguistic Competence

Unmet needs-to-services mismatches are evident among some ethnic and racial minority populations, who are far more likely to encounter problems in access to traditional substance abuse and mental health services and to receive lower quality services when they do receive care (Wells, Klap, Koike, and Sherbourne, 2001; Harris, Edlund, and Larson, 2005). Problem drinking and illicit drug use go untreated, yet E-therapy is expected to build substance abuse treatment capacity for such hard-to-reach and traditionally underserved groups. The treatment community is charged with providing effective substance abuse treatment modalities for all ethnicities. How do culture and race affect appropriate substance abuse treatment strategies for minority populations? What is the pivotal role of dialect and language when providing substance abuse treatment services to specific target populations? Each of these topics will be discussed in this section.

Knowledge of Culture and Ethnicity

There is limited research available that addresses the benefits and concerns surrounding E-therapy, culture, and linguistic competence (HHS, 2001). Defining cultural competence and examining the underlying factors that often prevent minority groups and other ethnic or racial groups from seeking effective treatment is critical for the adaptation and development of culturally appropriate treatment interventions. Castro, Proescholdbell, Abeita, and Rodriguez (1999) define cultural competence as “the capacity of a service provider or an organization to understand and work effectively in accordance with the cultural beliefs and practices of persons from a given ethnic/racial group.” Failing to customize E-therapy substance abuse treatment to accommodate the different cultural needs, experiences, and beliefs of the individual client can be a serious mistake.

Culture (e.g., norms, traditions, and religious rituals) plays an important role in clients’ lives (Maheu, 2001). For example, research indicates that minority groups often rely on cultural coping mechanisms within the community to address stress and
perceived mental or substance use disorders. In African American and Latino communities, discussing challenging life events with a clergy member or traditional healer is readily accepted and often preferred to traditional treatment methods (Levin, 1986; Risser and Mazur, 1995). Young, Griffith, and Williams (2003) surveyed 99 African American pastors on the amount of time they spent counseling parishioners. The pastors averaged approximately 6 hours a week counseling members of the congregation, often addressing serious mental health and substance abuse concerns. Native American populations may more readily seek assistance from traditional informal service providers or tribal elders than from a licensed mental health professional (Walls, Johnson, Whitbeck, and Hoyt, 2006). Marbella, Harris, Diehr, Ignace, and Ignace (1998) interviewed 150 Native American adult clients at a Wisconsin Indian Health Center and found that 38 percent of the respondents would seek help from a traditional healer in conjunction with Western health care. In addition, 61.4 percent of the clients indicated they would follow the advice of the traditional healer if the advice given by the western-influenced physician differed from the traditional healer.

Linguistic competence is especially relevant in the delivery of services via electronic forms of communication (Maheu, 2001). Users may be native English writers or persons who use English as a second language. English-proficient providers also cannot assume that all persons accessing E-therapy services understand English as well as the clinician. Allowing the client to fully participate in developing treatment interventions by providing feedback has proven beneficial for the client and practitioner (HHS, 2001). No doubt, familiarity with colloquial expressions, idioms, and local variations of word usage is critical to that feedback. Maheu (2001) also states that to offer behavioral health (substance abuse and mental health) care in the absence of such knowledge and understanding about specific patients can easily be considered outside the standard of care and can serve as major impediments to informed consent, clinical assessment, client education, and direct care. Therefore, it is important to be aware of cultural beliefs and communication nuances among minority groups, as they are important components for practitioners to incorporate during online counseling sessions.

As a practitioner, it is essential to recognize that standard substance abuse curricula and general interventions may not necessarily provide the best treatment strategy for an individual from a minority group. Cultural competence is about adapting practices and interventions to meet the needs of diverse cultural groups (Davis, 1997). Studies conducted by Jerrell and Wilson (1997) indicate that ongoing training in cultural competence is crucial for providing minority clients with culturally appropriate services and treatment options. In that manner, a culturally engaged practitioner always considers a client’s cultural background and experiences, which may influence the utilization of E-therapy as a relevant form of treatment for substance abuse.

**Barriers to Cultural Competence**

Beliefs and attitudes about particular groups of people usually dictate individuals' behavior toward that group, regardless of the accuracy of the perception (HHS, 2001).
Mistrust of the medical community has been documented repeatedly, according to the Epidemiologic Catchment Area study conducted in the early 1980s (HHS, 2001). In the study, nearly 50 percent of the African Americans surveyed reported a fear of receiving mental health treatment, compared with 20 percent of whites. Current-day discrimination and racism coupled with historical mistreatment are real barriers that may contribute to a lack of trust toward mental health treatment and the medical community (HHS, 2001).

In addition, a 1999 study funded by the Kaiser Family Foundation reported similar findings within minority populations. Results indicated that 12 percent of African Americans and 15 percent of Latinos, vs. 1 percent of whites, believed that they had received substandard medical care because of their race (HHS, 2001). Data from the Commonwealth Fund Minority Health Survey (1997) reported that 43 percent of African Americans and 28 percent of Latinos, compared with 5 percent of whites, perceived they were treated poorly by a health care professional because of their race and cultural background (HHS, 2001). Likewise, immigrants and refugees are also leery of the U.S. health care system. Consequently, the delivery of mental health and substance use disorder treatment services for undocumented people is in jeopardy because this population fears deportation and mistreatment (HHS, 2001).

Few research studies examine the link between effective culturally competent substance abuse treatment services through electronic modalities for minority individuals. Sanchez-Page (2005) identifies and addresses four counseling inadequacies in delivering culturally appropriate mental health treatment online.

- **Lack of culturally suitable evaluation tools.** Researchers and practitioners should design culturally suitable evaluation tools to measure the benefits of E-therapy compared with face-to-face counseling among minority populations and their white counterparts.

- **Lack of awareness about communication styles.** Practitioners must understand the important impact of cultural communications styles among minority populations and how the absence of verbal and nonverbal cues associated with online counseling may negatively influence the relationship between the practitioner and client.

- **Limited access to technology in communities of color.** Poverty and disproportionate access to technology within communities of color limit the use of E-therapy as a mainstream counseling option for minority groups. Consequently, further research is required to examine the usefulness of electronic therapy among minority populations.

- **Lack of culturally appropriate online interventions.** Develop culturally appropriate online interventions that address the cultural beliefs and practices of individuals from specific ethnic/racial groups (Castro, et al., 1999).
By effectively addressing important cultural factors, clinicians may begin cultivating the opportunity to advance the integration of E-therapy among underrepresented and underserved populations (Sanchez-Page, 2005).

Shame Associated with Mental Illness and Substance Abuse

Members of minority communities often have critical views about mental illness (HHS, 2001). In these communities, individuals who suffer from mental illness are often ostracized and subjected to shame and embarrassment by family members (HHS, 2001). Documenting the intensity of this stigma is difficult because minority groups are reluctant to address issues related to mental illness and substance abuse (HHS, 2001). Few cross-cultural studies have examined the relationship between race and mental illness. Zhang, Snowden, and Sue (1998) conducted a study comparing Asian Americans and whites living in Los Angeles. Data indicated that more than twice the number of whites (25 percent) would consider talking about their mental health challenges with a friend, compared with 12 percent of Asians. Study reports also showed that only 4 percent of Asian respondents would seek assistance from a mental health professional, compared with 26 percent of white respondents. Thirteen percent of white participants found it acceptable to discuss mental distress with a doctor, compared with only 3 percent of the Asian participants found it acceptable (HHS, 2001).

In the 1970s, the National Opinion Research Center began to evaluate societal views of mental illness. This extensive analysis initiated the 1996 General Social Survey (HHS, 2001), which gauged respondents’ personal opinions about mental illness when presented with various short stories depicting people diagnosed with mental illness. Study results indicated that respondents labeled people with mental illness as a menace and unfit to handle personal responsibilities. Intense criticism was aimed at individuals with substance abuse problems and schizophrenia. However, researchers observed that neither the race of the respondents nor of the individuals portrayed in the short stories factored into the stigma associated with mental illness (HHS, 2001).

On the other hand, a second study assessing public bias toward individuals with mental illness captured how different ethnic groups respond to people with mental illness (HHS, 2001). After interacting with individuals diagnosed with mental illness, Native Americans and whites reported a greater tolerance of people with mental illness, while African Americans, Latinos, and Asians reported less tolerance. The self-worth of family members and individuals diagnosed with mental illness is directly affected by the stigma of being labeled “crazy.” Often, the intense stigma attached to mental illness prevents people, particularly those within minority groups, from receiving treatment for mental illness. However, cultural sensitivity and acknowledgement of cultural stigma associated with receiving mental health and substance abuse treatment services is helpful when relating to minority clients (HHS, 2001).

Culturally Appropriate Treatment Services

Integrating fundamental parts of ethnic group culture, including styles of
communication, value systems, historical background, and religious and traditional beliefs, are believed to increase the use of mental health services among minority clients. Researchers recognize that by adapting mental health treatment services to a client’s familiar culture, potentially significant treatment outcomes may be realized (HHS, 2001). During the last decade, practitioners and other mental health care professionals began emphasizing the importance of delivering culturally competent mental health services while encouraging buy-in from minority consumers, families, and communities. For example, a noted culturally appropriate mental health care service delivery model designed for children and adolescents with severe emotional disabilities concentrates on the strengths of ethnic groups’ culture for effective service delivery (Cross, Bazron, Dennis, and Isaacs, 1989). Principal components involved in adapting this mental health care service delivery model include policy, training, resources, practice, and research.

Linguistic competence is equally significant in developing culturally appropriate treatment services. The National Center for Cultural Competence at Georgetown University defines linguistic competence as the “capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served” (The National Center for Cultural Competence, 2006). For example, the bilingual website “Amigos” utilizes an electronic psychoeducational tool to help minorities access health-related resources (Guanipa, Nolte, and Lizarraga, 2002). Providing availability to computers, and educating the targeted community about mental health care and multiculturalism, was the objective of establishing “Amigos.” By implementing electronic modalities similar to the “Amigos” program, minority groups may cautiously utilize culturally and linguistically competent mental health and substance abuse treatment services. Continuing research by practitioners and further development of culturally appropriate online interventions may encourage the use of E-therapy by minority populations.

**Summary**

- Developing and testing the effectiveness of culturally appropriate online substance abuse treatment interventions requires buy-in from minority consumers, families, communities, and mental health professionals.

- Therapists should recognize that the historical discrimination that minority groups have experienced in encounters with the medical community and the resulting feelings of mistrust from these encounters may influence the willingness of individuals to seek mental health and substance abuse treatment.

- Poverty and limited access to technological resources may influence the
utilization of E-therapy as a mainstream counseling option within some minority groups. In addition, consider that standard substance abuse curricula and general interventions may not necessarily provide the best treatment strategies for minority communities.

- Practitioners must recognize and emphasize the importance of providing culturally competent treatment services and integrate fundamental components of ethnic group culture, including communication styles and religious and traditional beliefs. Integrating these cultural components may increase the use of mental health services among minority clients.

**Legal and Regulatory Issues**

The past several years have brought rapid changes to service delivery through the use of E-therapy. However, the development of laws and ethics codes governing its practice has lagged behind (Alleman, 2002; Barnett and Sheetz, 2003). Practitioners are required to adhere to their professional associations’ codes of ethics. In addition, the license to practice necessitates following the requirements set forth by licensing boards. The increased use of E-therapy has led to many unanswered questions in terms of licensure, ethics, client protections, and practitioner protections. Each of these issues will be discussed in this section.

**Licensure**

In most cases, the delivery of substance abuse treatment is regulated by the State in which practitioners serve clients. Regulations vary depending on the type of practitioner and the jurisdiction of practice. For this reason, most practitioners must be licensed in each State or province where they provide services within the “scope of practice” of that jurisdiction’s license (Mallen, Vogel, and Rochlen, 2005). The conduct of E-therapy complicates this issue, as most forms of electronic service delivery can easily occur across jurisdictional lines. This presents legal challenges that have not been clarified to date (Barnett, 2005; Darkins and Cary, 2000). For example, practitioners providing treatment to clients outside of the State in which they are licensed may be practicing outside of the “scope of practice” for their licenses. As a result, these practitioners may be in violation of the rules set forth by their respective licensing boards and liable for any harm to clients (A. K. Burlew, personal communication, Aug. 28, 2006; Recupero and Rainey, 2005). In addition, with a practitioner-client relationships formed across jurisdictional lines, it is unclear which region’s regulations take precedence (Manhal-Baugus, 2001).

To date, California has passed the most comprehensive legislation related to the conduct of E-therapy (National Conference of State Legislatures [NCSL], 2005). According to a component of the California Telemedicine Act, only clinical psychologists or medical doctors licensed in the State of California can administer E-therapy to clients who are State residents (Manhal-Baugus, 2001). As of September 2005, approximately
18 States had enacted legislation related to the use of E-therapy for treatment purposes. In addition, several of these states, including Arizona, Montana, Vermont, and West Virginia, had established laws similar to California’s in terms of the practice of E-therapy. In addition, Montana and Puerto Rico require a special license to practice E-therapy within their jurisdictions (NCSL, 2005).

The need for the clarification of jurisdictional licensing issues is evident. To alleviate complications, many practitioners specializing in substance use disorder treatment and E-therapy endorse the formation of a national licensing system or reciprocal licensing among jurisdictions (Alleman, 2002; Manhal-Baugus, 2001; G. Stofle and E. Singleton, personal communication, Aug. 28, 2006; Terry, 2002). In addition, some licensing boards are working toward license reciprocity, which would alleviate a number of issues related to practicing in multiple States (Mallen, et al., 2005). Until such legislation is passed, field experts recommend that practitioners provide services only in jurisdictions in which they are licensed to practice (Barnett, 2005; Barnett and Scheetz, 2003; CSAT E-Therapy Expert Panel Work Group Meeting, Aug. 28, 2006). It is also important for practitioners to know where their clients reside, to ensure that they are not in violation of any regulations. Experts further advise that practitioners be completely aware of the parameters under which they are permitted to practice E-therapy in their respective jurisdictions and the areas in which their clients reside (Barnett, 2005; Gluekauf, Pickett, Ketterson, Loomis, and Rozensky, 2003).

Ethics

Because E-therapy is a relatively new field, there are few ethical codes that relate specifically to providing services electronically. Further, there is no consensus as to whether or not separate ethical guidelines for online practice are necessary (Ragusea and VandeCreek, 2003). It should be noted that the potential for ethical violations is high due to limited privacy, varied locations of participants, and the inability (in many cases) to confirm the identity of clients (Castelnuovo, et al., 2003).

While a few organizations have ethics codes created specifically for E-therapy, others have adapted their existing codes of ethics to include electronic communication. For example, the American Counseling Association, the American Psychological Association, and the National Board of Certified Counselors have revised their ethics codes to include E-therapy (American Psychological Association, 2002; Manhal-Baugus, 2001). Specifically, the codes were changed to address concerns about confidentiality, informed consent, licensure, and emergency procedures.

In 2000, the International Society for Mental Health Online approved a set of suggested principles of practice for those providing E-therapy (ISMHO, 2000). These principles address informed consent, standard operating procedure, and emergencies and seek to mediate a number of ethical issues related to providing E-therapy.

Client Protections
Ensuring the protection of clients is key to successful service delivery. In terms of E-therapy, establishing and retaining such security requires the adherence to client privacy regulations, obtaining informed consent, and providing for clients in the event of emergency.

At the Federal level, the Health Information Portability and Protection Act (HIPAA) protects the transfer and sharing of client information. As most practitioners are keenly aware, this legislation requires client consent to release medical information, with some exceptions. This legislation also applies to the electronic transfer of medical records, and practitioners must adhere to specific guidelines when sharing client information (Maheu, et al., 2005). However, in some cases, State and local regulations may supersede HIPAA (McMenamin, personal communication, July 7, 2006).

Practitioners should check the guidelines in their jurisdictions to verify their responsibility in terms of transferring client information.

An additional component to client protection is informed consent, which was established to protect the client’s right to participate in treatment (Recupero and Rainey, 2005). As is the case with any form of treatment, clients are required to be provided with the following information, in accordance with applicable regulations:

- The treatment process or procedure
- Benefits associated with the treatment or procedure;
- Risks associated with the treatment procedure;
- Actions taken to prevent client risk
- Procedures for emergencies.

It is recommended that practitioners provide this information to clients prior to initiating treatment. Further, clients should have the opportunity to assert their understanding of the information provided to them (Recupero and Rainey, 2005).

ISMHO also offers the following information on E-Therapy

- The average time needed to provide the client with a response for asynchronous forms of communication
- The counselor’s right to privacy and the possibility of restrictions on the client’s use of any communication with the practitioner;
- The name and qualifications of the practitioner and how to confirm the information provided
- Alternatives to receiving assistance via E-therapy (ISMHO, 2000).

**Practitioner Protections**
Practitioners of E-therapy must also be vigilant about their own protection. In particular, treatment providers must be aware of issues related to malpractice and privacy. In terms of malpractice, one of the biggest concerns is the inability to have consistent face-to-face contact with the client, except in cases where videoconferencing is used (Maheu, et al., 2001). Without initial face-to-face contact, inaccurate assessment or misdiagnosis is possible. For this reason, an initial face-to-face consultation is recommended to facilitate accurate assessment and to determine the client’s appropriateness for E-therapy (G. Stofle, personal communication, Aug. 28, 2006).

It is also important for practitioners to have malpractice insurance coverage in every jurisdiction relevant to their practice, as most clients will file a suit in their area of residence (Maheu et al., 2001). As was previously mentioned, most States require licensure in the State of practice and do not allow interstate treatment to occur on a regular basis. A malpractice suit filed in a State other than that of the practitioner would prove detrimental to further practice without the proper licensure and insurance coverage.

Practitioners have the right to privacy in a manner similar to clients, but they are not protected by regulations. The provision of E-therapy complicates the practitioner’s ability to maintain his or her confidentiality when using text-based forms of communication, as the client also has a record of the exchange (Alleman, 2002). Nonetheless, as was previously mentioned, the practitioner should inform the client of his or her right to privacy.

Summary

- Most practitioners must be licensed in each State or province where they provide services within the “scope of practice” of that jurisdiction’s license. The conduct of E-therapy complicates this issue, as most forms of electronic service delivery can easily cross jurisdictional lines.

- As of September 2005, approximately 18 States had enacted legislation related to the use of E-therapy for treatment purposes. Laws in Montana and Puerto Rico require a special license to practice E-therapy within their jurisdictions.

- Experts recommend that practitioners provide services only in jurisdictions where they are licensed to practice and that they know where their clients reside to ensure that they are not in violation of any regulations.

- Service providers should be completely aware of the parameters under which they are permitted to practice E-therapy in their respective jurisdictions, as well
as the areas in which their clients reside.

- In terms of E-therapy, establishing and retaining client protections requires adherence to local, State, and Federal client privacy regulations, obtaining informed consent, and providing resources for clients in the event of emergency.

- Practitioners have the right to privacy in a manner similar to clients, but they are not protected by regulations.

### Administrative Issues

#### Introduction

Traditional face-to-face therapy requires standard confidentiality and privacy measures (Maheu, et al., 2001; Stofle, 2001). Specifically, practitioners must ensure that HIPAA regulatory procedures and codes of conduct are followed. In addition, providing E-therapy services involves implementing electronic safeguards to prevent hackers from accessing patient records and to prevent computer viruses from corrupting electronic data (Zack, 2004). Several different security options are available to practitioners and clients for maintaining a secure computer network. For a licensed therapist practicing E-therapy, experts recommend securing clients’ electronic records by utilizing password protection programs, computer network firewalls, wiping software, and document encryption. Critical administrative responsibilities include maintaining accurate billing statements, properly secured client files, and reliable technical support (Zack, 2004). Each of these topics will be explored in this section.

#### Electronic Security Measures

##### Password Protection Programs

When selecting a password, computer specialists suggest using a short phrase that is at least eight characters long (Zack, 2004; Stofle, 2001). Randomly selecting a variation of numeric, nonalphanumeric, lower and uppercase characters will increase the degree of difficulty in guessing the password. Also, automatic screen savers provide additional security to password protection software by appearing within a few minutes on the computer screen when the computer is not in use. In the case of illness or disability, online therapists recommend writing down the computer password and storing it in a safe deposit box. Providing a trusted colleague with instructions on how to access the stored computer password if an emergency occurs is encouraged.

##### Computer Network Firewalls

Further computer network security measures are attainable by installing firewall software or specialized hardware equipment. Firewalls allow the computer owner to
filter selected information from the Internet through their personal computer network. Unwelcome electronic solicitations are significantly decreased with firewall protection. In addition, a network router operating between the cable/DSL modem can be adapted to encode identified data from the Internet to the owner’s personal computer (Maheu, et al., 2005).

**Wiping Software**

Wiping software is designed to overwrite computer hard drives with a haphazard series of zeros and ones. Information technology experts recommend wiping the computer hard drive before selling a used computer and discarding used floppy disks and CD-ROMs. For therapists providing E-therapy services, “wiping” ensures permanent deletion of client files and an additional layer of computer security before disposing of a computer that was used for E-therapy (Zack, 2004).

**Document Encryption**

Another method used to protect online counseling transmittals is document encryption. Encryption involves deliberately scrambling the text of a document by devising a basic mathematical equation and an unusual “key” and then applying the equation to the document. The scrambled text is readable after a second mathematical equation and unusual “key” are applied to the document.

Options include symmetric encryption and public key encryption. Both are used to encrypt confidential documents (Maheu, et al., 2001; Zack, 2004). Symmetric encryption requires one key to encode and decode a confidential file. Notably, symmetric encryption proves to be an effective security measure, because without the decryption key the message remains unreadable to a potential computer hacker. Public key encryption consists of a public and private key set. Anyone may access the public key necessary to e-mail a therapist an encrypted message; however, only the therapist may decrypt and read the message by using a private key. Public keys are posted on websites or e-mailed to clients, while private keys are password protected and located on the practitioner’s personal computer (Maheu, et al., 2005; Zack, 2004).

**Administrative Responsibilities**

**Billable Services**

Medicare deemed online videoconferencing billable in October 2001 (Maheu, et al., 2001). Similar reimbursement rates for face-to-face counseling would be applicable to synchronous or asynchronous videoconferencing. However, health insurance companies do not cover text-based therapy. Therefore, clients utilizing text-based counseling services must pay the practitioner directly, usually by credit card. To alleviate confusion over payment responsibilities, therapists should explain the reimbursement restrictions surrounding text-based therapy to potential clients (Zack, 2004; Stofle, 2001).
Client Records

Regulatory procedures require practitioners to obtain and securely store client paper records. Likewise, electronic client files and online communications are protected by similar stringent privacy and confidentiality policies (Zack, 2004). Undoubtedly, health care organizations report that the most obvious threat to electronic patient files is computer hackers. Within larger health care agencies, client records tend to be more vulnerable to security breaches. Unfortunately, careless employees pose a risk to exposing confidential patient information. Employees may print clients’ records on unsecured copiers, leave private records unattended, select easy computer passwords, or talk to coworkers about client information (Maheu, et al., 2005). However, practitioners and health care employees are responsible for practicing ethical behavior in the workplace and so they must ensure that patient information is properly secured.

Technical Support

Experienced online therapists recommend investing in a reliable, 24-hour computer technical support service. Usually, computer companies offer technical support services along with the purchase of the computer.

Summary

- Overall, the implementation of effective electronic security measures and administrative responsibilities is critical to ensuring a confidential and client-friendly online counseling atmosphere.

- Effective security measures to prevent unauthorized access to confidential information and to establish a secured computer network include installing firewalls, using wiping software to erase clients’ electronic records when disposing of an old computer, and utilizing document encryption.

- Choosing simple words, phrases, or names of family members for computer passwords is risky and does not provide the security that is required to protect clients’ electronic files. Selecting unusual words or odd groupings of numbers and letters offers an increased level of security.

- Maintaining strict confidentiality when handling client files is paramount. Observing HIPAA regulatory procedures and codes of conduct is essential when practicing E-therapy.
Preventing Medical Errors: Best Practices for Mental Health Professionals
Chapter 5

Introduction

Susan is a 63 year-old woman who had been in therapy with Mary Klein for 6 months, dealing with issues of grief and loss due to the recent death of her husband. The relationship between Susan and her husband had been quite conflictual, and Susan described a pattern of somatic illnesses that allowed her to elicit care and concern from a generally unresponsive man.

Prior to a scheduled appointment, Mary receives a call from Susan stating that she is experiencing chest tightness, shortness of breath and dizziness. Mary calms Susan down, stating that these symptoms are only anxiety, and encouraged her to keep her appointment.

When Susan does not arrive for her appointment, Mary is slightly concerned, but he thinks that maybe the anxiety was too great to allow her to drive. He later gets a call from Susan’s son, indicating that he had taken her to the hospital and that she had suffered a mild heart attack.

The saying “to err is human” is one that most people are familiar with, but some errors, such as the one described above, can have potentially tragic consequences. A landmark 2000 report, To Err is Human: Building a Safer Health System by the Institute of Medicine, brought attention to the issue of preventable medical errors. This report focused primarily on medical settings. According to this report, a between 44,000 and 98,000 Americans die each year as a result of medical errors. A subsequent report published in 2012, however, found that approximately 200,000 Americans die from preventable medical errors including facility-acquired conditions, and that millions may experience errors (Andel et. al, 2012). Additionally this study looks at the economics of medical errors, and estimates that such preventable errors cost between $735 billion to $980 billion annually. Anders (2012) concludes that quality care is not being delivered consistently throughout U.S. hospitals, and that poor quality is costing payers and society a great deal.

The mandate for increased quality is important. “To err is human” provides several means for reducing medical errors, such as: 1) Establishing a national focus to create leadership, research, tools, and protocols to enhance the knowledge base about safety; 2) Identifying and learning from errors by developing a nationwide public mandatory reporting system and by encouraging
health care organizations and practitioners to develop and participate in voluntary reporting systems; 3) Raising performance standards and expectations for improvements in safety through the actions of oversight organizations, professional groups, and group purchasers of health care, and 4) Implementing safety systems in health care organizations to ensure safe practices at the delivery level.

Five years after this landmark report, Leape & Berwick (2005) published a follow-up examining whether the report has had an impact on reducing medical errors. They found that although the changes are not as sweeping as desired, attitudinal changes in organizations have occurred. There has also been focus on medical errors at a federal level, with Congress funding patient safety research through the Agency for Healthcare Research and Quality (AHRQ) (see http://www.ahrq.gov/).

Another important result of “To err is human” has been changes in the practice of health care. In 2010, The Joint Commission and Accredited Health Care Organizations (JCAHO), the group that provides accreditation to U.S. hospitals and other health care facilities began requiring hospitals to implement 11 safety practices, including improving patient identification, communication, and "surgical site verification" (marking a body part to ensure surgery is performed on the correct part). These National Patient Safety Goals have been reviewed annually, and include mandates for behavioral health settings. The behavioral health goals and an example of each are listed below:

- Improving the accuracy of patient identification (such as by taking photographs of patients on admission to behavioral health settings)
- Improving the effectiveness of communication among caregivers (such as by eliminating confusing abbreviations in notes or orders)
- Improving the safety of using medications (care taken with medications that have similar names)
- Reducing the risk of health care-associated infections (such as through adequate handwashing procedures)
- Accurately and completely reconciling medications across the continuum of care (such as through providing discharge summaries with medications clearly indicated)
- Encouraging patients’ active involvement in their own care as a patient safety strategy
- Identifying safety risks inherent in its patient population (such as individuals at risk for suicide)

Although many of these goals are more applicable to hospital rather than outpatient settings, goals such as encouraging patients to be active in their own care, increasing communication among treatment professionals and identifying risk factors are universal, as is the spirit of the Joint Commission recommendations. One principle commonly found in the ethical codes of counselors, social workers and psychologists is that of “beneficence and nonmaleficence”. Simply put, these codes states that clinicians strive to “do no harm” to those with whom we work. The American Psychological Association (2002) *Ethical Principles of Psychologists*, for example, states that “in their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research.” It goes on to outline the areas that could potentially jeopardize psychologists’ ability to help those with whom they work.

This course will examine the impact of medical errors on patients in mental health settings. It will reference best practices and ethical guidelines that can help to reduce and prevent medical errors.

Educational Objectives:

- Discuss the Joint Commission’s National Patient Safety Goals for behavioral health
- Define “Medical Errors”
- Recognize approaches to prevent medical errors
- Utilize Root Cause Analysis process to evaluate medical errors
- Identify medical errors common in medical health
- Review ethical guidelines related to competence (including multicultural competence), informed consent, confidentiality and mandated reporting
- Discuss the Health Insurance Portability and Accountability Act (HIPAA)
- Discuss trends in assessment of suicide
- Describe assessment of medical conditions that present as psychological problems
- Describe reasons that accurate differential diagnosis is needed

**Definition of Medical Errors**

How do we define medical errors? Medical errors are mistakes made by mental health professionals within the normal work of their practice and which
result in harm to the patient" (http://medical-dictionary.com/). All errors constitute a failure in service delivery have consequences for people at a time in which they are vulnerable (National Academy of Sciences, nd). Medical errors range from relatively minor ones that do not have lasting results or can be easily rectified, such as misdiagnosing an adjustment disorder as a depressive disorder, to those with more serious consequences such as failing to act to attain help when a client threatens self-harm

Corey, Corey & Callanan (2010) suggest that one framework for studying errors is to break them down by type. They identify two types of errors: acts of commission and acts of omission. Clinicians commit acts of commission when they make mistakes, such as incorrectly diagnosing someone. Clinicians commit acts of omission when they fail to act in some way, such as a failure to report child abuse. Although it is not necessary to specifically identify medical errors using this schema, it provides a useful set of questions for the mental health professional: Am I doing everything I can within best practice guidelines? Have I missed doing something I could do?

In addition to the National Patient Safety Goals, JCAHO defines the most acute medical errors, which they term “sentinel events.” JCAHO’s Sentinel Events Policy was revised in 2013 (Full text of this article is available at http://www.jointcommission.org/assets/1/6/CAMBHC_2012_Update2_21_SE.pdf. Sentinel events are “unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof”. The phrase, "or the risk thereof" suggests that should such an event recur, it would carry a significant chance of an adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response. The terms “sentinel event” and “medical error” are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events. JCAHO’s policy has four goals: 1). To have a positive impact in improving care, treatment, or services to individuals served and preventing sentinel events; 2). To focus the attention of an organization that has experienced a sentinel event on understanding the factors that contributed to the event (such as underlying causes, latent conditions and active failures in defense systems, or organizational culture), and on changing the organization’s culture, systems, and processes to reduce the probability of such an event in the future; 3). To increase the general knowledge about sentinel events, their contributing factors, and strategies for prevention, and 4). To maintain the confidence of the public and accredited organizations in the accreditation process.

It is important to note that JCAHO makes a distinction between an adverse outcome that is primarily related to the natural course of the individual’s illness or underlying condition and a death or major permanent loss of function that is
associated with the treatment or lack of that condition, or otherwise not clearly and primarily related to the natural course of the individual illness or underlying condition.

Examples of sentinel events include: An individual served commits suicide within 72 hours of being discharged from a behavioral health care setting that provides around-the-clock care; Prescribed medication results in a loss of function or death; Any elopement, or unauthorized departure, of an individual served from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function.

While these examples refer to inpatient settings a more realistic idea of medical errors that impact mental health professionals can be gleaned from malpractice data. Most malpractice suits are similar to medical errors in other fields as they involve a situation in which the treatment provider deviates in some way from accepted standards of practice and this deviation results in harm to the client. The majority of malpractice cases do not stem from unforeseeable problems, but rather from situations that could have been avoided if only they were recognized and anticipated. The following is a list of malpractice claims against psychologists over a 15-year period (Pope, 2003). The list is presented in descending order of frequency.

- Sexual violations
- Incompetence in developing or implementing a treatment plan
- Loss from evaluation
- Breach of confidentiality or privacy
- Improper diagnosis
- Other (a category of individual claims not falling into any other category)
- Suicide
- Defamation (e.g., slander or libel)
- Countersuit for fee collection
- Violation of civil rights
- Loss of child custody or visitation
- Failure to supervise properly
- Improper death of patient or third party
- Violation of legal regulations
- Licensing or peer review issues
- Breach of contract

Like the medical errors cited in the JCAHO listing, these situations which have been the focus of legal proceedings, occur within vulnerable populations.
and have the propensity of causing harm to the client. As a review of this list shows, these offenses can occur across many practice settings.

**Root Cause Analysis**

One approach to addressing medical errors is Root Cause Analysis. Root Cause Analysis is a retrospective approach to analyzing errors that has its basis in industrial psychology and human factors engineering (Wald & Shojania, 2001). As the name suggests, root cause analysis attempts to identify the underlying cause of a problem so it can be addressed, rather than simply treating the presenting symptoms. Root Cause Analysis assumes that mistakes do not just happen but that they can be traced to identifiable causes. This allows the person or organization that made the mistake to take steps to ensure that it does not occur again. The product of the root cause analysis is an action plan that identifies the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future.

The National Center for Patient Safety ([http://www.va.gov/NCPS/rca.html](http://www.va.gov/NCPS/rca.html)) states that the goal of a Root Cause Analysis is to determine

1) What happened
2) Why did it happen
3) What to do to prevent it from happening again.

When you use Root Cause Analysis you will generally find three types of causes ([http://www.mindtools.com/pages/article/newTMC_80.htm](http://www.mindtools.com/pages/article/newTMC_80.htm)):

- **Physical causes** – Tangible causes such as material items failing in some way. An example of this would be if a psychiatric medication caused an adverse reaction
- **Human causes** - People did something wrong or did not do something that was needed. An example of this would be a therapist failing to take precautions to ensure the safety of a suicidal patient
- **Organizational causes** - A system, process, or policy that people use to make decisions or do their work is defective. An example of this would be an organization policy that delays the reporting of child or elder abuse

In the remainder of this course, we will be using this approach to Root Cause Analysis to analyze vignettes that involve mental health medical errors. This
paper will cite the appropriate sections of the APA Ethics Code (2002) when discussing these vignettes.

Competence

Mental health professionals can avoid many medical errors. There is a direct relationship between minimizing medical errors and maintaining professional competence. The issue of competence is important, and the American Psychological Association established a task force to look at issues in professional competence (see http://www.apa.org/ed/resources/competence-report.aspx) for the final version of the 2006 report. The APA has subsequently come out with Revised Competency Benchmarks for Professional Psychology (2011), as well as A Guidebook for Competency Benchmarks (2012). Please see http://www.apa.org/ed/graduate/benchmarks-guide.aspx. Maintaining professional competence is an ethical mandate for all mental health professionals.

The issue of attaining and maintaining professional competence has been the focus of a number of authors (e.g., Welfel, 2012; Knapp and Vandecreek, 2012; Pope and Vasquez, 2007; Roberts et al., 2005.) Despite the inclusion of competence in our ethical codes, Pope and Vasquez (2007) note that competence is a sometimes a difficult concept to define. They go on to list what they consider “evidence” of a clinician’s competence: formal education, professional training, and supervised experience. Although these are good indicators for early career professionals, perhaps a more comprehensive description can be found in a later definition offered by Pope and Brown (1996), which describes competence as the ability to perform according to the standards of the profession. They list three factors in competence: knowledge, technical skills and emotional competence. Each of these factors has implications for clinicians in the goal of decreasing medical errors.

Competence implies that the treating clinician has the appropriate knowledge to identify therapy goals and interventions within the context of the patient’s diagnosis and presenting issues. In addition to formulating goals, it is important to have the technical expertise to apply these interventions. Pope’s (2003) list cited earlier lists incompetence in developing or implementing a treatment plan as a leading cause of malpractice suits. At the most basic level, competence means that a clinician would not treat a patient who presents with an issue with which they are unfamiliar or that requires specialized skills and knowledge. If a situation occurs within the course of an already established therapeutic relationship and that involves something that is outside the mental health professional’s areas of competence, he or she can choose to refer the
patient to another provider or to seek these skills through reading and consultation. Often the former approach ensures a greater degree of safety for the client.

In addition to knowledge and skills, emotional competence is an important factor. Clinicians need to be aware of personal problems that may interfere with their ability to provide care. These problems could include issues such as a divorce, a medical or psychological illness (including abuse of substances), or compassion fatigue. The later is a condition common in treatment providers who work with trauma patients.

The concerns related to impaired professionals apply not only to self-knowledge and self-reflection, but also to knowledge that the treating professional has about colleagues. According to the NASW code of ethics, social workers who have direct knowledge of a social work colleague’s impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action. If it becomes apparent that the professional colleague is not taking adequate steps to seek help, social workers are bound to address the impairment through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

The final area related to maintaining competence is something that Bennett et al. (2006) refer to as “conscientious further education.” It is important that mental health professionals keep up with changes in the field and within their scopes of practice. Again, this helps to minimize error rates.

Case Study

Kenneth Jones has been treating Lisa M., a 23-year-old college student with depression, for the past 18 months. Over the past two weeks, Lisa has revealed to Kenneth Jones that when her depression has been bad, she has coped by binging and purging. Kenneth is not familiar with treating bulimia, and initially tells Lisa that she will refer her to another therapist. Lisa resists, and Kenneth Jones continues to see her weekly, but does not address the bulimia directly. Lisa’s symptoms continue to increase in frequency, and at times Lisa purges multiple times a day.
At work one day, Lisa experiences severe vertigo to the point that she seeks medical attention. The physician does blood panels and finds that Lisa’s results are abnormal to a potentially dangerous level.

Root Cause Analysis

What happened

A client experienced a serious medical complication.

Why did it happen

The therapist was unfamiliar with treating eating disorders and did not direct the client to seek medical monitoring.

What to do to prevent it happening again

The therapist will receive training and supervision in any specialized psychological issues with which he is not familiar.

Discussion

The NASW Code of Ethics that is relevant for this situation is:

4.01 Competence

(a) Social workers should accept responsibility or employment only on the basis of existing competence or the intention to acquire the necessary competence.

(b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.

(c) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.

This case clarifies how the lack of knowledge and skill in treating a particular problem can result in medical error. Although many clinicians are generalists trained to work with many populations, there are many disorders that require
specialized knowledge and skill. In the case above, the clinician was unaware of the dangers of frequent purging, and failed to require the client to be medically monitored.

Case Study

Dr. Marcus Bill, a licensed clinical social worker, never dreamed that he would find himself in a treatment center. It all started with what he believed was an innocent comfort food. He had always liked Jello, and following the bankruptcy of the Humvee dealership in which he had invested most of his retirement, he became depressed and found himself eating more and more. He probably would have had no ill effects, other than mild weight gain, if his local supermarket had not run out of the cool-whip. He always bought tubs of cool-whip on his way home from work. On that fateful shopping trip however, he purchased his first whipped cream in a can.

From the first moment he inadvertently inhaled the nitrous oxide from the whipped cream can he was hooked. He worried that it was not right, but reasoned that his clients were better off with a happy than a sad therapist. It was not long before he had a dorm fridge in his office and every client was offered a large helping of Jello topped with mounds of whipped cream. The whipped cream was often fashioned into a representation of the issue that the client was working on. As the whipped cream creations and Dr. Bill’s behavior became increasingly surrealistic, both his clients and co-workers became concerned. Eventually, Dr. Bill’s co-workers conducted an intervention that led to Dr. Bill voluntarily checking into a local treatment center.

1) What happened

   Dr. Bill was providing therapy while impaired by a substance.

2) Why did it happen

   He became addicted to a substance that he took to alleviate symptoms of depression.

3) What to do to prevent it happening again

   If he becomes depressed, he should seek treatment.

Discussion
The NASW Code of Ethics states

4.05 Impairment

(a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.

(b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.

Cultural Competence

The idea of competence also encompasses the need for mental health professionals to be culturally competent treatment providers. Legal and ethical mandates for mental health professionals stress the need for these professionals to respect and promote the welfare of individuals and families. All client behaviors are learned and displayed in a cultural context. Correct assessment, meaningful understanding and appropriate intervention require awareness of the multicultural context. For a full discussion of issues related to cultural competence, please see section one of this document. Additionally clinicians may familiarize themselves with issues related to multicultural competence by reviewing any of the books in the reference section, including Garcia & Petrovich (2011), Comas-Diaz (2011), and Hogan (2012).

Medical errors connected with lack of cultural competence can occur in client assessment, understanding or intervention.

Multicultural competence is a key competency for all mental health professionals. It comes as no surprise that multicultural competence is an important part of the NASW Ethical Code. There are a number of provisions connected to multicultural competence.

1.05 Cultural Competence and Social Diversity
(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients’ cultures and be able to demonstrate competence in the provision of services that are sensitive to clients’ cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

2.01 Respect

(b) Social workers should avoid unwarranted negative criticism of colleagues in communications with clients or with other professionals. Unwarranted negative criticism may include demeaning comments that refer to colleagues’ level of competence or to individuals’ attributes such as race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

4.02 Discrimination

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

6.04 Social and Political Action

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex,
Case Study

Jane Todd is scheduled to see a new client, Mr. Chang, who was referred to him by Mr. Chang's son Sam. Mr. Chang is clearly very hesitant to be meeting with him. Sam, who attends the first session to provide information, tells Jane that his father has seemed increasingly depressed since his mother has passed away. Sam further tells Dr. Todd that the couple was “inseparable” and that he is fearful that his father may try to take his own life if he does not start to feel better.

While it is difficult to get Mr. Chang to open up, he does comment to Jane that the only time her feels happy is when he is praying at the shrine he has set up to his wife. Mr. Chang says that when he is there, he can sometimes hear her voice, and feels comforted by her presence. When Dr. Todd hears this, he recognizes that the problem is “very serious” and that Mr. Chang’s grief is clearly “complicated,” “probably by guilt.” He privately informs Mr. Chang’s son that his father may be experiencing psychotic thoughts. Jane Todd recommends that Mr. Chang consult with a psychiatrist for medication.

Case Study

Ross Weiner is seeing a new client, Akl Rgin, who is a 55-year-old man of Cambodian descent. Mr. Rah has been living in the United States for over 15 years. Recently he has been laid off from his job and has been feeling very anxious. He states in the initial interview that he has felt dizzy, that his vision is blurry, and that he has had trouble breathing. He worries that he will not easily find employment, and that his family may face difficulties.

Ross is considering a diagnosis of panic disorder, until Aki begins to discuss the khyl that he believes is beginning to overtake his body. Not understanding, Ross questions Aki. Aki responds: “It is the wind. The wind is taking over. It may kill me. Ross is very concerned about the possibility of psychosis, and rather than working on anxiety management techniques, he schedules Aki with the psychiatrist.

1) What happened

The therapists diagnosed these clients with severe mental illnesses.
2) Why did it happen

These therapists were not practicing in a culturally sensitive way, and did not understand the customs or thought processes of Chinese-American/Cambodian clients.

3) What to do to prevent it happening again

These therapists should take steps to educate themselves when working with a client from a culture they are unfamiliar with; they should also consult the DSM-5, which has helpful information related to cultural concepts of distress.

Discussion

According to NASW Provision 1.05 Cultural Competence and Social Diversity

(b) Social workers should have a knowledge base of their clients’ cultures and be able to demonstrate competence in the provision of services that are sensitive to clients’ cultures and to differences among people and cultural groups.

There are a number of excellent resources available to support more accurate diagnosis and treatment of diverse clients, including updates to the DSM that support a more culturally sensitive approach to assessment. When in doubt, consult these resources or with colleagues more familiar with this cultural group.

Informed Consent

Another common medical error is not providing clients with appropriate information to allow for informed consent. As mentioned in the first part of this text, Informed consent is “a process of communication and clarification” (Pope & Vasquez, 2011). Informed consent involves clarifying why clients are seeking treatment, what their expectations of the therapy process are, and their thoughts about what treatment will entail. The clinician also needs to discuss these factors with the client. As a result, mental health professionals are often able to refine their own understanding of the clients’ presenting problems. Failure to obtain informed consent is in itself a medical error. Additionally, this process aids in correct diagnosis and treatment, reducing the possibility of errors in diagnosis and treatment planning.

Informed consent is an essential aspect of the establishment of the professional relationship in which psychologists participate. When done
effectively, it helps promote other individuals’ autonomy, engages them in a collaborative process, and helps to reduce the likelihood of exploitation or harm, among a number of potential benefits (Rosenfeld, 2002).

Why provide informed consent? Informed consent allows clients to make appropriate decisions about treatment. An important factor in this is the clinical concept of competence to consent to treatment. When a person is incompetent to consent to treatment it means that a person’s judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned and knowledgeable decision concerning his or her treatment. Gupta and Kharawala (2012) published a comprehensive review of the issues connected with informed consent, focusing on the challenges. They state that informed consent has three essential elements: voluntarism, information disclosure, and decisional capacity. They define voluntarism as “the ability of an individual to judge, freely, independently, and in the absence of coercion, what is good, right, and best subjected to his / her own situation, values, and prior history.” This is closely related to the idea of decisional capacity, and can be challenging for clinicians to assess.

While informed consent provides clients with information to make decisions about the treatment process, the amount of information the clinicians choose to share may vary from clinician to clinician and based on the client’s presenting issues. It is sometimes a challenge to provide appropriate informed consent and not to overwhelm an already harried client.

The NASW Code of Ethics provides specific standards with regard to informed consent. These standards include:

1.03 Informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients’ right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

(b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social
workers should take steps to ensure clients’ comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.

(c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients’ interests by seeking permission from an appropriate third party, informing clients consistent with the clients’ level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients’ wishes and interests. Social workers should take reasonable steps to enhance such clients’ ability to give informed consent.

(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients’ right to refuse service.

(e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.

Case Study

Carolyn is a 42-year-old woman who has been diagnosed with Bipolar disorder, and been working with Ben Synder, a clinical social worker, for the past 5 years. Dr. Snyder has recently become concerned because she is seeing signs of disorganization that she feels may be indicative of a returning mania. She expresses concerns to Carolyn, who states that she is “fine” and that her problem is that work is simply quite stressful.

Ben Synder remains concerned, thinking that Carolyn is minimizing. She phones Carolyn’s brother and her psychiatrist. All of them decide that Carolyn needs to increase her medications, and her psychiatrist Dr. Karlin writes a prescription for a larger dose of Lithium at the next visit. Ben is relieved to see that Carolyn’s behavior improves.

Root Cause Analysis

What happened

A medication change was made without a client’s knowledge

Why did it happen
Ben. Synder/Dr. Karlin did not fully assess a client’s decisional capacity and Dr. Karlin did not provide informed consent about the recommended medication change.

What to do to prevent it happening again

The therapist will consult with the client about her medication suggestions and the psychiatrist will do the same. In addition to providing informed consent, it is unclear from the description whether

Discussion

The NASW Code of Ethics that is relevant for this situation is:

Standard 1.03 Informed Consent

a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services

Standard 1.07

b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

HIPAA (Health Insurance Portability and Accountability Act)

Providers should also be aware of Federal statutes contained in the Health Insurance Portability and Accountability Act (HIPAA). Part One of this material discussed HIPAA in detail; this discussion is meant to provide a summary of the main provisions of HIPAA. Providers are also encouraged to read about HIPAA in more detail. Among treating professionals, people in the mental health fields have been the least effected by HIPAA due to the already strict ethical provisions regarding confidentiality and informed consent. It is still important to be familiar with HIPAA’s main components.

The U.S. Department of Health and Human Services has exhaustive reference material available on their website ce4less.com ce4less.com ce4less.com ce4less.com ce4less.com
(http://www.hhs.gov/ocr/privacy/index.html). In addition to being familiar with HIPAA guidelines, it is also important to note that California laws on confidentiality of therapy disclosures as well as patient recordkeeping are among the most stringent in the nation, and most will not need to make major changes with regard to existing procedures. The Ethical guidelines of the professions have also been well thought out, and contain information specific to the electronic transmission of health information, a major component of HIPAA laws. For a practitioner’s response, please see Yang & Kombarakaran (2006)

If you are an individual mental health provider or work for a hospital, health plan or health care clearinghouse that transmits information electronically you are affected by HIPAA. HIPAA provisions call these individuals or institutions “covered entities.” If you are not currently a covered entity it is still important to be familiar with HIPAA as its scope is expected to broaden in the future.

HIPAA has several components:

- **Portability standards** that ensure the continuity of healthcare
- **Privacy standards** that govern the disclosure of protected health information
- **Security standards** that protect the development and maintenance of health information

HIPAA was established to protect the privacy of protected health information (PHI). Broadly defined, protected health information is any information about health status, provision of health care, or payment for health care that can be connected to a person.

The HIPAA Privacy Rule creates national standards to protect individuals’ medical records and other personal health information.

- It sets boundaries on the use and release of health records.
- It gives patients the right to examine and obtain a copy of their health records and to request corrections if data is incorrect.

The Privacy Rule requires activities, such as:

- Notifying clients about their privacy rights and how their information can be used. Providers are required to notify clients about Privacy Practices during their first session (notice of privacy practices).
• Adopting and implementing privacy procedures

• Securing client records containing individually identifiable health information so that they are not readily available to those who do not need them

**Case Study**

Kelly, a registered nurse, is seeking counseling due to substance use issues. She is referred to her Employee Assistance Program (EAP), who engages the services Josh Vindrihan. Josh is surprised to see that the EAP requires that he fax them psychotherapy notes with an updated treatment plan at the conclusion of each session, but is told that this is required for payment. Josh assumes that the information is confidential, and will only be shared with the EAP.

Josh is shocked when he receives a call from an irate Kelly, informing him that she has been terminated from her job due to her treatment prognosis. She states that in her termination meeting her supervisor quoted information that she had considered to be private therapy disclosures. Kelly states that she will be reporting her concerns to the ethical board and likely seeking legal action.

1) What happened

Confidential patient information was provided to a third party without advance knowledge of the client.

2) Why did it happen

The therapist did not provide informed consent with regard to third party disclosures.

3) What to do to prevent it happening again

Discuss concerns with the EAP and be aware of how information will be used.

**Discussion**

The NASW Code of Ethics includes the following sections that are relevant to this situation.

1.03 *Informed Consent*

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed
Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients’ right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

1.07 Privacy and Confidentiality

Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed. Information germane to the purpose for which the communication is made.

Although this is a difficult case, as Josh clearly needed to be paid for his services, he was unaware of how his psychotherapy notes were being used. It is important to assess in advance of treatment what information third parties will require and how these will be used. Standard 4.04 would suggest that only limited information be provided to third parties in situations where there is concern by the treatment professional.

Confidentiality

In looking at medical errors, it is also important to consider the ethical mandate to maintain client confidentiality. Clients have the right to expect that disclosures made as part of the therapeutic process remain private. Kenneth Pope’s review of malpractice claims also found breach of confidentiality to be a leading cause of litigation. This is particularly concerning as confidentiality is central to developing a trusting and productive therapeutic relationship. Other authors have also discussed the importance of patient confidentiality with regard to prevention of medical errors (Bond, 2011; Brendel, McGowan, 2012; Wei, Schouten & Edersheim, 2010; Welfel, 2012; Knapp and Vandecreek, 2012;). For a discussion of confidentiality in adolescent clients see Hardoff (2012).
Violations of confidentiality are a common medical error. It is the clinician's responsibility to define the degree of confidentiality that can be promised. Limits to client confidentiality include harm to self or others, legal requirements in cases involving child or elder abuse and threats to others, and disclosures court ordered as part of a legal proceeding. There are also specific limits based on treatment setting, such as working as a member of a treatment team, other coordination of care issues, insurance reviews, or supervisory situations. Generally speaking, it is helpful to have clients sign a written statement that includes information about limits to confidentiality. A client should understand in advance the circumstances under which the mental health professional is required to disclose information.

With the exception of the conditions listed above, a provider cannot release a client's mental health records unless the client has provided a valid written, signed, specific, and time-limited authorization allowing the clinician to do so. According to ethical standard 1.07(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

Minors have more limited rights in terms of confidentiality. Parents have the right to examine treatment records. Clinicians can request that parents give up this right or provide only general information.

With many clients paying for services using health insurance or EAP benefits, it is also advisable for clinicians to discuss specific third party requirements. These requirements can range from the need to share the dates of therapy and client diagnosis to more comprehensive clinical information. Some EAP organizations, for example, review clinician progress notes. Again, it is important to discuss these issues at the outset of therapy.

The term *privilege* is related to but not synonymous with confidentiality. Privilege refers to the right to withhold information from a court. Although the scope of privilege laws varies statewide, all states have laws that govern clinician/client communications. Privilege exists for the benefit of the client and belongs to the client.

Given the various issues related to confidentiality, it is helpful to review Fisher’s (2012) model. This model is comprehensive and is an excellent summation of issues related to confidentiality. Fisher’s model has several components. The first is for the mental health professional to *prepare* for confidentiality concerns. This includes understanding clients’ rights and their ethical responsibilities, learning the laws that affect their abilities to protect
confidential information, clarifying personal ethical positions about confidentiality and its legal limits, devising informed consent forms, and being prepared to discuss confidentiality in understandable language. Step two is the actual informed consent process, which involves informing clients about limits on confidentiality and roles or potential conflicts of interest that might affect confidentiality. The third component of Fisher’s plan is obtain informed consent to disclose voluntarily when disclosures are required, disclosing without client consent only if legally unavoidable, informing clients adequately about content and implications of potential disclosures, and obtaining and documenting client consent before disclosing. Fisher also discusses responding ethically to legally-imposed disclosure situations. This involves notifying clients of pending legal requirements for a disclosure and limiting disclosure of confidential information to the extent legally possible. Lastly Fisher cautions providers to avoid the “avoidable” breaches of confidentiality, such as those that occur through poorly trained staff and record keeping practices.

**Case Study**

Manny Wright had been seeing Fred and Wanda for couples counseling for about a month when Wanda brought up the topic of sexual intimacy. Fred had been adopted as a child by a couple who raised him to believe that physical intimacy was wrong not only outside the bonds of matrimony, but inside as well.

Manny worked individually with Fred, teaching him some relaxation techniques to help Fred overcome the anxiety he experienced when even contemplating sexually intimacy. Fred and Wanda became comfortable with a program of successive approximations of intimacy and they were soon regularly consummating their marriage.

Fred next reported that Wanda expressed a wish to become more varied in their lovemaking routine. Manny then introduced Fred to the Indian book, Kama Sutra that described different sexual positions Fred and Wanda might try. As Fred was much too shy to attempt any of the sexual positions in the office with Wanda, Manny had Fred practice on a 6-foot tall Barney doll. Manny captured pictures or video on his iPhone and then wirelessly transferred these images to Fred’s iPhone so he would have them for a reference at home.

All was well until Manny’s iPhone was stolen. One week later he received a panicked phone call from Fred who had been alerted by friends who had seen his video with Barney on YouTube. Fred later received a letter from his parents who said that they were very disappointed and that they had raised him different than that.
Root Cause Analysis

1) What happened

Confidential patient information was made public.

2) Why did it happen

The therapist did not protect confidential patient information. The fact that the information was recorded made the need for confidentiality especially important.

3) What to do to prevent it happening again

Store confidential client information in a place that is not accessible to others.

Discussion

The NASW Code of Ethics includes the following sections that are relevant to this situation.

*Standard 1.07 Privacy and Confidentiality*

(I) Social workers should protect the confidentiality of clients’ written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients’ records are stored in a secure location and that clients’ records are not available to others who are not authorized to have access.

Case Study

Taylor Janning is a clinical social worker specializing in treating sexual addiction. She has been working with Melvin Brown, a high school principal, for the past year. Melvin has a history of sexual inappropriateness, and she is concerned when he discloses in session that he has been “sexting” with Melanie, a younger teacher at the school. They discuss the fact that Melvin could find himself in a compromising position should this behavior continue. Melvin works hard to stop, and is able to discontinue the sexting.

Unfortunately, Melanie has not deleted the compromising photos from her cell phone, and when one Melanie’s students gets a look at her phone, rumors begin to fly, and Melvin finds himself on the front page of the local newspaper with the headline “High School Principal Sexting Scandal.” An enterprising
reporter discovers that Melvin has been in counseling, and calls Taylor for a statement.

Taylor is very upset, and without thinking, defends Melvin, stating that he has worked very hard on his sexual addiction, but that relapse occurs even in the best of circumstances. She tells the reporter that Melvin’s prognosis is excellent, however, and that he has come a long way in treatment. Melvin is fired from his position, and the school board goes so far as to quote Taylor’s statement, saying that Melvin could relapse at any time. They imply that students could be at risk.

Root Cause Analysis

1) What happened

Confidential patient information was made public.

2) Why did it happen

The therapist did not protect confidential patient information. Even though the therapist was attempting to protect the client, she should not have revealed information without his consent.

3) What to do to prevent it happening again

Obtain consent prior to intervening

Discussion

The NASW Code of Ethics includes the following sections that are relevant to this situation.

Standard 1.07 Privacy and Confidentiality

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media.

Case Study
Michael Hoffman is a practicing social worker, and also an adjunct professor at a local community college, teaching a course on abnormal psychology. He begins working with a new client, who has OCD. The client is a high-powered executive at a local financial services firm. The client, Jim, is struggling with obsessions regarding inanimate objects, believing that they have feelings. He continues to hold on to objects from his childhood, including Jim-Jim, a jester marionette, who he sings to sleep every night. He cannot sleep until he has sung Jim-Jim Rockabye Baby exactly 15 times. Jim also keeps a photo of Jim-Jim in his top desk drawer.

Michael is teaching a unit on OCD, and knows that this would be the perfect story to illustrate the symptoms of OCD. He shares the story with his class. One of his students’ husbands, Carl, works for the local Merrill Lynch office, and she shares the story with him. Carl is struck by the coincidences and sneaks into Jim’s office. He finds a picture of Jim-Jim in Jim’s top drawer.

Jim arrives to the office that day, and is serenaded by a rousing chorus of Rockabye Baby.

Root Cause Analysis

1) What happened

   Confidential patient information was made public.

2) Why did it happen

   The therapist did not protect confidential patient information

3) What to do to prevent it happening again

   Ensure that case material used in teaching does not contain any identifying information

Discussion

   The NASW Code of Ethics includes the following sections that are relevant to this situation:

   Standard 1.07 Privacy and Confidentiality
Mandatory Abuse Reporting

Another serious medical error involves failing to report suspected abuse. Professionals working with children under the age of 18 are considered mandated reporters. This means that they are required to report suspected child abuse. All states have passed some form of mandatory child abuse and neglect reporting law in order to qualify for funding under the Child Abuse Prevention and Treatment Act (CAPTA). The laws pertain to mental health providers working in private practice and institutional settings (NASW General Council, 2013, Korbin & Krugman, 2013).

Mandatory abuse reporting is discussed fully in the first section of this training material. The following summarizes some important points:

- California Penal Code, Sections 11164-11166, which pertains to child abuse, requires that mandated reporters, make a report of child abuse whenever a "reasonable suspicion" of abuse exists. An abuse report is required whenever a mental health provider learns about the abuse in his or her professional capacity.

  Types of child abuse covered under this statute include:
  - Physical abuse/Injury
  - Sexual abuse
  - Neglect
  - Willful cruelty
  - Unjustifiable punishment/ unlawful, corporal punishment

- Current law authorizes but does not require the reporting of instances where a child suffers, or is at substantial risk of suffering, serious emotional injury.

- Sections 15610, 15630-15634 of the California Welfare and Institution Code, which pertain to elder abuse, require that mandated professionals report elder physical abuse, abandonment, isolation, financial abuse, or neglect of any elder or dependent. An “elder” is a person over age 65 who resides in the state of California. A “vulnerable elder” is one whose
physical or mental health puts him or her at increased risk of abuse.

- The term “good faith” refers to the assumption that the reporter, to the best of his or her knowledge, had reason to believe that the child in question was being subjected to abuse or neglect. Even if the allegations made in the report cannot be fully substantiated, the reporter is still provided with immunity. There is a “presumption of good faith” in California.

While reporting of child abuse does raise some ethical concerns with regard to confidentiality, our ethical codes. However, confidentiality is not an absolute. Clinicians should discuss the exceptions to confidentiality during the initial meeting, and as needed to allow for informed consent. In the clinician’s role as a mandated reporter, by reporting child/elder abuse the provider is helping to prevent harm to another person.

**Case Study**

Mandy is a 15 year-old girl who came to Tori Halloway for an evaluation at the request of her probation officer. Mandy had been ticketed a number of times for running away from home, curfew violations, and a minor in possession charge. Mandy was dressed in baggy black clothing with short dyed black hair and black makeup. She was dramatic in appearance and speech. Tori notices cuts on Mandy’s arms, which Mandy says are from her pet cat.

Mandy lives with her mother and step-father who are her primary custodians. During the interview, Mandy states that her step-father frequently gets drunk and makes sexual advances towards her. She states that he has recently been trying to fondle her. According to Mandy, this happens while her mother (who is a nurse) is working a night shift. Mandy initially reported that her step-father supplied her with the vodka she and her boyfriend were caught with that resulted in her minor in possession charge. Later in the interview she stated that they stole the vodka from her boyfriend’s parents.

When asked about Mandy’s accusation, her mother reports that Mandy has always hated her step-father and would do anything to break them up. Her mother explains that Mandy’s step-father holds Mandy accountable for her behavior and expects her to help with household chores and to be respectful to adults. She goes on to state that Mandy wants to live full time with her father who has no rules, allows her to drink, and she is able to be with her boyfriend or talk to him whenever she wants.

Tori decides that Mandy is attention seeking and recommends family counseling and drug and alcohol treatment for Mandy. During the next week,
Mandy’s stepfather becomes drunk and tries to fondle her sexually while making sexually explicit statements. Prior to entering Mandy’s room, she was on the computer talking to her boyfriend. The boyfriend was able to record the stepfather’s words and actions, which were recorded by the Webcam on Mandy’s computer. The boyfriend called 911 and the police arrested the stepfather.

1) What happened

A client reported sexual abuse to a therapist who did not report the accusation.

2) Why did it happen

The therapist did not believe that the client was telling the truth so she did not make a report.

3) What to do to prevent it happening again

If there are signs that the abuse may be occurring, it is safer to make a “good faith” report rather than to risk harm to the child.

Discussion

The NASW Code of Ethics includes the following sections that are relevant to this situation:

1.07 Privacy and Confidentiality

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social
workers disclose confidential information on the basis of a legal requirement or client consent.

Duty to Protect

A topic that is related to abuse reporting is “Duty to Warn” or “Duty to Protect”. “Duty to protect” laws require mental health providers to secure help for potential victims when a client discloses violent intentions. Please see part one of this training material for information on the Duty to Protect laws. For further information, you may also see Soulier, Maislen & Beck (2010), Shat et al. (2013), Werth et al. (2008) and Sehiralti (2012).

There is variability in the interpretation of duty to warn cases, it is important for clinicians to be familiar with local laws (Simone & Fulero, 2005). As with many of the errors previously discussed, there is often a question of when to warn. Within the scope of therapy, many express ill intentions towards another, and these often remain a fantasy. Good clinical judgment is the provider’s most valuable tool in deciding when to make such a report. The mental health provider should always use the phrase “clear and imminent danger” as a guideline. Fox (2010) cautions that the threshold for the duty to warn or protect often rests beside the criteria permitting an exception to confidentiality, placing mental health professionals in tenuous positions.

Responding to Suicidal Risk

Of all the medical errors discussed in this paper, one of the most serious is the failure to properly identify a client’s risk of suicide. Suicide was the 10th leading cause of death for all ages (CDC, 2010). In addition to completed suicide, there were approximately 535,000 visits to emergency departments in the United States due to self-inflicted injuries (McCaig et al., 2006). Suicide was among the sentinel events referenced by JCAHO. For an in-depth discussion of contemporary challenges, please see Jacobson et al., (2012), Jobes (2006/2008) and Stellerecht, Joiner & Rudd (2006).

Just how prevalent are suicide attempts? The latest data available from the Centers for Disease Control and Prevention (2010) indicates that 38,364 suicide deaths were reported in the U.S. in 2010. Nationally, the suicide rate increased 3.9 percent over 2009 to equal approximately 12.4 suicides per 100,000 people. The rate of suicide has been steadily increasing since 2000. Suicide rates among those 35 to 64 years old increased 28 percent (32 percent
The greatest increases in suicide rates were among people aged 50 to 54 years (48 percent) and 55 to 59 years (49 percent).

Another important factor is the connection between mental illness and suicide. Ninety percent of people who die by suicide have a diagnosable and treatable psychiatric disorder at the time of their death. Psychiatric co-morbidity increases risk for suicide, especially when substance abuse or depressive symptoms coexist with another psychiatric disorder or condition.

Consider these key facts:

- Suicide claims more than twice as many lives each year as does homicide (Centers for Disease Control and Prevention, 2009)

- On average, between 2001 and 2009, more than 33,000 Americans died each year as a result of suicide, which is more than 1 person every 15 minutes (Centers for Disease Control and Prevention, 2009)

- More than 8 million adults report having serious thoughts of suicide in the past year, 2.5 million report making a suicide plan in the past year, and 1.1 million report a suicide attempt in the past year ((Centers for Disease Control and Prevention, 2009)

- Almost 16 percent of students in grades 9 to 12 report having seriously considered suicide, and 7.8 percent report having attempted suicide one or more times in the past 12 months (U.S. Public Health Service, 2012).

There are ethnic and racial differences in suicide prevalence rates as shown by the following table:

<table>
<thead>
<tr>
<th>Race</th>
<th>Number of Suicides</th>
<th>Population</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>White (Not Hispanic)</td>
<td>32,010</td>
<td>200,127,372</td>
<td>16.0</td>
</tr>
<tr>
<td>Black or African American</td>
<td>2,091</td>
<td>39,437,133</td>
<td>5.3</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2,661</td>
<td>50,477,594</td>
<td>5.3</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>1,017</td>
<td>16,133,872</td>
<td>6.3</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>444</td>
<td>2,569,567</td>
<td>17.3</td>
</tr>
</tbody>
</table>

_Suicide Figures from the Centers for Disease Control for the year 2010. All rates are per 100,000 population._

_Progression of Suicidal Ideation_
Often there is a transition that takes place along the continuum from ideation to plan to attempts. 34% of individuals who think about suicide report transitioning from seriously thinking about suicide to making a plan, and 72% of planners move from a plan to an attempt. Among those who make attempts, 60% of planned attempts occur within the first year of ideation onset and 90% of unplanned attempts (which probably represent impulsive self-injurious behaviors) occur within this time period (Kessler, et al., 1999).

Given the seriousness of this issue, it is important that mental health professionals be aware of how to appropriately assess and respond to suicide risk. Despite the fact that this is not an uncommon matter for clinicians, Pope and Vasquez (2007) state that this is a source of “extraordinary stress” for many treatment providers. They make a number of recommendations for clinicians. These include screening all clients for suicide risk during the first contact and throughout therapy, ensuring that suicidal clients do not have easy access to means that they may use to commit suicide, increasing sources of support for suicidal clients, working with the client’s strengths and desire to live, communicating hope, using contracts when appropriate, exploring fantasies regarding suicide, hospitalizing clients only after considering drawbacks as well as benefits and communicating caring.

**Risk Factors for Suicide**

There are a number of factors that may increase risk or been found to be statistically related to the presence of suicidal behaviors. They do not necessarily impart a causal relationship, but rather they serve as guidelines for the clinician to weigh the relative risk of an individual engaging in suicidal behaviors. In assessing for suicide risk, treatment providers may wish to consider the following factors from the National Strategy for Suicide Prevention: Goals and Objectives for Action (2001):

**Biopsychosocial Risk Factors**
- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

**Environmental Risk Factors**
• Job or financial loss
• Relational or social loss
• Easy access to lethal means
• Local clusters of suicide that have a contagious influence

**Social/cultural Risk Factors**
• Lack of social support and sense of isolation
• Stigma associated with help-seeking behavior
• Barriers to accessing health care, especially mental health and substance abuse treatment
• Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
• Exposure to, including through the media, and influence of others who have died by suicide

**Intervention**

Too often mental health professionals do not assess for suicidal ideation or avoid asking direct questions about suicide for fear of “putting ideas” in client’s heads. Some important steps are outlined below.

1) Ask the questions about suicidal ideation, intent, plan, and attempts. These questions can include: Are you feeling hopeless about the present or future? Have you had thoughts about taking your life? When did you have these thoughts and do you have a plan to take your life? Have you ever had a suicide attempt?

2) Engage in crisis intervention and management efforts that restore the individual to a state of feeling in control in a safe, secure, and stable environment. This may include securing any lethal methods of self-harm, decreasing isolation, decreasing anxiety and agitation (such as through medication) and engaging the individual in a safety plan. Hospitalization may be necessary.

**Case Study**

_Dawn McClean had been treating Vincent for 6 months for severe depression following a hospitalization for overdose on prescription painkillers and alcohol. Therapy to this point had focused on Vincent’s family of origin, especially the physical abuse by his schizophrenic, alcoholic parents. Memories of his parent’s double suicide had been rekindled after Vincent’s best friend had killed himself 2 weeks before._
The previous week, Dawn felt very uncomfortable in the session because Vincent was so down, making comments about feeling worthless and not even wanting to go to the local NRA meet and greet even though he had been an active member for the past 10 years and was on the board of directors.

This week Dawn was pleased to note a dramatic change in Vincent’s outlook on life. Where last week Vincent had been despondent and sad, this week he seemed much more calm and composed. He even brought Dawn a Smith and Wesson 44 magnum pistol, just like Dirty Harry used. Dawn took this as a good sign – Dawn had mentioned earlier in passing that she was a Clint Eastwood fan and that he had always wanted a 44 magnum. Dawn would simply take the value of the pistol off of Vincent’s bill. The ethics code didn’t prohibit bartering, and besides, Vincent said he had plenty of other pistols.

Vincent also reported success on other tasks. Dawn had been working with him to become more engaged socially and to not utilize procrastination and avoidance. This past week Vincent stated that he had been busy visiting or calling people, tying up loose ends and “making things right” He had even met with his lawyer to update his will.

Dawn’s transcriptionist, a social work student, recognizes Vincent’s warning signs of suicide. She calls the police who arrive to find Vincent intoxicated and preparing to shoot himself with one of his many loaded weapons.

1) What happened

Dawn did not recognize the warning signs of suicide in a patient.

2) Why did it happen

Dawn misperceived his client’s symptoms, interpreting them as signs that his client was making progress.

3) What to do to prevent it happening again

Dawn must educate herself on the warning signs of suicide.

Because the consequences of suicidal ideation can be so severe, every therapist should be thoroughly familiar with the signs and symptoms of suicide.

Failure to Detect Medical Conditions
Another frequently cited medical error is a mental health provider's failure to diagnose medical illness when psychological symptoms are associated with this condition. These disorders are typified by the presence of mental symptoms that are the consequences of an underlying medical condition (Chaung, 2006). Despite the inclusion of these criteria in the DSM, study of medical illness is not covered in many psychology, counseling or social work programs.

Both research and clinical experience support the view that unrecognized medical illnesses in mental health, as well as in primary care, treatment settings can directly cause or exacerbate a patient's presenting psychological symptoms. Grace and Christansen (2007) conducted a study of 24 psychiatrists, 20 primary care physicians, 31 psychologists, and 17 social workers. They were asked to complete a questionnaire designed to measure the respondents' knowledge of masked medical illness. The questionnaire consisted of 10 different clinical vignettes in which a patient is seeking treatment for psychological problems that are due to a hidden medical illness. Study findings suggested that mental health providers were at increased risk of not recognizing masked medical illnesses in their patients. On the basis of these findings, the authors proposed collaborative and educational approaches to minimize this risk and improve patient care are described.

In his definitive text, When Psychological Problems Mask Medical Disorders: A Guide for Psychotherapists, James Morrison (1999) lists 60 medical illnesses that may result in psychological symptoms. Such symptoms include, but are not limited to, depression, anxiety, dementia, perceptual changes (e.g., hallucinations), depersonalization, personality changes, and emotional labiality. Clearly these symptoms may also be the result of a mental disorder. Another author to discuss this issue is Hersen (2004).

Morrison (1999) suggests that clinicians screen for possible medical illness during the initial assessment and beyond, but notes that it may be difficult for mental health clinicians to diagnose physical illnesses. Symptoms of disease may be gradual at first and many clients have consulted medical doctors, and testing has been inconclusive. Morrison (1999) notes that it is easier to detect a medical issue in an existing client that presents with a personality or behavior change, as clinicians can compare these symptoms to a prior baseline. He also suggests that clinicians remain vigilant when clients discuss new physical symptoms, symptoms that don’t fit the working diagnosis or when a client has symptoms that don’t resolve despite appropriate treatment. Morrison (1999) cites several “sources of error,” such as clinicians’ tendencies to focus only on what they know best or to seek a “comfortable” diagnosis.
How can mental health professionals screen for medical disorders? In her discussion of mental disorders secondary to general medical conditions, Chaung (2006) provides a helpful list of features that suggest a medical origin to psychiatric symptoms:

- Late onset of initial presentation
- Known underlying medical condition
- Atypical presentation of a specific psychiatric diagnosis
- Absence of personal and family history of psychiatric illnesses
- Illicit substance use
- Medication use
- Treatment resistance or unusual response to treatment
- Sudden onset of mental symptoms
- Abnormal vital signs
- Waxing and waning mental status

Chaung (2006) also provides a comprehensive listing of medical conditions that result in psychological symptoms. She divides these categories that are helpful in thinking about this topic. These include symptoms that are a result of medical and toxic effects (e.g., alcohol or drug related mental symptoms), diseases of the central nervous system (e.g., tumors, multiple sclerosis, normal pressure hydrocephalus), infectious diseases (e.g., HIV, pneumonia), metabolic and endocrine disorders (e.g., thyroid disorder, hypo/hyperglycemia), cardiopulmonary disease (e.g., myocardial infarction, congestive heart failure) and another category (e.g., systemic lupus, anemia).

Clearly it is impossible for clinicians to be familiar with every medical condition that may result in psychological symptoms, and a workup with a medical provider is a good rule of thumb for new clients.

It is also helpful to be aware that some medical conditions may result in increased risk for suicide including diseases of the central nervous system (epilepsy, tumors, Huntington’s Chorea, Alzheimer’s Disease, Multiple Sclerosis, spinal cord injuries, and traumatic brain injury), cancers (esp. head and neck), autoimmune diseases, renal disease, and HIV/AIDS. Chronic pain syndromes can contribute substantially to increased suicide risk.

Clinicians should consult with medical doctors when needed to appropriately assess or rule out physical illness.

Case Study
Joe is a 72 year-old man who had been in therapy with David Wepfer for about a month dealing with estrangement from his children. Since age 18, Joe abused alcohol and he experiences great guilt over beating his children when he would come home drunk.

At the beginning of his fifth session, Joe stated that he had a rough week. He reported that he was looking through an old photo album of pictures of his children when suddenly his right arm went numb. He also felt dizzy and had a severe headache. Joe seemed confused and had difficulty finding the right words to speak.

David explained to Joe that he was suffering from conversion disorder and that he obviously had lost the use of the arm that he used to spank his children. Joe mumbled his appreciation and tried to exit through a closet David guided him to the elevator. David later learned that a cabbie drove Joe to the emergency room where he was treated for a stroke.

1) What happened

David’s patient had a stroke and David misdiagnosed the symptoms told him.

2) Why did it happen

David did not recognize that his patient was describing stroke symptoms and attributed the symptoms to a psychological disorder.

3) What to do to prevent it happening again

David will complete continuing education regarding common medical problems which may present with psychological symptoms.

Discussion

The NASW Code of Ethics that is relevant for this situation is:

1.04 Competence

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.
It is unreasonable to expect that therapists will be able to recognize and appropriately diagnose all medical conditions. However, mental health practitioners should be familiar with the major chronic medical conditions and their impact on mental health (Kolbasovsky, 2008). Ideally, the client will sign a release so care can be coordinated between the therapist and the client’s physician. Then, the therapist can consult with, and refer any medical concerns to the physician.

Assessment

Faulty Differential Diagnosis

Closely related to the issue of inaccurately identifying a medical condition is that of faulty differential diagnosis. There are a number of benefits of accurate differential diagnosis. According to Coolidge and Segal (2001), there are a number of benefits of accurate differential diagnosis. First, accurate differential diagnosis facilitates communication among professionals, and provides a common language. For example, if an inpatient hospital refers a patient who has paranoid schizophrenia, most mental health professionals will recognize that delusions and anger are part of the symptom picture. Accurate differential diagnosis will also help professionals to better organize their diagnostic thinking, such as allowing them to accurately probe for symptoms. Third, it presents an interface with the legal arena, especially in cases where issues of competency may be called into question. Forth, accurate differential diagnosis helps facilitate appropriate treatment, such as influencing the type of medication or therapy that may be needed. This would lead to use of empirically supported treatment approaches. A fifth benefit of accurate differential diagnosis is that it helps clinicians bill for and receive payments by third-party payers.

Accurate differential diagnosis requires that clinicians have good working knowledge of DSM diagnoses, and be able to identify whether a patient meets the diagnostic threshold for the illness. The DSM-5 has a number of decision trees and flow charts that help with accurate differential diagnosis for disorders including mental disorders due to a general medical condition, substance induced disorders, psychotic disorders, mood disorders, anxiety disorders, and somatoform disorders.

Thus said, although most clinicians know the diagnostic criteria for many mental disorders, it is always helpful to review these. It may be helpful to have a working hypothesis, rather than formulating an opinion prematurely. Aklin and Turner (2006) point out the high rates of misdiagnosis due to inadequate use of diagnostic criteria.
The tendency towards misdiagnosis may be higher among ethnic minority groups. As mentioned in the section of this training material on multicultural competence, this may lead to inappropriate treatment interventions. In 2001, Surgeon General David Satcher issued the report *Race, Culture, and Ethnicity and Mental Health* in which he documented disparities in access and treatment that leave minority individuals untreated or improperly treated. Aklin and Turner (2006) follow up on this disparity, and also cite a number of studies that demonstrate proportionally more ethnic minorities than Caucasians are likely to be misdiagnosed when assessed for psychiatric disorders. This is especially true when open clinical interviews are used. Semi-structured interviews, on the other hand, result in an increase in diagnostic accuracy with ethnic minorities.

For clinicians assessing ethnically diverse clients, it is important to be aware of the many characteristics that may lead to inappropriate diagnosis. These characteristics include but are not limited to lack of comfort with mental health assessment and treatments, discomfort with a racially/ethically different examiner, previous experiences with stigma and judgment, and lack of financial resources to pursue treatment. These realities may actually result in faulty diagnosis, a medical error.

**Case Study**

*Rosanne Carmichael is a social work intern working in a large mental health clinic. As part of her current rotation she is assigned the task of assessing Towanda, a 21-year-old African American mother of two children. Towanda tells her that she is mandated to seek counseling as part of the community housing program she is applying for, a program that provides housing for women in recovery from substance abuse and their children. Towanda states that she really needs the housing, and hopes that Rosanne will approve her for this.*

*Although Rosanne tells her that she is only completing the assessment to assign her to the right therapist, and not to recommend housing, Towanda states that she knows “the truth here.” Towanda responds to questions evasively, or with one-word answers. When asked about her motivation for treatment, Towanda answers in a confrontational tone that she “doesn’t see how talking to an uppity doctor will help,” and asks why Rosanne is taking so many notes and who she is reporting their conversation to.*

*Rosanne notes the body language Towanda displays, her reticence to answer questions and symptoms of “paranoia,” anger, and emotional distance, and diagnoses Towanda with likely paranoid schizophrenia. She refers Towanda to a therapist and for a medication consultation.*
1) What happened

   Rosanne inappropriately assessed Towanda.

2) Why did it happen

   Rosanne misdiagnosed Towanda due to lack of multicultural competence and experience with diverse populations.

3) What to do to prevent it happening again

   Rosanne needs appropriate supervision and will also need experience working with People of Color.

Discussion

The NASW Code of Ethics that is relevant for this situation is:

   1.05 Cultural Competence and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

Over Diagnosing

   In addition to the concerns listed above, many clinicians are aware of the tendency to over diagnosis. This may be due to thresholds that are too low. There is also concern about so-called “diagnostic trends.” Although systematic study is needed, the idea that diagnostic trends, which often do not match the
It is important that treatment professionals complete a comprehensive differential. As many of these diagnoses are pediatric diagnoses, it is also important that assessors have experience with a given population, be it children, older adults, etc. in order to make an accurate diagnosis and assess treatment needs.

Case Study

Tom Collins, a newer social worker, is working with the Keller family. The family is presenting for support due to the recent difficulties they are having with their 5-year-old son Adian. Since he has started kindergarten, Adian has been throwing temper tantrums, and has been irritable. He does not follow the rules the family establishes and often seems upset and out of sorts.

In session, Tom witnesses one of Adian’s outbursts. He is unprepared for just how intense the crying is, shocked at the amount of time it takes to soothe him. This reminds him of the outbursts he has seen in the past from manic patients. Tom has been reading about pediatric bipolar disorder, and feels that Adian may have this. He tells the Kellers that a child psychiatrist should assess Adian, but that it is likely that he is bipolar and needs medication.

1) What happened

Tom inappropriately assessed Adian.

2) Why did it happen

Tom did not have enough experience with this age group and settled on a “trendy” diagnosis.

3) What to do to prevent it happening again

Tom needs to practice within his area of competence

Discussion

The NASW Code of Ethics that is relevant for this situation is:
1.04 Competence

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

Termination of Treatment/Financial Aspects

One of the most challenging aspects of treatment relate the financial aspects of providing therapy services. It is also the basis of medical errors. Conflicts over billing, payment for services, and collections, are common catalysts for triggering a Board complaint or malpractice suit. Some ethical provisions related to payment for services include:

1.13 Payment for Services

(a) When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients’ ability to pay.

(c) Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.

It is ethical to terminate treatment due to a lack of payment of fees (see Treloar, 2010). Many circumstances affect a client’s ability to pay, include a change in or loss of insurance coverage, or a patient not paying while continuing to come for treatment. While termination is acceptable, it must still be done properly. Termination should never occur while the client is in a state of crisis, and subsequent sessions should focus on stabilization and referral. Additionally it is sensible to avoid the problem in the first place by clearly outlining fees and fee collection procedures during the informed consent process. Use of collection agencies is permissible, however, clients should be given reasonable opportunities to pay balances and billing companies should be given minimal client information.
The following case illustrates some of the complexities of the financial aspects of treatment.

**Case Study**

Kevin O’Neill, a clinical social worker, has been working with Vera Kane, a client with a history of severe trauma. Kevin and Vera initially met while Vera was psychiatrically hospitalized. Kevin is not part of Vera’s insurance panel, and agrees to see her on a sliding scale basis. Despite Kevin’s generosity, after working together for several months, Vera begins to accrue a hefty bill, which she promises to pay as soon as she can. She has frequent excuses that tug on his heartstrings, and she brings Kevin little gifts, such as cookies and cards saying that he is “the best therapist ever.” There is little progress on paying down her bill however, and it continued to accrue.

Kevin was surprised when Vera arrived to the next session wearing a Black Eyed Peas T-shirt, and describing how she and a friend had an awesome weekend away. The two flew to a concert in Chicago, stayed in a hotel, andpartied the weekend away. When Kevin starts to calculate how much the weekend cost her, he becomes incensed, and confronts Vera. She tearfully agrees that it was quite expensive, but does not seem overly concerned that the money she spent could have paid off some of her therapy balance. Kevin angrily tells her that he can no longer see her, and suggests that she contact her local community mental health center.

Following the termination, Kevin receives several phone calls from Vera, indicating that she is in crisis. He does not return the calls, deciding that Vera is being manipulative and knowing that she can seek crisis services at the mental health center. He is surprised when he receives a phone call from the hospital, stating that Vera has been admitted due to a serious suicide attempt. Kevin states that he is no longer her therapist, and refuses to discuss the situation further.

1) What happened

Kevin was unclear about financial responsibilities and terminated Vera without warning and without facilitating an appropriate referral.

2) Why did it happen

Kevin should offer sliding scale arrangements only when he is clear that the client can afford them, communicate the consequences of unpaid balances and ensure that referrals are clear.
3) What to do to prevent it happening again

Kevin should familiarize himself with the relevant ethical standards related to fee arrangements and termination

Discussion

The NASW Code of Ethics that is relevant for this situation is:

1.13 Payment for Services

(b) Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary.

(c) Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.

Conclusion

To err is human. Although mental health providers are not perfect, it is important to take steps to reduce medical error. These steps include recognizing approaches to prevent medical errors, retrospectively utilizing root cause analysis process to evaluate medical errors when they do occur, being familiar with ethical guidelines related to consent, confidentiality and mandated reporting, maintaining competence through consultation and further education, and being aware of trends in assessment of suicide and medical conditions that may be masked by psychological symptoms.
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Chapter 2


Chapter 3


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