

CALIFORNIA LAW AND PROFESSIONAL ETHICS (6 HOURS)

INSTRUCTORS

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SUMMARY

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LEARNING OBJECTIVES

Upon completion of this course, the learner will be able to:

PART I

1. Discuss the scope of practice for mental health professionals, including ethical codes and legal requirements.
2. Define confidentiality and informed consent.
3. Explain relevant California laws governing professional practice, including laws regarding minors' consent and confidentiality, mandated reporting, and laws governing subpoenas.
4. Explain achieving and maintaining professional competence, including self-assessing for burnout and developing cultural competence.
5. Describe ethical concerns related to dual relationships, termination, and patient abandonment.

PART II

6. Describe the role of the mental health professional in working with domestic violence cases, including advocacy, navigating systems, and safety planning.
7. Discuss ethical and legal issues related to domestic violence.

PART III

8. Discuss the components of HIPAA, including its established ethical and legal requirements.
9. Describe the informed consent procedure, including the Notice of Privacy Practices and patient access to information.

PART IV

10. Identify the types of technology available for telemedicine.
11. Recognize the ethical principles related to the practice of telehealth, including confidentiality and privacy.
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PART V

13. Define patient safety goals and medical errors in behavioral health.
14. Explain how root cause analysis analyzes medical errors.
15. Identify medical errors common in mental health.

INTRODUCTION

Most mental health professionals have a working definition of ethics. With some variations, ethics are codes that mental health associations develop in order to set professional standards for defining appropriate behavior and professional expectations and for protecting clients from harm. Ethics, then, refers to professional rules of conduct, rules that are codified in various ethical codes.

Although this definition is comprehensive, another important aspect of professional codes is the idea that they are enforceable. Take, for example, this paragraph from the elemental American Association for Marriage and Family Therapy's (AAMFT) Code of Ethics:

The AAMFT strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as described in this Code. 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 from consultants, attorneys, supervisors, colleagues, or other appropriate authorities. (AAMFT, 2015)

This statement is a reminder that ethical standards are generally written in broad statements and apply in varied roles and contexts. Ethical standards are not exhaustive, and a standard's failure to specifically address a certain behavior does not mean the conduct is necessarily either ethical or unethical.

Part I of this course, California Law and Ethics, 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 learning material discusses the provision of telehealth. Part V provides an alternative lens through which to look at ethical issues, using the framework of medical errors and root cause analysis.

PART I. CALIFORNIA LAW AND ETHICS

The California Board of Behavioral Sciences document *Statutes and Regulations Relating to the Practices of Professional Clinical Counseling, Marriage and Family Therapy, Educational Psychology, Clinical Social Work* (2022c) begins 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” (p. 18). The statutes are broad in scope and cover a multitude of issues upon which marriage and family therapists, clinical social workers, psychologists, and counselors can make informed judgments and choices concerning their efforts and can address many ethical issues that arise from working with people.

California’s population 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 clinicians are critical.

Continuing education requirements for California mental health professionals contain an ethics requirement that includes 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, 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 learning material. Case studies and “Questions to Consider” will also illuminate key learning concepts. Participants in this course are encouraged to reflect on the questions posed prior to each section before reviewing the material within the segment.

LEARNING OBJECTIVES

Upon completion of this course, the learner will be able to:

1. Discuss scope of practice for mental health professionals, including ethical codes and legal requirements.
2. Define confidentiality and informed consent.
3. Explain relevant California laws governing professional practice, including laws regarding minors’ consent and confidentiality, mandated reporting, and laws governing subpoenas.
4. Explain achieving and maintaining professional competence, including self-assessing for burnout and developing cultural competence.
5. Describe ethical concerns related to dual relationships, termination, and patient abandonment.

SCOPE OF PRACTICE FOR THE PROFESSIONS

According to the American Association for Marriage and Family Therapy, **Marriage and family therapists (MFTs)** “are mental health professionals trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems” (AAMFT, 2022). 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 practice includes relationship and pre-marriage counseling as well as client-centered advocacy efforts.

As of January 1, 2022, the scope of practice for California marriage and family therapists was amended in order to modernize and clarify the profession (California Code 4980.02; BBS, 2022b,c). The changes were to the wording only, not to the scope of practice itself. The new wording can be seen at https://www.bbs.ca.gov/pdf/law_changes_2022/other_law_changes.pdf.

Educational psychologists are mental health professionals 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; and
- (i) coordinating intervention strategies for management of individual crises.

(Board of Behavioral Sciences [BBS], 2022c [Chapter 13.5, Section 4989.14]).

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 Workers (NASW) *Code of Ethics* (2021), 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.” Social work focuses on individual well-being in a social context as well as the well-being of society. “Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living” (NASW, 2021). Clinical social workers provide mental health services for the assessment, prevention, diagnosis, and treatment of mental, behavioral, and emotional disorders in individuals, families, and groups. Their goal is to enhance and maintain their clients’ physical, psychological, and social function.

The core values of social work are

- service;
- social justice;
- dignity and worth of the person;
- importance of human relationships;
- integrity; and
- competence.

(NASW, 2021)

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

Licensed professional clinical counselors (LPCCs) 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. All 50 states license LPCCs (American Counseling Association [ACA], n.d.). In California, LPCCs are among the professionals who can be termed “psychotherapists” (Shouse California Law Group, 2020a).

Content of Statutes and Regulations Relating to the Practices of Professional Clinical Counseling, Marriage and Family Therapy, Educational Psychology, Clinical Social Work

Statutes and Regulations Relating to the Practices of Professional Clinical Counseling, Marriage and Family Therapy, Educational Psychology, Clinical Social Work was developed by the California Board of Behavioral Sciences (BBS; 2022c) 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. This learning material 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. Readers of this learning material are encouraged to become familiar with the *Statutes* as well as with 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. The BBS publishes updates and amendments to laws and regulations at https://www.bbs.ca.gov/about/law_reg.html. Mental health practitioners should check the site periodically to stay current.

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 difference?
- Which ethical and legal standards came into conflict during a recent ethical dilemma?
- Why are ethics important?
- How do ethical problems occur?

Many ethical issues faced by mental health professionals involve legal concerns. 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. As this course proceeds, 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, 2018b).

Professional ethics and state law bind California mental health professionals. Consider the following statement found in the AAMFT *Code of Ethics* (2015):

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.

Boundaries set by both law and ethics codes provide the lenses through which to view 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 the 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.

- People are human and make mistakes.
- Clients misreport.

- Situations can be unpredictable or unforeseen.
- Situations can be foreseen, but there is no way to avoid them.
- Professionals are new or inexperienced.
- Professionals are ignorant to the issue.
- Agency policies can be inadequate.
- Guidelines are not adequate for the situation.

As the list makes clear, some of these reasons are in the provider's control and others are not. 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. The following sections of this document will consider ethical and legal issues related to the practice of marriage and family therapy, social work, counseling, and educational psychology.

Licensure of Mental Health Professionals

Questions to Consider

- Why is licensure important?
- What standards do you believe are important in the licensure of California's mental health professionals?
- What specific coursework and training is necessary for your specialty area?

One important topic discussed in the *Statutes* is that of licensing for mental health professionals. Legal standards pertaining to licensure govern the establishment of a minimum set of requirements involving training and experience 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; must 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 that 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, child development, 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 that also prepares 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 considerations for work with diversity. Applicants licensed after 2004 must have additional coursework in aging and long-term care. In addition, licensure requirements also exist with regard to fieldwork and supervised experience. The Board of Behavioral Sciences offers a handbook for future MFTs that can be found online at https://bbs.ca.gov/pdf/publications/lmft_handbook.pdf. This handbook contains an overview of “the path to licensure,” as well as details concerning licensure requirements (BBS, 2022a).

Educational psychologists must be familiar with the areas discussed previously, including a thorough understanding of academic learning, 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 postgraduate work in pupil personnel services. They must also have two years of full-time, or the equivalent of full-time, experience as a credentialed school psychologist in the public schools. Furthermore, they need to have one year of supervised professional experience in an accredited school psychology program or one extra year of full-time (or the equivalent of full-time) experience as a credentialed school psychologist in the public schools obtained under the direction of a licensed educational psychologist or a licensed psychologist. Applicants must pass an examination specified by the board (BBS, 2022c).

Clinical social work applicants must have knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior. Their practice 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. Details concerning these requirements can be found in Section 4996.2 of the laws and regulations provided by the BBS (2022c, p. 96).

Concerning licensed professional clinical counselors:

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. (California Association for Licensed Professional Clinical Counselors, 2019, quoting the ACA)

For professional counselors whose graduate coursework began after August 1, 2012, or was completed after December 31, 2018, qualification for licensure or registration requires possession of a master's or doctoral degree in counseling or psychotherapy, obtained from an accredited or approved institution. Detailed requirements can be seen in the laws and statutes available through the BBS (2022c), Section 4999.33, starting on page 129. Effective on January 1, 2022, certain requirements for licensure were removed. Professional clinical counselors no longer need at least 150 hours of clinical experience in a hospital or community health setting, although the total number of experience hours has not changed. The requirement for additional specified education, supervised experience, and continuing education in order to treat couples and families has been removed. It is still important, however, for LPCCs to work within their scope of competence (California Code 4980.03; BBS, 2022b,c).

Confidentiality

Questions to Consider

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

Case Example

John, a 16-year-old high school junior has been in treatment with clinical social worker Sandra Connell for the past year. Sandra has become increasingly concerned by John's 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, given the seriousness of the situation, it is a legal and ethical mandate that she get him help. John is very resistant and storms out of the office when Sandra tells him that she will be contacting his parents. Did Sandra handle this situation well from a therapeutic standpoint? Did she handle the situation well from an ethical standpoint?

Confidentiality is a therapeutic, legal, and ethical issue. At first, the topic of confidentiality would seem simple, but as the case above illustrates, it is actually a 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 the contents of a patient's medical records. Although many of the factors related to confidentiality are familiar to mental health providers, this topic, so central to the practice of

mental health professionals, needs to be discussed in detail (Bond & Mitchels, 2014; Knapp et al., 2017).

Confidentiality is also a leading cause of ethical complaints and a common cause of litigation. Pope and Vasquez (2016) found that failing to protect client confidentiality was the fourth most frequent basis of disciplinary action. This is particularly concerning as confidentiality is central to developing a trusting and productive therapeutic relationship.

Mandates related to confidentiality are found in the ethical codes of all professions. The NASW *Code of Ethics* (2021), for example, states: “Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons” (Standard 1.07[c]). 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” (Standard II, Confidentiality; AAMFT, 2015). Another unique situation involves school psychologists who seek parental consent for issues such as educational or psychological testing. Although 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” (I.2; NASP, 2020).

All 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 others” (NASW, 2021). 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 of John, 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 of 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 parties (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.

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 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 the Health Insurance Portability and Accountability Act (HIPAA), such a disclosure is required. In emergency situations, a verbal release is permitted.

Knapp and colleagues (2017) also urge that clinicians using technologies such as the Internet, Zoom, and emails inform clients about the limits of confidentiality through these means of communication. This guideline is also included in several ethical codes, including NASW's (2021), which states that

social workers should take reasonable steps to protect the confidentiality of electronic communications, including information provided to clients or third parties. Social workers should use applicable safeguards (such as encryption, firewalls, and passwords) when using electronic communications such as e-mail, online posts, online chat sessions, mobile communication, and text messages. (Standard 1.07[m])

Despite the 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. This is not only good practice; it is also an ethical mandate. The AAMFT standards (2015), for example, state,

Marriage and family therapists disclose to clients and other interested parties at the outset of services the nature of confidentiality and possible limitations of the clients' right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures. (Standard 2.1)

California law allows 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; and
- where there is a reasonable suspicion of the potential for danger of violence to others.

Concerning child abuse, California's guidelines (California Department of Education, 2021) state that "one does not have to be physically present or witness the abuse to identify suspected cases of abuse, or even have definite proof that a child may be subject to child abuse or neglect." All that is necessary is a "reasonable suspicion."

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 the client might endanger. No privileged communication exists when the therapist has reasonable cause to believe 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 communication 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.

Another issue is that 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” (Standard I.2.4; NASP, 2020). 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; and insurance companies or other gatekeepers to services, such as care managers who approve hospitalization. Clinicians who accept third party payment are also “covered entities” under HIPAA. This Act comes with its own rules and will be discussed in a later section.

Clients must be told in advance if there is information that will be shared with third parties, as when sharing a diagnosis or other information with an insurance company in order to receive payment for rendered services. A general guide is that third-party disclosure should include a minimal amount of information, that is, only what is necessary. For example, insurers may require only a date of service, Current Procedural Terminology (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. (Standard 1.08[a]; NASW, 2021)

Social workers should also “take steps to protect the confidentiality of other individuals identified or discussed in such records” (Standard 1.08[c]; NASW, 2021). Although these recommendations come directly from the social workers’ code, they offer good overall practice guidelines.

Privileged communication refers to a private statement that the recipient must keep in confidence for the benefit of the communicator. California has several types of evidentiary privilege (e.g., lawyer-client privilege and penitent-clergy privilege; Shouse California Law Group, 2020b). In the case of psychotherapists, 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 California Evidence Codes 1013 and 1014 (Shouse California Law Group, 2021). The code is very specific with regard to who holds privilege:

- 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 the identified patient is a group, family, or couple, the practitioner must receive a waiver from each and every member of the group before releasing any information.
- If the 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 guardian ad litem.
- If the patient is a minor, the practitioner 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 California Evidence Code 1016). This is a situation in which law conflicts with ethics. Let us first turn to Standard 1.07(j) in the *NASW Code of Ethics* (2021), 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, the court may require that the information be revealed.

However, California Evidence Code 1015 opens a legal avenue to mental health providers. If a practitioner receives a subpoena from an attorney to provide copies of clinical records, he or she may claim privilege on behalf of the client (per California 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.

California's Confidentiality of Medical Information Act (California Civil Code 56.10-56.16) 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 another and that disclosure is necessary to prevent the threatened danger. This Act 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 not, 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, or information about sexual or gender identity?

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

Case Example 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 says 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 Example 2

Katie, a 16-year-old student, has come to her school social worker/counselor to reveal that she is pregnant and is planning to terminate her pregnancy. She has the support of her 17-year-old boyfriend, Chris. She insists that she will not tell her mother, who is a single parent.

What are these clients' 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 minors' welfare?

The concept of confidentiality also extends to minors' rights to confidentiality and to consent to treatment. These rights 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.

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: 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 (a) 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 (b) is an alleged victim of incest or child abuse (California Family Code 6924). 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 convulsive therapy or psychosurgery or psychotropic medication without parental consent (California Family Code 6924).

The mental health treatment or counseling of a minor includes involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. The professional person who is treating or counseling the minor states in the client record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian (California Family Code 6924).

While all mental health clinicians may work with minors, these issues are of particular concern to school psychologists. The NASP ethical code (2020) presents several guidelines pertaining to minors that relate to the 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 that the student understands what is being offered, honors the student's stated choice, and guards against overwhelming the student with choices that the student does not wish to make or is not able to make. (Standard I.1.4a)

Additionally, school psychologists are ethically bound to respect the wishes of parents who object to school psychological services and must 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 – for example, the presence of a communicable disease (Standards I.2.5 and I.2.6; NASP, 2020).

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 et al., 2017).

MANDATED REPORTING

Questions to Consider

- Do you always report suspected cases of child/elder abuse? Why or why not?
- Why is mandated reporting necessary?
- Are there any professional or ethical difficulties that arise from the need to be a mandated reporter?

An estimated 656,000 children across the United States were victims of child maltreatment in fiscal year 2019 (U.S. Department of Health and Human Services, Administration for Children and Families [ACF], 2021). 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 federal 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 and abuse of dependent adults. The laws apply to mental health providers working in private practice and institutional settings.

Defining Abuse

Federal laws set minimum standards for defining child abuse and neglect, but states are responsible for defining maltreatment in their own laws (Child Welfare Information Gateway [CWIG], 2019b). Civil statutes define maltreatment and outline the steps in reporting suspected child abuse and determining the grounds for state intervention. Despite these laws and statutes, many professionals are uncertain as to when a report is required.

There are definitions of abuse to help professionals determine what is abuse, as well as certain signs and symptoms that may manifest when abuse and neglect occurs. Practitioners who are aware of these definitions and signs are better equipped to assess, identify, and treat abused and neglected children, elders, and dependent adults.

Child Abuse

The Child Abuse Prevention and Treatment Act (CAPTA) defines child abuse or neglect as

any recent act or failure to act on the part of a parent or caregiver that results in death, serious physical or emotional harm, sexual

abuse, or exploitation, or an act or failure to act that presents an imminent risk of serious harm. (Child Welfare Information Gateway [CWIG], 2019a)

California law generally defines a minor as a person under the age of 18 (California Family Code 6500; FindLaw, 2018). Child abuse is generally divided into the categories of physical abuse, neglect, sexual abuse, and emotional abuse – sometimes with the added categories of medical neglect and sex trafficking (ACF, 2021).

Broadly speaking, neglect can be physical, educational, or emotional. 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. Educational neglect, as defined by the Child Welfare Information Gateway (n.d.), is a result of “the failure of a parent or caregiver to enroll a child of mandatory school age in school or to provide appropriate homeschooling or needed special education training.” In emotional neglect, which is different from emotional abuse, caregivers fail to respond to or deny proper care and attention to the child’s affective needs.

California Penal Code, Sections 11164 through 11166, which pertain to child abuse, require 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 California law include:

- **Physical abuse/Injury:** Physical action by the child’s caregiver that results in an injury. Physical abuse can produce various injuries and injury patterns in children. Injuries can include fractures, burns, bruises, subdural hematoma, abusive head trauma, and shaken baby syndrome, for example.
- **Sexual abuse:** Can involve any penetration, contact, or intrusion, however slight, of the vagina or anal opening, for purposes of sexual arousal or gratification, except for acts that may reasonably be construed to be normal caretaker responsibilities; interactions with, or demonstrations of affection for, the child. Also excluded are acts performed for valid medical purposes. Also included in California’s definition of sexual abuse are intentional masturbation in front of a child and various types of sexual exploitation.
- **Neglect:** California Penal Code 270 defines child neglect as a parent willfully omitting, without lawful excuse, to furnish necessary clothing, food, shelter, or medical attendance or other remedial care for the child.
- **Child endangerment:** California Penal Code 273a covers child endangerment, which involves willfully exposing a minor child to “unjustifiable pain, suffering, or danger.” Even if the child suffers no harm, the crime is in exposing the child to the risk of harm. Storing a firearm in an easily accessed location can fall under the classification of child endangerment (Shouse California Law Group, 2020c).
- **Corporal injury on a child:** California Penal Code 273d covers the imposition of “inhuman corporal punishment or an injury resulting in a traumatic condition.” This category includes punishments such as slapping a child hard enough to leave a mark or punching a child (Shouse California Law Group, 2020d).

Concerning emotional abuse and the mandatory reporting of such abuse, California Penal Code 11166.05 states

Any mandated reporter who has knowledge of or who reasonably suspects that a child is suffering serious emotional damage or is at a substantial risk of suffering serious emotional damage, evidenced by states of being or behavior, including, but not limited to, severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others, may make a report to an agency specified in Section 11165.9.

Elder and Dependent Adult Abuse

Concerning elder and dependent adult abuse, Sections 15610 and 15630 through 15634 of the California Welfare and Institutions Code, which pertain to elder abuse and abuse of dependent adults, require that mandated professionals report physical abuse, abandonment, isolation, financial abuse, or neglect of any elder or dependent adult. January 1, 2022, saw a change in the age limits of elder abuse. An “elder” is now a person over age 60 who resides in the state of California.

January 1, 2022, also saw a change in the age limits for dependent adults, who are people between the ages of 18 and 59 who have certain mental and physical disabilities that keep them from being able to do normal activities or protect themselves (California Department of Social Services, 2022a; Judicial Council of California, 2022b).

Section 15610.05 of the Code defines abandonment as “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.”

According to Section 15610.30, financial abuse of an elderly or dependent adult includes taking or keeping (or assisting in taking or keeping) “real or personal” property “for a wrongful use or with intent to defraud, or both.” Taking or keeping the elder’s or dependent adult’s real or personal property through “undue influence” is another type of abuse. Such wrongful actions are considered abuse even if the property is taken from a representative of the elder or dependent adult.

Another form of abuse involves the deprivation of “goods and services necessary to avoid physical harm or mental suffering” (Section 15610.35). These goods and services can include medical care, transportation, assistance with personal hygiene, adequate clothing, adequate heating and ventilation, protection from health and safety hazards, and protection from malnutrition.

Section 15610.39 covers protection from “imminent danger,” which means “a substantial probability that an elder or dependent adult is in imminent or immediate risk of death or serious physical harm, through either his or her own action or inaction, or as a result of the action or inaction of another person.” Sometimes, therefore, individuals need to be protected from their own actions or unwillingness or inability to act.

A problem addressed in Section 15610.43 is the isolation of an elder or dependent adult. The victim might be deprived of receiving mail or telephone calls, or friends and family might be told that the person is not at home. Also mentioned in Section 15610.43 are false imprisonment and physical restraints.

Section 15610.53 describes abuse that causes “mental suffering” as

fear, agitation, confusion, severe depression, or other forms of serious emotional distress that is brought about by forms of intimidating behavior, threats, harassment, or by deceptive acts performed or false or misleading statements made with malicious intent to agitate, confuse, frighten, or cause severe depression or serious emotional distress of the elder or dependent adult.

According to Section 15610.57, neglect can mean either neglect by caregivers or individuals’ neglect of themselves. Neglect includes, but is not limited to, 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.

Physical abuse, per Section 15610.63, includes assault, battery, assault with a deadly weapon, unreasonable physical constraint or prolonged or continual deprivation of food or water, various types of sexual assault, and misuse of a chemical restraint or psychotropic medication.

Recognizing Abuse

Mandated reporters are required to report abuse if they observe abuse directly, if a child or older or dependent adult discloses abuse, or if they have reasonable suspicion of abuse. Being knowledgeable about the signs of child and elder abuse assists clinicians with making informed decisions about reporting.

Signs of Child Abuse

Certain signs might alert professionals to the possibility of child abuse. These include signs of physical and sexual abuse, as well as neglect.

Physical Abuse

Consider the possibility of physical abuse when the child:

- has unexplained burns, bites, bruises, broken bones, or black eyes;
- has fading bruises or other marks noticeable after an absence from school;
- displays a fear of caretakers; or
- abuses animals or pets.

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; or
- attaches very quickly to strangers or new adults in the environment.

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; or
- states that there is no one at home to provide care.

(Child Welfare Information Gateway, 2019c)

Signs of Elder Abuse

Professionals should take indicators of elder abuse seriously. However, it is important to consider that some elder abuse signs may not be definitive indicators of abuse, but may rather be evidence of a decline of physical or mental states as a result of aging. Elder abuse signs include:

- Sudden change in behavior such as decreased grooming, staring vacantly, fear, agitation, anxiety, unexplained crying, disorientation, depression, unusual behavior (e.g., biting or rocking) withdrawal, or shame.
- Discrepancies between a person's standard of living and his or 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.
- 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.
- Malnourishment, as evidenced by weight loss, including dehydration (cracked lips, sunken eyes), poor overall hygiene, oversatiation in session, inappropriate clothing, lack of healthcare appliances such as dentures or glasses.
- Physical injuries, bruises, especially when not over bony prominences; unexplained or implausible injuries, multiple emergency room or physician visits; broken glasses.
- Bed sores or other preventable conditions.
- Reports of urinary tract infection, vaginal or anal bleeding.
- Medical needs not attended to.
- Sudden, unexplained changes in the victim's living arrangements, such as a younger person moving in to "care for" the person shortly after meeting.

(HelpGuide, 2022; National Institute on Aging, n.d., 2020)

There are other indicators of elder abuse, but it is important to assess each situation on a case-by-case basis. Possible indicators include when the caregiver:

- does not want the elder or dependent adult to be seen on his or her own;
- provides a different accounting of events than the one given by the elder;
- fails to cooperate with the recommended treatment plan;
- attempts to isolate the person from family, friends, or activities;
- denies the elder the right to make decisions;
- exhibits observable behaviors such as substance use or displays of anger; or
- depends on the elder for financial support.

Reporting Abuse

Mental health professionals who learn of or suspect child abuse must file a report immediately or as soon as is practicably possible by phone and then must prepare and send a written report within 36 hours of receiving the information concerning the incident (California Penal Code Section 11166). The initial report should be made to any police department or sheriff's department or, if they are set up to take reports, a county probation department (California Department of Justice, 2017).

Mandated reporters of elder or dependent 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 reporting by telephone, then submit a written report or Internet report within two working days (California Welfare and Institutions Code 15630[b][1]). Written reports must be submitted on a Department of Justice form that may be downloaded from California's Adult Protective Services website at <https://www.cdss.ca.gov/adult-protective-services>. In the case of elder and dependent adult abuse, two forms are available, one for financial abuse and the other for other types of abuse. The mandated reporter must include information supporting the report.

A mandated reporter who 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 be imposed.

There are safeguards in place for professionals who report child abuse. Mandated reporters who report suspected child abuse in "good faith" are immune from criminal and civil liability (California Penal Code Section 11172[a]). The same immunity holds for mandated reporters of elder abuse (Kaass Law, 2021). 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.

Any person applying for a license as a marriage and family therapist in California needs to complete at least seven hours of training in child abuse assessment and reporting (BBS, 2022c, p. 28). 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 Code or the equivalent in another state or territory.

ADVERTISING PROFESSIONAL SERVICES

Question to Consider

- What must you consider in advertising professional services?

In a competitive marketplace, mental health professionals need to market their services in a way that allows them to stand out from others. The California statutes define advertising as including, but not being limited to,

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 or magazine or in any directory, or any printed matter whatsoever, with or without any limiting qualification. (Business and Professional Code Section 4980.03(e))

With the proliferation of online advertising, clinicians' claims and information are readily available to the public.

The statutes prohibit mental health professionals from "advertising in a manner that is false, fraudulent, misleading, or deceptive" (BBS, n.d.). Professional codes are more explicit than this broad legal definition. Take, for example, the social work, and marriage and family therapy codes. The guidelines found in these ethical codes are helpful to professionals in reviewing their own advertising practices.

The *Clinical Social Work Association Code of Ethics* (2016) 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. (VIII. Public Statements)

The AAMFT *Code of Ethics* (2015) also has specific guidelines related to advertising professional services (Standard IX). 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

- accurately represent their competencies, education, training, and experience relevant to their practice of marriage and family therapy in accordance with applicable law;
- ensure that advertisements and publications in any media are true, accurate, and in accordance with applicable law;
- do not hold themselves out as being partners or associates of a firm if they are not;
- do not use any professional identification if it includes a statement or claim that is false, fraudulent, misleading, or deceptive;
- claim degrees for their clinical services only if those degrees demonstrate training and education in marriage and family therapy or related fields;
- make certain that the qualifications of their employees and supervisees are represented in a manner that is true, accurate, and in accordance with applicable law;
- represent themselves as providing specialized services only after taking reasonable steps to ensure the competence of their work and to protect clients, supervisees, and others from harm; and
- correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist's qualifications, services, or products.

Advertising of professional services continues to be an evolving area, especially in terms of online provision of services. The advertising approaches of some psychotherapy websites are potentially inconsistent with American Psychological Association (APA; 2017a) standards. For example, some sites may make disparaging comparisons with face-to-face treatment and suggest that a person who wanted to see an office therapist would need to wait weeks to do so. Some websites may not distinguish e-therapy from traditional service, leaving the impression that the two types of service are always equivalent. Websites may also offer 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. Some online sites do not contain avenues for dissatisfied e-clients to file a grievance about service. The selling of books or tapes authored by e-therapists is a practice that, while not unethical, leaves the impression that the online therapist is an “expert,” without requiring the therapist to back up the impression with facts.

DUTY TO PROTECT (TARASOFF AND 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:

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. (Ewing, 2005)

Many professionals reading this 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). In 1969, Prosenjit Poddar, an exchange student at the University of California at Berkeley, killed Tatiana Tarasoff after she rejected his romantic advances. Poddar was diagnosed with paranoid schizophrenia prior to the killing by the school’s psychologist. 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 (GoodTherapy, 2015).

Tatiana Tarasoff’s parents sued the university, the therapist, and the police for negligence. The case went to the California Supreme Court, which 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 therapists are liable if (a) they should have known about the dangerousness based on accepted professional standards of conduct and (b) 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. (Merrill, 2013)

Tapp and Payne (2011) warn that it is important that all mental health providers be aware and knowledgeable about their liability exposure from third parties as a result of “Tarasoff II” (the decision that resulted when the California Supreme Court reheard the case; Knoll, 2019). One such area that mental health providers should understand is the legislation California passed in 2013 in order to clarify the Tarasoff statute. California Civil Code Section 43.92 states, with regard to the duty to protect, that

There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as

defined in Section 1010 of the Evidence Code in failing to protect from a patient's threatened violent behavior or failing to predict and protect from a patient's violent behavior except if the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

In these situations, the psychotherapist's duty is to make "reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency." In this statute, the "duty to warn and protect" was changed to the "duty to protect" (Weinstock et al., 2014), and yet the duties of therapists did not change along with the wording.

Returning to the more recent Ewing case, Ewing's parents sued Goldstein and the hospital. They contended that Colello posed a foreseeable danger to their son and that both Goldstein and the hospital knew of the threat but failed in their duty to warn either Ewing or a law enforcement agency. At trial, Goldstein claimed he was not liable 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 (Ewing, 2005).

On appeal, in both the case against the therapist and the case against the hospital, the California Court of Appeal held that the plaintiffs had a right to take their claims to trial. The court held that Colello's father's statements to the social worker and Goldstein could have triggered the "duty to warn" (Ewing, 2005). 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 Section 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" (Zur, 2019). 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. (FindLaw, 2022)

The expanded duty from now on applies to credible threats received from the client or the client'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 the Ewing ruling, it appears clear that mental health professionals must take steps to protect the welfare not only of clients, but also of the clients' extended circle. According to Welfel (2016), 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 or 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.

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?

Case Example

Melanie Walters, a licensed MFT, has been working with John and Mary. She has seen the couple in counseling for six months and is supporting them in managing Mary's depression. Melanie receives a phone call from John, expressing concern 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 many of their communication problems are improving, the eating disorder does not need to be the focus of treatment. Mary's purging episodes continue to increase in frequency, although Melanie remains unaware of the behavior. At work one day, Mary experiences severe vertigo. Mary's primary care physician finds that Mary's blood panels are abnormal. Melanie feels bad 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?).

This Case Example 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 the NASW considers it one of the core values of the profession of social work. Despite the importance of the concept of competence, it can be difficult 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). Knapp and colleagues (2017) view the competency areas of technical knowledge, social skills, diversity competence, and emotional competence as particularly important.

Attaining and maintaining professional competence are mentioned in all professional codes. The NASW code (2021) provides a comprehensive description of competence. According to Standard 1.04 of the code, 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.

- 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.
- exercise careful judgment and take responsible steps (including education, research, training, consultation, and supervision) when standards do not exist for an emerging area of practice.
- ensure that they have the necessary knowledge and skills to competently provide services via technology should they choose to do so. This competence includes understanding communication challenges when using technology, implementing strategies to address these challenges, and complying with the laws governing technology and social work practice.

Similarly, the NASP code (2020) states in Standard II.1.1:

School psychologists recognize the strengths and limitations of their graduate preparation 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 effective services. When no appropriate provider is available, school psychologists explain the limitations of their experience to parents and seek consultation, continuing professional development, and supervision as appropriate and necessary to ensure that students do not go without assistance.

In looking at these provisions, it is clear that clinicians must practice within their scope of competence. Such was not the case with Melanie in the previously mentioned Case Example. She was skilled in couples work, but clearly practicing outside the scope of her competence. Melanie could have addressed this problem by referring Mary to a counselor who specializes in eating disorders or obtaining supervision on this case with someone skilled in treating eating disorders. Standard 2.05 in the NASW (2021) *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.

Additionally, competent 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 (2020), for example, states in Standard II.1.2: “School psychologists refrain from any work-related activity in which their personal problems may interfere with professional effectiveness.” These problems could include issues such as a divorce or 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 arise subsequent to a professional entering practice, providers may choose to limit their practice size or not see patients whose problems mirror their own, or they may take a leave of absence.

Attaining and maintaining competence are 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).

Compassion Fatigue and Burnout

Alyssa Santoro is a social worker in a hospital program for women with posttraumatic stress disorder (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. Although she is scheduled to work Monday through Friday, she has begun stopping by the hospital on 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 to worry about.”

An area of competence that merits special attention is self-monitoring for the possible effects of compassion fatigue and burnout. Although there are a number of definitions of this phenomenon, all share the idea that helping professionals can be affected by their work with clients and that these effects can sometimes be negative. Other terms for compassion fatigue are “secondary traumatic stress” and “burnout” (Zhang et al., 2018).

Compassion fatigue is a general term that refers to the overall emotional and physical exhaustion that human service professionals can experience (Smullens, 2015). These physical and emotional responses can result from the continued and chronic use of empathy when treating clients who are experiencing distress, trauma, or crises. In the clinical relationship, empathy and compassion are generally provided to the client in a one-way direction. Clinicians do not expect their clients to be empathetic and reciprocal to them. Ethical guidelines of practice compel practitioners to set boundaries with their clients, to not engage in dual relationships, and to not expect the client to meet the personal needs of the clinician (Smullens, 2012). The one-way offering of clinical services that incorporates unconditional regard, compassion, and empathy is an integral part of human services practice. Yet continued work with people who are suffering can affect the professional, personal, and social areas of clinicians’ lives. Symptoms of compassion fatigue include impairments to the ability to be therapeutically effective, as well as physical and emotional effects. Many of these symptoms are similar to the symptoms of primary PTSD.

According to Lombardo and Eyre (2011), the symptoms of compassion fatigue are as follows:

Relational and Work-related Symptoms

- avoidance or dread of working with certain patients;
- boundary issues, such as over-involvement with patients;
- reduced ability to feel empathy toward patients or families; and
- frequent use of sick days.

Physical and Emotional Symptoms

- irritability and a lack of joyfulness;
- poor concentration, focus, and judgment;
- sleep disturbances;
- excessive use of substances; and
- anxiety.

It is important for treating clinicians to understand the concept of compassion fatigue and to practice self-assessment. One resource for assessing compassion fatigue is the ProQOL (<https://proqol.org/>), developed by traumatologist Dr. Beth Hudnall and her colleagues. It is available free of charge.

What can helping professionals do to lessen their chances of developing compassion fatigue? Gentry and colleagues (2004) suggest that clinicians develop a personal plan of care so as to achieve a healthy work-life balance. This strategy 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.

Given the relationship between burnout and ethical lapses, slips, and violations, it is also important for clinicians to hold themselves accountable for recognizing the signs of burnout and developing plans to address it. Practitioner burnout refers to a progressive state of ineffectiveness or inoperability in professional performance (Smullens, 2012). Clinicians who experience burnout commonly report feeling stressed and being unable to cope effectively (Fye et al., 2020). Clinician burnout affects the profession as a whole because it often leads to talented workers leaving their positions and, possibly, the profession entirely. Burnout does not just affect the individual practitioner; it also affects clients and can affect whole systems of care. Burnout is multi-dimensional and involves specific interactions between the clinician and the work environment. The hallmark signs of burnout include

- increased resignation,
 - irritability,
 - quickness to anger,
 - emotional exhaustion,
 - depersonalization, and
 - diminished feelings of personal accomplishment.
- (Schiff & Lane, 2019; Smullens, 2012).

Unattended burnout symptoms can lead to high turnover rates in an agency, increased ineffectiveness of clinical interventions, and overall feelings of work dissatisfaction. Clinicians who experience burnout commonly report feeling stressed and being unable to cope effectively (Fye et al., 2020). When levels of stress overwhelm an individual's coping mechanisms, maladaptive responses may arise. Practitioners can become increasingly avoidant, problem-focused, or ineffective. They may become disillusioned with their work in a particular field or job. They may question their ability to be competent practitioners as their self-efficacy wanes.

The three major symptoms that indicate burnout are emotional exhaustion, withdrawal or depersonalization, and reduced performance (InformedHealth.org, 2020; Maslach, 1982; Pihl-Thingvad et al., 2019). Providers experiencing burnout often feel emotionally drained, unable to cope, tired, and run down. Individuals who are in difficult work environments and exhibiting signs of burnout can develop physical and psychological manifestations, such as stomach or bowel problems, high blood pressure, overeating, substance use, insomnia, and mental health disorders such as depression and anxiety (Holman et al., 2019). Burnout can cause reduced work performance and poor professional or ethical boundaries. Clinicians may withdraw from work-related activities (e.g., not returning client phone calls in a timely manner, exhibiting reluctance to

schedule appointments, and non-completion of paperwork), and/or struggle to maintain appropriate boundaries or demeanor with their clients, colleagues, or supervisors. Practitioners may have difficulty concentrating or completing tasks. They may feel restless and ineffective. These signs and symptoms gradually build up over time with prolonged stress and overwhelm work and personal functioning (Pihl-Thingvad et al., 2019).

Providers working in high-stress fields, such as child or adult protective services, child welfare, and jobs involving other high-risk populations, are more likely to experience burnout. This situation may affect not only clinicians' feelings about their own work, but also their behaviors. Clinicians who are not supported or who feel incompetent to provide services are likely to leave their positions and may decide to leave the profession altogether. This is a detriment to these fields because:

- new clinicians will then not have the opportunity to be mentored;
- the clients, including children, served in these high-stress fields are commonly contending with poverty and accompanying instability as well. When burnout affects the work force, high-need and long-term clients commonly contend with lots of turnover. They therefore experience continued instability in their care and do not have the benefit of working with seasoned clinicians or of receiving the therapeutic advantage of a long-term relationship with the same provider; and
- without support, the numbers of clinicians willing to work with these high-stress, impoverished populations could dwindle, leaving a vacuum that affects already underresourced individuals, families, and communities.

Further, problems related to social justice are generated by burnout in high-stress areas of practice that the human service and mental health professions must consider. Impoverished clients and communities commonly serve as a training ground for many students and young professionals in the field; however, due to the lack of resources these communities and clients are without the power to retain the professionals who use these impoverished environments to fine-tune their talents, acquire skills and experience, and obtain or meet required licensing obligations. Commonly, these communities and clients are then abandoned as the now trained and seasoned practitioners move on in their careers.

Because burnout is connected to a specific work context, organizational factors play roles in either helping to reduce burnout or adding to the pressures leading to it.

There are a number of online assessment tools that can help clinicians identify burnout in themselves or their clinician clients. These self-assessments are designed for practitioners to identify signs of burnout so they can take corrective steps to interrupt burnout and prevent negative consequences. These self-assessment resources include:

American Psychiatric Association Well-Being Self-Assessment 2.0

This tool is designed for psychiatrists and includes questions about background, identification, and climate of the workplace. The assessment tool is in the form of an anonymous survey that provides data to the American Psychiatric Association (n.d.a) about the rates and causes of burnout in the field of psychiatry.

In addition to the assessment tool, the portal includes resources on well-being and burnout. It can be found at:

<https://www.psychiatry.org/psychiatrists/practice/well-being-and-burnout/assess-yourself>

Burnout Potential Inventory

The Burnout Potential Inventory (Potter, 1998) asks the individual to rate a list of situations from “rarely bothersome” to “constantly bothersome.” The inventory can be found at:

http://www.docpotter.com/beajob_pot_test.html

Conner-Davidson Resilience Scale

The Connor-Davidson Resilience Scale is a 25-question self-reported measure of personal resilience (Lall et al., 2019). The scale can be found at <http://connordavidson-resiliencescale.com/>

Maslach Burnout Inventory

The Maslach Burnout Inventory is a 22-question survey that covers three domains: emotional exhaustion, depersonalization, and low sense of personal accomplishment (Lall et al., 2019). The survey can be found at <https://www.mindgarden.com/117-maslach-burnout-inventory-mbi>

Mayo Clinic Well-Being Index

The Well-Being Index (Mayo Clinic, n.d.) is designed to help clinicians with self-awareness and to help them access resources (Lall et al., 2019). The Index includes self-assessment in nine domains: likelihood of burnout, fatigue, suicidal ideation, quality of life, meaning in work, work-life integration, risk of medical error, dropout risk, and overall well-being. Information about the index can be found at: <https://www.mayo.edu/research/centers-programs/program-physician-well-being/mayos-approach-physician-well-being/mayo-clinic-well-being-index>

Mental Health America

This website offers a 16-item self-assessment questionnaire designed to measure an individual’s level of stress (Lall et al., 2019). The questionnaire can be found at:

<https://www.mhanational.org/get-involved/stress-screener>

MindTools

As part of its COVID-19 toolkit, this website provides an online self-assessment for burnout. The self-assessment is in a pdf format and includes 15 statements. Clinicians can respond to the statements on a Likert scale that ranges from “not at all” to “very often.” The self-assessment can be found at:

https://www.astrazeneca.com/content/dam/az/PDF/2020/covid-19-toolkit/Burnout_Self-Test.pdf

Perceived Stress Scale

The Perceived Stress Scale is a measure of personal stress (Lall et al., 2019). The scale is a 10-question measure. For each question, the individual’s answers rank from “never” (0) to “very often” (4). The scale can be accessed at:

<https://das.nh.gov/wellness/docs/percieved%20stress%20scale.pdf>

Professional Quality of Life Scale (ProQOL)

The Professional Quality of Life Scale is a commonly used measure of the negative and positive effects of helping others (Lall et al., 2019). The ProQOL has three sub-scales: compassion satisfaction, burnout, and compassion fatigue. The scale can be accessed at:

https://proqol.org/ProQol_Test.html

The Ways of Coping Checklist

The Ways of Coping Checklist is designed to identify the thoughts and actions that individuals use to cope with stress and the ways they cope within specific situations (Lall et al., 2019). This checklist contains 68 questions, to which respondents answer with a “yes” or “no.” The scale can be accessed at:

<https://prevention.ucsf.edu/sites/prevention.ucsf.edu/files/uploads/tools/surveys/pdf/Ways%20of%20coping.pdf>

Work-Life Balance Quiz

The Canadian Mental Health Association (2022) offers an online self-assessment tool designed to explore work-life balance. This quiz allows individuals to agree or disagree with 15 statements. The quiz can be found at: <https://cmha.ca/find-info/mental-health/check-in-on-your-mental-health/work-life-balance-quiz/>

Taking steps to deal with burnout involves assessment, knowing when the signs and symptoms of burnout are present, and developing a plan to address burnout, such as a plan for self-care. There are several steps that practitioners can take to develop a self-care plan (Wonders, n.d.):

1. *Be proactive.* Clinicians should take immediate steps when they suspect they are burned out at their jobs. They can conduct a self-assessment using one of the resources mentioned earlier, or they can acknowledge that burnout is likely and decide to make a self-care plan.
2. *Schedule self-care.* Self-care activities may not be the priority in an immediate situation or crisis. However, as a long-term plan, they need to be considered essential. Practitioners can build blocks of time into their schedules, even if only minutes, to conduct self-care activities or micro-practices.
3. *Consider micro-practices.* When full blocks of time are impractical, small micro-practices can help. Even if practitioners have only a few minutes between appointments, they can close the door and take deep breaths, focusing concentration on inhaling and exhaling. They can take a moment to sniff a relaxing essential oil or apply pleasant-scented lotion while focusing on the present moment.
4. *Consider themselves a priority.* Clinicians are accustomed to advising clients about taking care of their needs. Practitioners should follow their own advice. Eating a healthy diet, moving one’s body, getting enough sleep, and engaging in social activities that bring happiness are important for overall well-being.
5. *Pay attention.* Clinicians should take a few moments to check in with their feelings, thoughts, and bodily sensations. Paying attention to body, feelings, and thoughts can give clues about what is needed for feeling better.
6. *Set boundaries.* Clinicians need to maintain clear boundaries and take care not to overextend themselves. Learning to maintain boundaries helps clear space for self-care activities.

7. *Seek supportive relationships.* Practitioners help clients understand that the people who are in one’s life have profound impacts on one’s quality of life. This same idea applies to practitioners. Practitioners should seek supportive relationships both at work and at home.
8. *Unplug.* Too much computer time, television time, phone time, and device time can be draining and fuel isolation. Clinicians should take time every day to unplug from devices to enjoy self-care activities such as going for a walk, reading a book, doing yoga, or visiting a friend.
9. *Create new habits.* Developing a self-care plan and sticking to it is important for long-term well-being. At first, putting personal needs at the forefront may feel uncomfortable or foreign. Keeping to a self-care plan will get easier over time.
10. *Seek support.* Sometimes symptoms of burnout can lead to significant psychological dysfunction, such as depression or anxiety. In cases in which additional support is needed, practitioners should seek professional help.

When developing a self-care plan, clinicians should consider activities in multiple domains, such as: (a) emotional and spiritual activities, (b) workplace strategies, (c) the physical domain, and (d) the psychological domain (Tarantola, 2018).

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

Questions to Consider

- What is “cultural competence”?
- How do you assess whether you are culturally competent?
- In which circumstances should a provider refuse to provide services?

Case Example

Gerald Siran, a licensed MFT, received a phone call from a couple seeking family counseling because of 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 (A’s) that the family expected. Gerald, who felt out of his depth because he lacked 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 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 all 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? Cross's time-honored definition is often cited. Cross and colleagues (1989) define 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 people's ability to accept differences and continually assess themselves regarding culture and the dynamics of difference, as well as 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.

Saldaña (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 among these components are the **personal attributes** of the counselor, which include a willingness to work with diverse populations and the ability to communicate genuine warmth and empathy. Knapp and colleagues (2017) 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 of their worldviews, they exercise care when making determinations of normality or abnormality.

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 for promoting non-discriminatory practices. Some of these ethical codes include:

- Standard 1.05 of the NASW (2021) *Code of Ethics* 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 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.
- Standard I.1 in the AAMFT (2015) *Code of Ethics* states: "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, sexual orientation, gender identity or relationship status."
- The NASP Model for Comprehensive and Integrated School Psychological Services (under *The Professional Standards of the National Association of School Psychologists*, 2020), Domain 7, states that school psychologists "acknowledge and respect diversity in family systems. They identify varying world views, cultural and family contexts, and other factors that have an impact on family-school partnerships and interactions with community providers, and they consider these factors when developing and providing services for families." (p. 8)

- The American Mental Health Counselors Association (AMHCA; 2020) *Code of Ethics* states that counselors must “recognize the important need to be competent with respect to cultural diversity; CMHCs are sensitive to the diversity of different populations and to changes in cultural expectations and values over time.”

California’s BBS licensees may be subject to disciplinary action for refusing to perform licensed services based on race, color, sex, religion, ancestry, disability, marital status, national origin, or sexual orientation. 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

Some key points about this topic for clinicians to be mindful of are:

- Individual and institutional racism continue to affect the quality of life for ethnically diverse clients, and this is often reflected in stressors that lead to emotional problems.
- Racial/ethnic minority groups have less access to health care, and the nature of services is inadequate; these minorities are also 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 ethnically 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, self-reflection, and culturally sensitive diagnosis, 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 and nonverbal helping styles and can play many helping roles beyond the traditional counselor-therapist roles (Council of National Psychological Associations for the Advancement of Ethnic Minority Interests, 2003).

The DSM-5-TR and Diversity

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (the *DSM-5*; American Psychiatric Association, 2013), recently updated as *DSM-5-TR* (American Psychiatric Association [APA], 2022a) 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 United States, Western Europe, and Canada (Cummings, 2015). The 2022 update to the manual, *DSM-5-TR*, took steps to address the ethnoracial differences, racism, and discrimination

present in the previous versions through the use of a review committee and ethnoracial equity and inclusion work group. The activities of these entities included overseeing appropriate disparity-reduction practices in the revision process whereby the finalized version of the manual avoided perpetuating stereotypes or including discriminatory clinical information. Further, the *DSM-5-TR* provides information on variations in symptom expression, attributions of disorder precipitants and causation (i.e., cultural explanations), prevalence factors for varied demographic groups, cultural norms affecting the perceived level of pathology, and risk for misdiagnosis for members of socially oppressed ethnoracial groups (APA, 2022b).

The *DSM-5-TR* presents three concepts:

- **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. 871);
- **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. 871); and
- **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. 871).

One important aspect of the *DSM-5-TR* is that the descriptions found in the main entries alert practitioners to place symptoms in a cultural context. Panic disorder, for example, also describes **ataque de nervios**, a syndrome most associated with Spanish-speaking people from the Caribbean.

It is helpful for clinicians to familiarize themselves with cultural syndromes they might encounter in order to better understand their clients.

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?

Informed consent involves providing clients with information necessary to make educated decisions about treatment. Pope and Vasquez (2016) call informed consent “a process of communication and clarification” (p. 74). The informed consent process allows mental health professionals to structure the therapy relationship. The key factor in the success of therapy is good communication between therapist and client. One of the best ways to establish rapport and open communication with clients is to enable them to make informed choices about therapy. According to the NASP code (2020), informed consent means that “the person giving consent has the legal authority to make a consent decision, a clear understanding of what it is they are consenting to, and that their consent is freely given and may be withdrawn without prejudice” (p. 41).

Professional codes of ethics are generally very similar in the way they approach the informed consent process.

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 therapeutic relationship. The AAMFT code (2015) is explicit in defining the informed consent process. It states:

Marriage and family therapists obtain appropriate informed consent to therapy or related procedures and use language that is reasonably understandable to clients. 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. 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.

The AMHCA code (2020) instructs that

clients have the right to understand what to expect in counseling and the freedom to choose whether and with whom they enter a counseling relationship. ... CMHCs provide information that allows clients to make an informed decision about selecting a provider. Such information typically includes counselor credentials, confidentiality protections and limits, the use of tests and inventories, diagnoses, reporting, billing, and therapeutic process. Restrictions that limit clients' autonomy are explained.

According to the NASW code (2021), Standard 1.03(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.

Related to technology,

Social workers who use technology to provide social work services should obtain informed consent from the individuals using these services during the initial screening or interview and prior to initiating services. Social workers should assess clients' capacity to provide informed consent and, when using technology to communicate, verify the identity and location of clients. (Standard 1.05[f])

The National Board for Certified Counselors (NBCC; 2016) *Code of Ethics* instructs in Directive 72, "NCCs shall obtain a client's consent prior to the provision of services. In private practice or other similar situations, this consent shall be documented in writing in a counseling services agreement. This counseling services agreement shall become a part of the client's record."

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

- goals and length of therapy/psychotherapy services;
- risks and benefits of therapy;
- alternatives to therapy;
- fees and services, including procedures 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; and
- limits of confidentiality.

There are instances in which provision of mental health services can occur in the absence of client or 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 parental consent as long as the resulting interventions are under the authority of the teacher and within the scope of typical classroom interventions. Parental consent is not ethically required for a school-based school psychologist to review a student's education 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. Parental consent is required if the consultation about a particular child or adolescent is likely to be extensive and ongoing and/or if school actions 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 be notified when the school or school psychologist intends to administer to students a survey that screens for mental health

problems, and those parents must be given the opportunity to remove their child or adolescent from participation in such screenings. (NASP, Standard I.1.1, 2020)

Although 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 Example

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 and psychoeducational counseling. Loren has just completed eye movement desensitization and reprocessing (EMDR) training and feels that Jean would be an ideal candidate for this therapy. She tells Jean that she is going to try a new procedure for which she hears 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 EMDR, 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 protected health information (PHI).

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 forms are employed when a client needs to undergo psychosurgery or electroconvulsive therapy or is a participant in a research study (California Patient’s Guide, n.d.).

MULTIPLE OR NONSEXUAL DUAL RELATIONSHIPS

Questions to Consider

- Have you ever encountered the possibility of entering a dual/multiple relationship?
- Are all multiple relationships harmful?

The term “boundaries” refers to a set of rules that set relationships between mental health professionals and their clients apart from other relationships. Boundaries clarify behaviors that are appropriate in psychotherapy, provide limits and structure, and prevent harm to patients (Knapp et al., 2017).

Ethical codes and state laws demonstrate an awareness of potential conflicts of interest in relationships with clients. A number of areas could present conflicts of interest, but some of the most commonly occurring conflicts involve sexual relationships and nonsexual 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 relationships and nonsexual dual relationships.

Standard 1.06(c) of the NASW ethical code (2021) 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 (2020) also contain guidelines on dual relationships. The code states: “School psychologists avoid multiple relationships that diminish their professional effectiveness” (Principle III.4, p. 51). The AAMFT Code (Standard 1.3; 2015) 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; and
- entering a business relationship with a client.

Social, including sexual, misconduct on the part of the provider is typically progressive. The California Department of Consumer Affairs publication *Therapy Never Includes Sexual Behavior* (2019) describes several “warning signs” of inappropriate behavior and misuse of power that include

- entering a social relationship with a client;
- supporting the client's isolation from social support systems;
- confiding in a client; and
- relying on a client for personal or emotional support.

Another warning sign is bartering of services, which tends to be addressed specifically in the ethical standards of the professions. The AAMFT code (Standard VIII.5; 2015), 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.

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 Example

Geri, a 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?

Many potential issues exist with Geri's agreement to see Kim, even for only an assessment. Pope and Vasquez (2016) 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 (2016) 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;
- the unequal footing between therapist and client makes a truly egalitarian relationship impossible;

- the nature of the therapy would change; and
- this situation 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.

There is also the perspective that nonsexual dual relationships have the potential to develop into more intimate sexual contact. Although this escalation certainly does not always take place, it is important to consider the possible difficulties with a therapeutic relationship if the potential for conflict of interest may occur.

Online Relationships

The rapid proliferation of virtual relationships in recent years has resulted in more potential for blurring of boundaries. One challenge with online relationships is the confidentiality risks associated with use of social media. It is generally considered to be inadvisable to “friend” or “follow” clients on social networking sites. Clients would then potentially have access to personal information about the clinician or could inadvertently believe that the relationship exists outside of an online forum.

Challenges connected to social media are covered by a number of ethical guidelines, including those related to informed consent. Consider NASW’s (2021) Standards 1.03(e), stating that social workers “should discuss with clients the social workers’ policies concerning the use of technology in the provision of professional services”; 1.07(a): “Social workers should respect clients’ right to privacy”; and 4.03: “Social workers should not permit their private conduct to interfere with their ability to fulfill their professional responsibilities.”

Many other professional ethical codes have been updated to address online relationships with clients:

The AAMFT *Code of Ethics* (2015) states:

Prior to commencing therapy or supervision services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that technologically-assisted services or supervision are appropriate for clients or supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform clients or supervisees of the potential risks and benefits associated with technologically-assisted services; (c) ensure the security of their communication medium; and (d) only commence electronic therapy or supervision after appropriate education, training, or supervised experience using the relevant technology. (Standard 6.1)

The AMHCA *Code of Ethics* (2020) advises counselors that “Unless email and text messages are encrypted or otherwise secured or confidential, the client should be informed of the

risks and discouraged from using [them] as a means to disclose personal information” (B[6][h]); and “typically, unsecured, open chat rooms are discouraged as a platform for communicating with clients” (B[6][i]; and “CMHCs may maintain professional profiles that are kept separate from personal profiles. CMHCs need to be aware of their impact on clients should personal information or opinions be disclosed in a public platform” (B[6][j]; p. 6).

It is important for providers to develop policies for social networking, use of Skype or Zoom, email, texting, consumer review sites, and distance counseling. Although each of the major professional codes addresses the ethical use of technology, the information in the codes often refers to the general use of technology without providing specific guidelines. For example, providers may want to consider specifying in writing their policies about clients friending or responding to requests to follow clients, and including these policies in informed consent or treatment agreement discussions. The joint publication put forth in 2017 by the NASW, Association of Social Work Boards (ASWB), Council on Social Work Education (CSWE), and the Clinical Social Work Association, titled *Standards for Technology in Social Work Practice*, is an excellent resource for practitioners. The standards are divided into four main sections related to the ways in which social workers and cognate professionals use technology, and the second section on the design and delivery of services is especially relevant to the topic of the provision of distance counseling.

Consequences to the Therapist of Boundary Violations

In addition to consequences to clients, boundary violations have the potential to affect therapists as well. Boundary violations can result in:

- less personal time with family and friends,
- less job satisfaction,
- co-worker frustrations,
- burnout, and
- compassion fatigue.

Boundary violations can even result in extreme consequences, such as loss of job, license, professional identity, peers, and professional relationships.

SEXUAL RELATIONSHIPS WITH CLIENTS

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 issue of sexual relationships between a client and a therapist is an important one that can result in a great deal of harm to both parties. The standards of professional codes of conduct

have mandates that specifically prohibit sexual intimacies between clients and therapists. Standard 1.09 (Sexual Relationships) of the NASW *Code of Ethics* (2021) states:

(a) Social workers should under no circumstances engage in sexual activities, inappropriate sexual communications through the use of technology or in person, 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 relationships in the area of 0.9% to 3.6% for male therapists and 0.2% to 0.5% 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 & Vetter, 1991). Interestingly there is also evidence that sexual attraction to clients is a common occurrence, with 82% of therapists reporting that this has occurred for them at some point in their treatment (Pope & Vasquez, 2016). Consider the following case:

Case Example

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. Mark 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 Example, 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 in the state law and ethics codes.

Kenneth Pope (see references: Pope & Vetter, 1991), a mental health ethicist who writes about many topics but has a particular interest in the area of sexual intimacies between therapists and clients, conducted – along with colleague Valerie Vetter – a national survey of 1,320 mental health professionals. Pope and Vetter looked specifically at sexual relationships that had occurred between therapist and client following termination of treatment. They 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 clients. They 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 (Pope & Vetter, 1991).

California law also prohibits sexual relationships with clients. The California Business and Professional Code and the Civil Code (Section 43.93) clearly state that 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.

Further, according to California laws, any act of sexual contact, sexual abuse, sexual exploitation, sexual misconduct, or sexual relations with a client is unprofessional and illegal, as well as unethical, as set forth in Business and Professions Code Sections 726, 728, 729, 2960(o), 4982(k) and 4992.3(l).

Warning Signs of Sexual Inappropriateness

Any therapist in California who learns from a patient that the client/patient had a sexual relationship with a psychotherapist during the course of treatment has the legal obligation to give

the patient the brochure titled *Therapy Never Includes Sexual Behavior*, and to discuss the brochure with the patient (Business and Professions Code 728; Zur, n.d.a).

As indicated earlier, boundary violations are usually progressive – starting with more minor behaviors and snowballing into egregious behaviors. The list of warning signs in the brochure are as follows:

- telling sexual jokes or stories;
- sending obscene images or messages to the client;
- unwanted physical contact;
- excessive out-of-session communication (e.g., text, phone, email, social media, etc.) not related to therapy;
- inviting a client to lunch, dinner, or other social and professional activities;
- dating;
- changing any of the office's business practices (e.g., scheduling late appointments when no one is around, having sessions away from the office, etc.);
- confiding in a client (e.g., about the therapist's love life, work problems, loneliness, marital problems, etc.);
- telling a client that he or she is special, or that the therapist loves him or her;
- relying on a client for personal and emotional support;
- giving or receiving significant gifts;
- suggesting or supporting the client's isolation from social support systems, increasing dependency on the therapist; and
- providing or using alcohol or drugs during sessions.

(California Department of Consumer Affairs, 2019)

Consequences of Sexual Boundary Violations

Certainly, therapists are human and do make mistakes, but it is important always to bear in mind that sexual boundary violations are extremely detrimental professionally. Sexual intimacy with clients is a cause for revocation of licensure.

It is well established that sexual boundary violations harm the patient. Simon (1999) 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; and
- self-harm behaviors.

TREATMENT TERMINATION AND CLIENT ABANDONMENT

Questions to Consider

- Have you ever found yourself in a situation in which you were unable to continue working with a client? What did you do?
- How do you typically terminate treatment?

Another important ethical concern involves proper termination of treatment and client abandonment. In an ideal world, client termination would be planned, and it would be discussed by both therapist and client. In many instances, however, termination occurs prematurely. Instances also occur 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 (Standard 1.17[a], 2021), for example, states that “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.” Although it is sometimes challenging, termination should be a planned process. Consider the following case:

Case Example

Sierra is a 22-year-old client who has been in treatment with Mark Lewis, MFT, for 18 months. 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 therapist in this case do correctly? Incorrectly?

This case illustrates some of the considerations in treatment termination. There are a number of examples of client circumstances that are potentially difficult, as, for example, when

- a client cannot pay for services or now requires a sliding scale,
- there is a role change (e.g., an agency therapist is promoted to a non-clinical role),
- the therapist does not see continued need for treatment,
- there is a lack of treatment progress,
- there is a threat to the clinician, or
- a client's issues exceed the clinician's scope of competence.

Termination, defined by Younggren and Gottlieb (2008, quoted in Younggren et al., 2011) as “the ethically and clinically appropriate process by which a professional relationship has ended,” is generally considered to be a complex but important part of therapy. Mutually agreeable termination is the “ideal” situation. Roe and colleagues (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.

Premature termination is the ending of treatment without having adequately resolved the problems that were the initial impetus for therapy. This situation occurs frequently in practice, 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 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). 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 of Ethics* (Standard A.12, 2014, p. 6), which states that “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.”

It is important to recognize that failure to properly withdraw from a professional therapeutic relationship may expose the therapist to liability. Although it is not possible to foresee all the possible scenarios involved in treatment termination, some helpful recommendations are for clinicians to:

- talk about termination in the informed consent process or written document;
- document progress, lack of progress, and considerations for termination;
- plan for drop-outs; and
- 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 (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 the clinician believes that it is warranted (Mago, 2013).

PART II. ISSUES IN DOMESTIC VIOLENCE: LEGAL AND ETHICAL ISSUES

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.

According to the Centers for Disease Control and Prevention (CDC; 2021b), “about 1 in 4 women and nearly one in 10 men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime.” These statistics mean that approximately 30 million women and 12 million men have experienced intimate partner violence (CDC, 2019). Although these numbers seem high, they are gross underestimates. Many domestic violence victims do not report incidents of abuse to law enforcement for reasons such as fear of removal of children, 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 justice system. While clinicians cannot be experts in everything, it is important to have an 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 section of the course will provide an overview of intimate partner violence risks, a discussion of why survivors are reluctant to disclose abuse, the legal resources available to clients, and ethical obligations. It will also contain helpful information, including a summary of California laws on mandatory arrest and a sample safety plan.

The terms “domestic violence” and “intimate partner violence” will be used interchangeably.

LEARNING OBJECTIVES

Upon completion of this course, the learner will be able to:

16. Describe the role of the mental health professional in working with domestic violence cases, including advocacy, navigating systems, and safety planning.
17. Discuss ethical and legal issues related to domestic violence.

SCOPE OF THE PROBLEM

Until about the 1970s, domestic violence was widely seen as a “normal” part of marriage or intimate relationships. A significant shift in this view is now taking place within the criminal justice system because of the sheer dangerousness of intimate partner violence. Domestic violence presents many safety-related concerns. Mental health providers should be careful not to minimize safety concerns, and assessment of safety and risks should be an ongoing component of therapy.

Intimate Partner Homicide

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. Prior domestic violence is a strong risk factor for intimate partner homicide. According to the American College of Emergency Physicians (Riviello, 2014), an “overwhelming majority” of intimate partner homicide victims had been seen in emergency departments within the previous year. Risk factors for healthcare workers to look out for are “attempted strangulation, estrangement from the abuser, and pregnancy” (Riviello, 2014). Abused women become especially vulnerable during pregnancy (Campbell et al., 2021).

Some common warning signs of intimate partner homicide include

- 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; and
- history of drug or alcohol abuse (abusive partner or victim).

(Campbell et al., 2003)

Other Losses

In addition to homicide of victims of intimate partner violence, there are other losses, which include suicide and nonfatal injuries. Suicide.org estimates that one out of every four women who are the victims of domestic violence attempt suicide (Caruso, n.d.).

The number of men and women who suffer non-fatal injuries provides another frightening picture of potential losses associated with domestic violence. 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. In the same year, men experienced 101,000 nonfatal violent victimizations by an intimate partner. Over their lifetimes, about 33 million women and 13 million men have experienced contact sexual violence, physical violence, or stalking by an intimate partner (Breiding et al., 2014). After the incident, fewer than one in five victims seek medical care (Catalano et al., 2009). Only about half of domestic violence is reported to the police (Truman & Morgan, 2014).

REPORTING INTIMATE PARTNER VIOLENCE

Many victims of domestic violence fail to report abuse to the police. A 2015 report by the American Civil Liberties Union described the results of a survey of advocates, service providers, and “people working in membership-based organizations” concerning why victims of sexual assault and domestic violence often fail to report the crimes to the police. An overwhelming

majority – 88% – of respondents reported that police sometimes or often fail to believe the victims, and 83% reported that police sometimes or often fail to take the allegations seriously. More than half believed that the police were biased against certain groups, and many felt that the bias was against women in general. A huge majority (89%) reported concern over involvement with child protective services, and many worried over immigration status, loss of housing or employment or welfare benefits for either the victim or the perpetrator. Many of the respondents felt that survivors’ goals were different from those of the criminal justice system, and that they were not looking for punishment for or separation from the abuser.

This distrust of the legal system also extends to healthcare professionals. This distrust may be particularly strong when children are involved or children witness or are victims of family violence. One source of controversy is “failure to protect” statutes. These statutes may be enforced if a victim’s choice to remain with the abuser puts children in harm’s way. In some states, children can be removed from the family for this reason. California’s “failure to protect” statute is Welfare and Institutions Code 300(b).

Advocacy

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 Empowerment Wheel for domestic violence (see [Figure 1](#); National Center on Domestic and Sexual Violence, n.d.) is based on the **Duluth Wheels** (Domestic Abuse Intervention Programs, n.d.). 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.

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

Confidentiality: The clinician must first establish confidentiality. Discussing the possibility of victimization must take place 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. When there may be limits to confidentiality (discussion will follow), these limits 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 for a victim of abuse and the mandate to report child abuse. The following case illustrates the importance of managing confidentiality issues in a way that is sensitive and also affirms the integral role of the non-abusing parent.

Case Example

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 says that she is frightened to tell Trudi 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, the agency is less likely to take the children, and she stresses to Maribeth 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 support Maribeth in her efforts to take the children to a domestic violence shelter.

Figure 1. The Advocacy and Empowerment Wheel



Validation: It is important for clinicians to believe and validate reports of violence. 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, an 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 and often experience self-doubt and self-blame. Be aware of blaming statements and respond appropriately.

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: A victim's safety is critical for their recovery. According to the APA Presidential 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, and
- 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?"

Promote Access to Community Services: Know the resources in the community. If possible, provide victims with a written list 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. When making a referral to any of these agencies and organizations, 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 and 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 a.m. and 5:00 p.m., Monday through Friday, at 916-444-7163. This organization can provide clinicians and clients with hotline numbers for local domestic violence programs.

Victim/Witness Services

California/Victim Witness Assistance Centers and trained victim 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 (California Victim Compensation Board, n.d., 2022). For further information, please see <https://victims.ca.gov/for-victims/get-help/>.

Office of Victim and Survivor Rights and Services

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 addition to victim compensation, California’s Office of Victim and Survivor Rights and Services provides “information, notification, restitution, outreach, training, referral and support services to crime victims and their next of kin” (California Department of Corrections and Rehabilitation, 2022). For further information, see <https://www.cdcr.ca.gov/victim-services/>.

Criminal and Civil Courts

Some states have dedicated courts that act on criminal complaints pertaining to domestic violence. This ensures consistent responses to the problem. Domestic violence is no longer treated as a simple battery. Consequently, the system imposes enhanced and specialized sentences for these offenses. In the case of California, some of these cases are handled in the criminal courts, and some are handled in family court (Judicial Council of California, 2022a).

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 – prevent abusers from harassing attacking, threatening, or assaulting, and/or prohibits any type of contact;
- Stay-Away Order – prohibits abusers from coming within a certain radius of the victim;
- Move-Out Order – requests 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 – allows the victim to record communications made by the abuser in violation of legal orders;
- Animals – orders the abuser to stay away from the animal and not harm or dispose of it;
- Child Custody, Visitation, and Support provisions;
- Debt Payment – orders the abuser to continue paying accrued debt; and
- Property Restraint – orders 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; and
- 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 in providing 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; reauthorized in 2022) makes protection orders enforceable across 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. California Penal Code Section 273.6 covers punishments for the violation of protective orders.

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

Each California county has an adult protective services (APS) agency to help older adults (60 years and older) and dependent adults (disabled adults aged 18 to 59) when these adults are unable to meet their own needs or are victims of abuse, neglect, or exploitation (California Department of Social Services, 2022).

Child Protective Services

In defining Child Protective Services (CPS), the Family Violence Prevention Fund (n.d.) 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” (p. 1). Although state laws vary with regard to what is reportable to CPS, in all states clinicians are mandated to report any reasonable suspicion of child abuse or neglect.

Although women fear the possibility of a report being filed with CPS and children are sometimes removed from an abusive household, more often efforts are made to keep children with a non-abusing parent. A parent may be referred to a shelter or short-term housing. Child protective services often runs support groups and can refer women to additional resources.

Ethical Considerations: Confidentiality

Case Example

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, saying 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?

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 course, including the criminal justice system and CPS. The case vignette provides an example of potential disclosure of confidential therapy discussions to CPS. 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 specific state guidelines.

To begin, it is important to look at the obligation to maintain confidentiality, a standard shared by all professional codes. An example of this guideline is contained in NASW (2021) Standard 1.07(a), which states: “Social workers should respect clients’ right to privacy. Social workers should not solicit private information from or about clients except for compelling professional reasons. Once private information is shared, standards of confidentiality apply.”

This 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, and coordinating with a child’s school teacher or counselor.

Compelling Reasons to Break Confidentiality

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 others” (Standard 1.07[c]; NASW, 2021). This is a broad dictate and can include (but is certainly not limited to) harm to a minor child, harm to an older adult, harm to oneself, or harm to others. Should clinicians be required to break confidentiality, they 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” (Standard 1.07[c]; NASW, 2021) and, when possible, inform clients of the disclosure in advance.

Because clinicians are mandated reporters, they are required to report suspected cases of abuse. One common question is how certain do clinicians need to be in order to make a report of abuse and break confidentiality? Clinicians should remember that their mandate is to report suspicions, not investigate. On a therapeutic level, it is important to consider the potential consequences of reporting, including increased child endangerment if their disclosure triggers the report and/or loss of rapport with caregivers.

In addition to issues regarding suspected child abuse, clinicians are ethically bound to disclose information in situations in which they believe clients will harm themselves or others. With the link between domestic violence and suicidal thoughts and 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, a clinician may be compelled to seek help for an intended victim, even if that victim is an abusive partner.

Confidentiality and Privilege

Case Example

Carla Varnis, a clinical social worker, is working with Pamela, who has been a victim of domestic abuse. Carla receives a subpoena for medical records from Pamela’s husband’s attorney. Pamela’s husband has filed for custody of the children, 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?

The intersection of the court system and mental health system can prove to be challenging. In some cases, 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 situation is covered by NASW (2021) 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,” and by similar standards in other professions’ codes of ethics. 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 Standard 1.07(d) states that “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 educate the client about the potential effects of disclosures regardless of whether the disclosure is made “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 Pamela, 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 (Zur, n.d.b).

While the opposing lawyer can continue to fight to see Pamela'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 Protect

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

Case Example

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, saying 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."

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 Empowerment Wheel depicted earlier, it is vital 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 her ability to act in a therapeutic manner.

As discussed in the previous section of this learning material, *Tarasoff v. Regents of the University of California* (California Supreme Court, 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” (California Supreme Court, 1976, p. 340). In California, Diane has a mandatory duty to protect Gerald.

There is no “one-size fits-all” approach. According to the NASW publication *Social Workers and “Duty to Warn” State Laws* (2017), 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; and
- 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 one thing that may help is to make a call together to Child Protective Services. They will help us 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 defuse a potentially dangerous situation. Had Patricia been less cooperative and Diane felt that a credible threat still existed, enlisting the support of the authorities might have been necessary.

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.

DOMESTIC VIOLENCE SAFETY PLAN

Safety planning is an important component of domestic violence treatment. Experts on trauma work such as Herman (1997) and Bloom (2013) state that creating safety for trauma survivors is key to recovery. With survivors of domestic violence, creating safety often involves assessing lethality and developing a safety plan. Mental health professionals can use the warning signs of intimate partner homicide (previously discussed) 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 who is not the abuser's;
- control;
- threats of suicide; and
- stalking or spying behavior.

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:

- Important phone numbers, such as hotlines, clergy, school contacts, friends, and local domestic violence resources and shelters.
- Friends or neighbors who 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.
- Safe exit from the home. Practice ways to get out quickly if need be.
- Safer places within the home. Think about places where victims can go to be away from the abuser.
- Remove all weapons from the house, if possible.
- 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.
- Encourage clients to go over their safety plan often.

Other things clients should consider include:

- thinking about people who might help if they left. These people could keep a bag for them, lend money, or help with children and/or pets.
- getting a prepaid cell phone to pack in a bag.
- opening a bank account or getting a credit card in their name only.
- thinking about times when it is safer to leave without children.

Things to take:

<ul style="list-style-type: none">• Order of protection• Money• Keys to car, house, work• Extra clothes• Medicine• Welfare identification	<ul style="list-style-type: none">• Birth certificates• Social security cards• School and medical records• Bankbooks, credit cards• Driver's license• Car registration• Other important papers
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PART III. THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Case Example

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, 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 to focus on protecting employees and their families from insurance practices such as these. The initial version of HIPAA focused primarily on healthcare coverage, specifically ensuring that employees were not in danger of losing coverage if they lost or changed their jobs (HIPAA Security Suite, 2019).

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 healthcare transactions and addresses the security and privacy of health data. This has meant changes to existing procedures for many mental health providers (HealthCare Informatica, 2014).

This section of the learning material will focus on HIPAA and the implications for mental health practitioners. Ethical standards of the professions mandate that clinicians remain aware of state and federal regulatory standards. The AAMFT *Code of Ethics* (Standard 3.2, 2015), for example, states: "Marriage and family therapists pursue appropriate consultation and training to

ensure adequate knowledge of and adherence to applicable laws, ethics, and professional standards.” This section of the learning material will provide an overview of HIPAA. Resources for further study are also contained in the References section of this document.

LEARNING OBJECTIVES

Upon completion of course, the learner will be able to:

18. Discuss the components of HIPAA, including its established ethical and legal requirements.
19. Describe the informed consent procedure, including the Notice of Privacy Practices and patient access to information.

COMPONENTS OF HIPAA

HIPAA is the acronym for the Health Insurance Portability and Accountability Act. HIPAA has several components:

- **portability standards** that ensure the continuity of health care,
- **privacy standards** that govern the disclosure of protected health information, and
- **security standards** that protect the development and maintenance of health information.

Healthcare 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’s insurance 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; and
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 (strengthened by the ACA) 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 a health condition before enrolling in the company insurance plan. Under HIPAA, such denials are not allowed. If a plan generally provides coverage but denies benefits to an individual because he or she had a condition before coverage began, this is a HIPAA violation.

Under HIPAA, a plan is allowed to look back only six months for a condition that was being treated 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 six months prior to that individual's enrollment date in the plan. For example, if a person was diagnosed in the past with anxiety but did not receive treatment for the anxiety in the six months before enrolling in the plan, 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, and 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. The ACA has largely done away with exclusion periods, though they do still occur (Kagan, 2022). It is important to note that, if the ACA were to be overturned by the Supreme Court or any other way, HIPAA protections would remain unaffected (Bihari, 2022).

Case Example (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 healthcare plan. This certificate 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, and discharge date;
- client telephone or fax numbers;
- email address;

- Social Security number; and
 - client photographs.
- (HIPAA Journal, 2022)

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.

The Privacy Rule:

- sets boundaries on the use and release of health records;
- enables clients to find out how information may be used, and about certain disclosures of their information that have been made;
- gives patients the right to examine and obtain a copy of their health records and to request corrections if data is incorrect;
- establishes appropriate safeguards that healthcare providers and others must achieve to protect the privacy of health information; and
- enforces civil and criminal penalties if there is a violation of clients' privacy rights.

Although all of this may sound daunting, in actuality the requirements for most mental health providers are fairly straightforward. 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;
- training any employees (such as billing specialists and administrative personnel) so that they understand the privacy procedures;
- designating an individual to be responsible for seeing that the privacy procedures are followed; and
- 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”?

Any individual mental health provider or any mental health provider who works for a hospital, health plan, or healthcare clearinghouse that transmits information electronically is affected by HIPAA. Such individuals and institutions are called “covered entities.”

The term “covered entity” includes any mental health provider who submits 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 (HHS, 2017). Please note that if there is even a single electronic transmission to an insurance carrier or other third party, the HIPAA requirement states that the provider 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 section of the learning material.

Case Example

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 AND DISCLOSURES 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 provider’s ability to communicate with clients, to engage in treatment planning, or to coordinate care with other professionals. HIPAA policies recognize instances in which protected health information may be disclosed inadvertently. This situation is called “incidental disclosure” of protected health information. Many healthcare 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. The need may also arise to share some aspect of a client’s information with someone not directly involved in the patient’s clinical care, such as when a person doing the provider’s billing needs access to a diagnostic code. This situation is referred to as “incidental use.” The Privacy Rule permits these incidental disclosures of health information when the provider takes reasonable safeguards to protect an individual’s privacy (HHS, 2013). 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; and
- using passwords on computer files containing personal information.

Case Example

Jane is the director of a Partial Hospital Program (PHP). 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 helps to highlight the ambiguities that may be evident in applying HIPAA guidelines. Although the whiteboard displaying information may be considered an incidental use or 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. Minimal changes in procedure, such as handing each client a sheet specifying the groups that he or she 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. Even so, uses of protected health information for treatment are not exempt from the minimum necessary standards. 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 Notice of Privacy Practices, 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 (a) the provider would find it impossible to comply with both the state and federal law provisions or (b) 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, the provider can comply with both state and federal law by responding within 10 days.

As is evident from the above discussion, the content of the Notice of Privacy Practices will vary. In general, this document details routine uses and disclosures of protected health information, as well as an individual's rights and the duties of the provider or hospital 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 merely to provide 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 clients have 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 be necessary when speaking to representatives of health insurance plans before they approve or pay for the healthcare services. 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:** Occasionally breaking client confidentiality is both an ethical and legal mandate. The Notice of Privacy Practices should include information about instances when providers may need to disclose protected health information and yet do not specifically need to inform clients about these disclosures. The laws vary by state 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 issue involves ways in which details about psychological information are managed, and includes removal of patient identifiers when able to do so, as well as treatment of particularly sensitive information such as HIV/AIDS information, disability status, and 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 a client may access medical records. A later 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 Notice of Privacy Practices is the sheer amount of information that is covered in these documents. Many clients do not read the entire document, and a verbal explanation of confidentiality continues to be helpful. Many excellent examples of Notices of Privacy Practices are available online.

PATIENT ACCESS TO RECORDS

The HIPAA Privacy Rule allows 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. The rules do 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 policy in the Notice of Privacy Practices.

The Privacy Rule recognizes that there are situations in which access to records would be contraindicated. An individual's request to access PHI can be denied when:

- 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 healthcare provider) and access is reasonably likely to cause substantial harm to that person;
- the individual is notified in advance that access to PHI may be temporarily suspended because it was created during research; and
- the PHI was obtained from someone other than a healthcare 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.

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. Some exceptions to allowing access are

- 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, and
- when, and to the extent that, the parent agrees that the minor and the healthcare 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 section of the learning 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. Ross and Lin's 2003 review article published in the *Journal of the American Medical Informatics Association* found that there were no adverse consequences associated with allowing patients to review records in medical settings. However, more risks existed for psychiatric patients. The authors write that

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 descriptive 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.

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 next section.

Case Example

Lena, a clinical social worker in a hospital setting, receives a phone call from a former patient of the hospital requesting his records. The patient, who has previously been treated for bipolar disorder, makes allegations during the course of the conversation that lead Lena to suspect that he is in an active manic state. Concerned about HIPAA regulations with regard to patient access, Lena discusses the case with her supervisor, and together they call the patient to inform him such access will not be possible. They follow 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. The state of California directs clients to federal law concerning such access (Bonta, 2022; CPH & Associates, 2011). 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 Rule provides 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 the notes are not distinguishable as separate from the rest of the record, access to the information receives no 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 general guide 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, and
- progress to date.

Case Example

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 record he keeps for broader use. When Mark discovers this, he is 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 who provide forensic services, the Act has not generally had a great impact on those services. To understand why, it is important to think back to the definition of protected health information discussed previously: 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 for use in, a civil, criminal, or administrative action or proceeding" (Section 164.524[a][1][ii]) 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 EPHI. This is protected health information that is transmitted or maintained in electronic form, and does not include handwritten or orally transmitted information. Examples of EPHI include

- healthcare claims,
- healthcare payment and remittance advice,
- electronic requests for coordination of benefits, and
- electronic treatment request forms.

The Security Rule discusses administrative, physical, and technological safeguards. These safeguards include access to offices, computers, and files needed to keep electronic healthcare information confidential and secure. Thus, the Security Rule covers a practitioner or facility's administrative procedures, the securing and identifying of data on computers, and the transmission of information.

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 and making certain that computer files contain passwords known only to those who need to access data. The Security Rule takes into account the concept of scalability. This means that a solo practitioner is not expected to take the same steps to comply as a large practice or a healthcare facility needs to take.

Case Example

Dr. Robb, a psychologist in private practice, has just become familiar with the HIPAA Security Rule. 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 often takes files home to work on billing and submits payment requests on her home computer. As Dr. Robb cannot ensure the security of offsite transmissions, he asks his assistant to work on client information and needs only in the office.

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

- HIPAA standards apply to protected health information: “individually identifiable information relating to the past, present, or future health status of an individual that is created, collected, or transmitted, or maintained by a HIPAA-covered entity in relation to the provision of healthcare, payment for healthcare services, or use in healthcare operations” (HIPAA Journal, 2022); this broadly includes any part of a client's medical record or payment history;
- HIPAA sets boundaries on the use and release of health records;
- HIPAA gives patients the right to examine and obtain a copy of their own health records and request corrections;
- HIPAA establishes appropriate safeguards that healthcare providers and others must achieve to protect the privacy of health information;
- providers must notify clients about their privacy rights and how their information can be used; and
- mental health practitioners must adopt and implement privacy procedures.

In 2009 President Barack Obama signed the Health Information Technology for Economic and Clinical Health (HITECH) Act. This Act, part of the economic stimulus package created to counter a severe economic downturn, had the goal of expanding the use of electronic health records (EHR). The harsher penalties in the Act promoted compliance with the HIPAA Privacy and Security Rules (HIPAA Journal, n.d.b). One HITECH rule allows patients to learn who has accessed their EPHI, and “under what authority” (ComplianceHome, 2019; HIPAA Journal, n.d.a).

PART IV. CONSIDERATIONS FOR THE PROVISION OF TELEHEALTH

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?

The COVID-19 pandemic has accelerated the use of telehealth to provide online psychotherapy. The same laws that protect 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. In 2017, the Board of Psychology released a *Notice to California Consumers Regarding the Electronic Delivery of Psychological Services*. Practitioners are encouraged to be familiar with the content of this notice, which is found at https://www.psychology.ca.gov/consumers/internet_thrpy.shtml.

The following section of the learning material will discuss the provision of telehealth, including its challenges and benefits, cultural and linguistic considerations, and regulatory and ethical considerations associated with this medium.

LEARNING OBJECTIVES

Upon completion of this course, the learner will be able to:

20. Identify the types of technology available for telemedicine.
21. Recognize the ethical principles related to the practice of telehealth, including confidentiality and privacy.
22. Explain best practices in telehealth, including risk management and working with different populations.

THE ROLE AND EFFECTIVENESS OF TELEHEALTH

The pandemic has sown the seeds for permanent changes in the ways health care is provided, regardless of locale. The initial need for telehealth, prompted by access and efficiency requirements, is now bolstered by the need to meet CDC (2021a) safety and accessibility guidelines. The use of telehealth options enables the healthcare workforce to provide essential care to consumers despite the strain of COVID-19 limitations such as social distancing and wearing masks outside of the home.

The Health Resources and Services Administration defines telehealth as the “use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and landline and wireless communications” (HHS Office for Civil Rights, n.d.).

The federal government and private insurance companies are facilitating the use of telehealth with unprecedented ease. The Department of Health and Human Services (HHS; 2022) continues to encourage the use of telehealth to deliver non-life-threatening care such as wellness visits, eye exams, nutrition counseling, and mental health support.

“As virtual care becomes more integrated into the patient-provider engagement ecosystem through technology and regulatory advancements, traditional “bedside manner” will become “websiteside manner” (InstaMed, 2022). This shift to increased virtual interactions between consumers and clinicians will force providers to reexamine previous “ways of doing” components of care, such as building rapport and establishing trust through positive communication skills. In addition to managing all the practical transitions necessary to provide telehealth, providers must ensure that they are practicing within legal and ethical parameters. In order to do so, telehealth training to utilize this modality skillfully is paramount. Callan and colleagues (2017) identify six areas of needed training in telehealth:

1. telemental health therapy,
2. case conceptualization and change mechanisms,
3. cognitive neurosciences,
4. ethics and professional guidelines,
5. governing legislation and regulations pertinent to behavioral health practice, and
6. professional communication and record keeping.

Undoubtedly, compared to in-person appointments, some clinical nuance is lost with telehealth consultations no matter the training. In some cases, patients attending partial hospitalization programs were abruptly terminated without suitable virtual replacement. Both patients and practitioners who are hard of hearing have reported difficulty with using phone appointments. [Figure 2](#), extrapolated from Essig (2020), compares risks and rewards for in-person appointments.

Cost-effectiveness and increased availability of services afforded by telehealth reduces some health disparity in psychiatric and mental health services. Including patients and consumers in designing and lobbying for increased access through digital means would help with the so-called “digital divide” in society. Telehealth should be offered to improve options for consumers regardless of situational demands. Data supporting the use of telehealth effectively is needed to bolster regulation that may solidify its permanence.

Figure 2. In-Person Mental Health Therapy During the COVID-19 Pandemic

REWARDS	RISKS
What takes place on screen is fundamentally different relationally.	In-person psychotherapy won’t be “normal” with needed safety precautions (e.g., social distancing, masks, safe time limits for being in enclosed spaces).
Initial intakes provide more contextual nuance and information; easier to establish rapport?	Possibility of contact tracing threatens promise of confidentiality.

Insurance companies may impose time limit on teletherapy prematurely, compared to office visits.	Each participant a potential virus threat; may need to conduct appointments behind mask or shield. Risks personal and public health.
Greater need for mental health services after protracted pandemic and its consequences.	Barrier to access: Patients may stop treatment if they feel office or commuting to office is too dangerous.
	The personal and public health vigilance required reduces therapeutic benefit.

With the increase in telehealth as a primary source of healthcare delivery comes a new set of ethical challenges never before encountered. Thus, the exploration of ethical encounters engendered by telehealth is more important than ever.

TELEHEALTH TECHNOLOGY BASICS

Telehealth technologies are mechanisms to provide healthcare services remotely. They are commonly delivered through HIPAA-compliant, cloud-based sites. These services can be delivered through a variety of devices, including desktop computers, laptops, tablets, smartphones, and smartwatches. Telehealth platforms can allow clinicians to conduct online assessments, secure document storage, schedule appointments, offer online billing, provide secure messaging sites, and offer pdf forms and the ability to sign the forms electronically (eSign).

Telehealth services can be offered in a variety of settings, including private practice, agencies, and large consumer systems, such as hospitals. The types of technologies that are most effective may vary depending upon setting. Telemental Health Comparisons (2020) is an independent website that provides comparisons for telemental health software (<https://telementalhealthcomparisons.com/>). This site can be used when a provider registers for a free account.

Practitioners who would like to establish a telehealth practice should keep a few things in mind. One primary issue is being reimbursed for services. The platform selected should be easy to use, HIPAA compliant, and include a variety of useful provider tools, such as e-prescribing, client custom folders, a scheduling system, appointment alerts, data export options, electronic health record integration, and automated workflows. Providers should understand whether the telehealth system is cloud-based and compatible with provider equipment, such as computers or tablets. They should also know whether it incorporates adequate video resolution, full screen video options, mobile access, and camera abilities – such as tilting, rotating, and zooming. Finally, the technology a provider chooses should include, even if it comes at an additional cost, technical support. Providers are responsible for maintaining their equipment and assisting patients when problems arise. Technical support is vital and should include a variety of mechanisms, such as phone support, email, chat, live video, and website support.

Types of Technology

Live Videoconferencing

Live videoconferencing is a mechanism for providing synchronous services, meaning live interaction in real time (Chai & Lazar, 2021). Videoconferencing is a way for a provider and patient to see one another, interact, and engage on a live monitor or screen. Providers can use live videoconferencing to conduct screenings and assessments, render diagnoses, and provide healthcare appointments.

Store and Forward

Store and forward is an asynchronous mechanism that transmits information not in real time. It allows for information, resources, images, or video clips to be saved, forwarded, and used whenever convenient. Examples of store and forward technology are patient data, video clips, photographs, or other types of information that can be sent at a later time through texts or emails. This capability has benefit in behavioral health. For example, clients engaged in cognitive behavioral therapy can use store-and-forward technology to track targeted behaviors.

Remote Patient Monitoring

Remote patient monitoring remotely collects and sends data to providers at a remote location (Telehealth.hhs.gov, 2022). Remote patient monitoring systems can help providers assess the health status of a patient by collecting information, such as vital signs, weight, and blood pressure. Psychiatrists or prescribers may use remote patient monitoring to check health status before adding or changing medications.

Mobile Health (mHealth)

Mobile health applications use the Internet and wireless devices, such as smartphones and tablets, for clients and patients to obtain specialized health information, participate in online discussion groups, collect personal data, or receive peer support (American Academy of Allergy, Asthma & Immunology [AAAAI], n.d.). A number of mHealth apps are available for use in behavioral health services for a range of ages and conditions.

Secured vs. Unsecured Technology

Health data breaches and cyberattacks targeting medical information have steadily increased with the more frequent reliance on technology. Breaches to protected health information (PHI) are costly for service providers. When breaches occur, the provider is responsible for conducting investigations, notifying clients, recovering data, subscribing to credit monitoring services for clients, hiring security personnel, and strengthening the security of the telehealth technology (Zhou et al., 2019). In order to provide education to consumers and engage in practices that protect clients, clinicians should be familiar with the level of security of the technologies they use.

An unsecured network refers to an Internet connection that does not require a secure authentication process. Unsecured networks are generally public free wireless Wi-Fi connections (WhatIsMyIPAddress.com, 2022). Free Wi-Fi access allows anyone to use a network without a special authentication system. Although a public network is easy and convenient to use, it is

unsecured, so that someone could breach the connection and obtain personal data without consent of the user. Some public connections, also called hotspots, will have a user acknowledge terms and conditions. However, this acknowledgment does not secure the network site.

Most home wireless networks have built-in security features in their routers. There are typically passwords that allow access. However, in order for a home network to be secure, individuals need to take steps (WhatIsMyIPAddress, 2022). To secure a home network, the user needs to enable security settings and create a router password. There are different levels of encryption, such as WEP, WPA2, and WPA1, but each offers a level of security (WhatIsMyIPAddress, 2022). It is important to update and change passwords regularly.

A secured Wi-Fi network is one that uses passwords and security encryption methods to send wireless data (HealthIT.gov, 2019). WPA2 offers encryption that meets the IEEE 802.11i security standard of the Mobile Device Privacy and Security subsection of HealthIT.gov. Another way of providing a secure network is to use a virtual private network (VPN). A VPN provides encryption between a device and the server, so information that is sent or received is protected.

Platforms

A platform is a group of technologies that are used as a base for other applications, processes, or technologies and are commonly offered by a managed service provider for use in telehealth (Techopedia, 2020). A platform uses the computer (hardware) and operating system (software) on which applications run. The user purchases a set of standards and functions for the platform.

COMMON TELEHEALTH ETHICAL ENCOUNTERS

Most ethical transgressions that occur in telehealth are related to confidentiality (Aboujaoude, 2019). Consider the following situation:

A client is told that because of the pandemic the clinic where he receives therapy will be switching to a video conferencing platform to provide services. The client voices concern about privacy. He will provide consent to have therapy only by phone.

Self-determination is another guiding principle, particularly in the social work profession; with a handful of exceptions, practitioners must abide by the client's wishes. To take his concerns as a cautionary tale, though, practitioners might also want to reassure each client at the beginning of each appointment as to the setting and how privacy is protected.

Privacy is related to confidentiality and is also primary in serving clients. Lustgarten and colleagues (2020) expand the definition of telehealth privacy to include more than the patient's appointment. Technology is increasingly used in progress notes, in therapy services, emails, texting, telebehavioral health therapy, electronic medical records, cloud-based storage, application, and standardized assessments to expedite service provision and more efficient collaboration with payors. However, any of these uses can pose a threat of unintended breaches of confidentiality or privacy with untoward consequences. The following is a list of terms commonly used when discussing technology (and technology failures):

- The term **asynchronous communication** refers to data transfer taking place over a period of time. Examples include email and texts. “Asynchronous” is contrasted with “synchronous” (see below; AAAAI, n.d.; California Telemedicine & eHealth Center, 2022). Email is increasingly used in telehealth, but PHI is vulnerable to breaches through this medium. The client and provider have no control over the systems that maintain email. In addition, human error can result in breaches such as sending emails to the wrong recipient. Email phishing is another threat to patient data. It is recommended that practitioners use encrypted email services and inform patients about the potential risks in using email.
- **Synchronous** connections are in-person, live interactions that transmit information in both directions at the same time (AAAAI, n.d.). Examples of synchronous communication are speaking on the telephone or using videoconferencing.
- **Applications/“Apps”** used in telemedicine often are self-help tools enabling clients to record data or symptoms. Unfortunately, apps tend not to offer sufficient security. For example, clients expect to be able to use text messaging apps to communicate about their health care. The ease of texting may result in clients expecting to use it as their sole form of communication. However, to quote Lustgarten and colleagues (2020), “Threats to text messaging privacy can emerge from individual, corporate, and government actors” (p. 26). Individuals’ phones can be hacked, corporations may scan data for advertising or marketing purposes, and government agencies may intercept messages as part of surveillance programs. Therefore, clients should be informed that privacy is not assured with text messaging or other apps.
- An **electronic health record (EHR)** is a digital collection of health information about individual patients that is recorded in electronic formats and is capable of being shared among healthcare settings across network-connected information systems (CMS, 2021). Electronic health records generally include patient demographic information, intake forms, consent forms, medical history, medication, allergies, immunization status, laboratory results, medical test results, collateral patient data, crisis plans, progress notes, intake assessments, treatment plans, and financial information. Other terms for EHR are electronic medical record (EMR), personal health record (PHR), and electronic patient record (EPR). Managed services providers (defined below) may provide EHRs in telehealth and their storage – including the storage in HIPAA-compliant ways of completed health record templates for the clinician’s access and use.
- A **managed service provider** can offer various applications on a central server. Customers generally pay a fee to access the applications over secure Internet connections or a private network. Customers do not have to purchase, install, or maintain the software themselves. Rather, they rent (e.g., through monthly subscriptions) the applications they need from a managed service provider. The managed service provider generally handles software upgrades and software fixes (Insight, n.d.). Mental health practitioners may already be accessing these types of services if they use online billing applications or interact with particular applications when working with insurance companies.

- Another useful term is **distant site**. Sometimes telehealth services are provided to patients at remote clinics, called “originating sites” (see more below). The distant site is where the practitioner or physician is located while delivering remote services to patients in other physical locations (i.e., originating site).
- When an individual is receiving telehealth services, the **originating site** is where the client is located (as opposed to the distant site, where the practitioner is located; AAAAI, n.d.).

Privacy and confidentiality issues can manifest in many ways via telehealth. Consider some of these examples:

A patient comes to the tele-session visibly agitated. She explains that she has just had an argument with her neighbor. As she is explaining the situation, the neighbor comes in her door and says, “You better not be talking to anyone official about me.” The patient screams at her to get out of her house.

This type of unexpected intrusion would not happen in an office setting. Although the incident does give in vivo exposure to what the patient is experiencing, it is also an example of appointments being “maliciously observed by outside parties” (Lustgarten et al., 2020, p. 26).

About forty-five minutes into the video appointment, the patient asks her counselor if she would like to see the room renovation project she has been working on. The counselor agrees, and the patient takes her on a “tour” of the work being done in her house. While she is walking around with her videophone, the counselor sees a man in the background. Immediately she asks the client who is in the room with her, only to learn it is the handyman who is helping her remodel. It becomes clear that this man was able to hear both the client and clinician. The clinician expresses her concern and the patient says, “Oh, he’s okay.”

Clearly, this situation represents a confidentiality breach, but since the clinician was not told of the person in the background, is she at fault? Does ignorance of a breach exonerate one from sanctions? This scenario points to the need to have an informed consent specific to the provision of telehealth which includes both the clinician’s *and* the client’s roles, rights, and responsibilities.

Creating an Informed Consent Form for Telehealth

Informed consent for telehealth should include risks associated with telehealth, exceptions to confidentiality, backup plans for technical difficulties and interruption of service, and emergency plans. Some insurers require that a separate informed consent be signed for telehealth services as a condition of reimbursement (Felton, 2020; Stoll et al., 2020).

Informed consent, which is typically obtained before or during the intake appointment, outlines in writing the client and clinician’s plan and guidelines for treatment. Informed adult consent typically includes treatment issues, such as:

1. privacy and confidentiality (e.g., HIPAA),
2. type of services that will be provided,
3. client rights and responsibilities,
4. clinician rights and responsibilities,
5. potential risks and benefits of services,

6. guidelines for appointments (e.g., scheduling and canceling),
 7. billing and fees associated with treatment,
 8. insurance coverage,
 9. record keeping,
 10. cases where disclosure is needed,
 11. how to contact the clinician, and
 12. other issues relevant to practice.
- (Center for Ethical Practice, 2022)

Informed consent for telehealth services includes all of these treatment issues as well as information that specifically relates to the risks, benefits, responsibilities, and roles of using technology (Person Centered Tech, 2020). In a telehealth consent form, clinicians may want to include:

1. the name of the software, service, or tool that will be used;
2. the benefits (e.g., convenience, flexibility) and risks (e.g., potential for faulty Internet connections or disruptions) of using telehealth services;
3. conditions under which telehealth may be inappropriate and the right of the clinician to make this determination;
4. right of the client to decide not to use telehealth technology;
5. telehealth setting and environment (e.g., etiquette, space, video skills);
6. back-up communication plan;
7. information about scheduling and canceling appointments (e.g., reminders of the time zones for the patient and practitioner, especially they are not located in the same time zone);
8. safety and emergency plan;
9. security and privacy concerns;
10. whether or not video or audio recordings are allowed; and
11. any other telehealth-related issues specific to a given circumstance.

Telehealth consent adds a layer of considerations that are different from those experienced during in-person appointments. Clinicians may need to practice first with a client before beginning regular appointments. Both the clinician and the client may need time to become familiar with the nuances of a specific software or application. They will likely need to discuss potential problems and solutions in order to reduce reluctance or anxiety about using technology. Some telehealth technology providers offer electronic consent forms built into their platforms. Clinicians should review their consent forms and other documentation forms in order to ensure that they cover the scope of practice for telehealth.

The most important feature of informed consent for treatment that a client signs is that it includes written protocols and procedures, including those for the handling of emergency situations (Crowe, 2017). Providers should know the contact information for local clinics and hospitals in case the client needs emergency intervention. Clinicians may need to establish collaborative relationships with local agencies so that crises are handled efficiently. All of this information should be included in an informed consent form. The National Association of Social Workers (2020) offers a sample of an informed consent form at:

<https://www.socialworkers.org/LinkClick.aspx?fileticket=fN67-dWQReM%3d&portalid=0>.

Usually, all video conferencing platforms are required to sign a Business Associate Agreement (BAA) as HIPAA compliant. This requirement was waived during the COVID-19 emergency. Thus, the need for patients to be aware of possible privacy concerns when using these platforms should be included in any informed consent. Practitioners should also take every precaution, such as using password-enabled connections, when using these applications. It should be noted that many pandemic-related regulatory changes and loosened restrictions are temporary.

As another risk management strategy, practitioners should ensure that their malpractice insurer covers cyber-liability and the provision of telehealth services.

Practicing Telehealth Etiquette

Clinicians need to set the tone for their appointments when using telehealth, and this starts with using proper telehealth etiquette. Social platforms characteristically are informal, and this informal approach can interfere with the development of professional interpersonal relationships (Gustin et al., 2020). According to Gustin and colleagues, “Telehealth requires professionals to develop the patient-professional relationship in a different and more deliberate way than during in-person encounters ... most failures with telehealth uses are associated with these human factors or soft skills” (p. 89).

Clinicians have always had to regard self-disclosure as a central topic for ethical consideration, and it is one in which they usually have control. In the face of telehealth and the pandemic, self-disclosure is increasingly evident and clinicians are not able to maintain the same amount of control as they usually would.

A clinician is forced to cancel a scheduled appointment because her daughter is very ill and has to be tested for COVID-19 at the same time as she was to meet with the client. She has never cancelled an appointment with this long-term client and feels the need to explain the situation since it is so uncharacteristic. The client is very understanding. Two days later the client calls the clinician to let her know she is thinking of her and hoping all is well. She prefaces her voicemail with, “I hope this is not too personal, but if you need someone to talk to or something, I just wanted you to know you could call me.”

Has a seismic shift taken place in their relationship, and if so, was it the result of an ethical boundary breach by the clinician in sharing information that made the client feel she needed to take care of her clinician? Or has it equalized the relationship in an authentic show of concern?

Creating psychological and physical boundaries is another mainstay of the therapeutic relationship that is affected by telehealth. Some clinicians may have to use their personal cell phones to contact clients or conduct appointments. The increased accessibility can result in text messages or calls outside normal business hours, blurring the physical boundary of the professional relationship. The American Telemedicine Association (Turvey and colleagues, 2013) recommends that strategies to curtail the possibility of boundary violations include setting clear parameters and rules for technology use in both verbal agreements and informed consents.

The at times informal environment of telehealth may result in a client asking the clinician’s opinion on a controversial topic. How should a clinician respond to be certain, both ethically and clinically, that he is appropriately protecting the client’s psychological safety and trust? Best practices would recommend keeping the primacy of the client and protecting therapeutic rapport in any response. As in any direct personal question, the clinician should respond to the feelings behind the words when possible. Certainly, if the client pursues the clinician’s non-direct answer

to her own direct question and continues to ask for an answer, therapeutic trust would require a more direct answer.

Confidence in addressing dilemmas demands that the clinician can identify whether the telehealth interaction poses a chance of patient exploitation. For example, if a patient begins to whisper during the appointment because a family member is in the next room and she doesn't want the person to hear what she is saying, what does the clinician do? Ensuring that the client is both physically and emotionally safe would be the clinician's priority.

Telehealth etiquette skills are not necessarily intuitive and need to be taught. (Gustin et al., 2020). Such skills "lay the foundation for a successful telehealth encounter with providers and patients" (Gustin et al., 2020, p. 91).

BEST PRACTICES IN TELEHEALTH

The NASW advises that, before providing telehealth services, social workers should check with their:

1. state licensing board,
 2. client's state licensing board if it a different state from the one in which the social worker is practicing,
 3. malpractice insurance/professional liability insurance carrier, and
 4. the client's payor (private insurance/Medicaid/Medicare).
- (Felton, 2020)

Regulations and restrictions vary per state for emergency telehealth services. Most states require that the practitioner be licensed in the state where the patient resides. However, some latitude has been afforded during the pandemic. In addition, different payors have differing parameters regarding the use of telehealth. For example, some insurers actually waived copayment responsibilities early in the pandemic. The Centers for Medicare and Medicaid Services (CMS) expanded regulatory flexibility for telehealth services under emergency declaration. Initially the regulation required that the provider use an interactive audio and video platform that afforded real-time communication. After public pressure and advocacy by organizations such as the NASW pointing out that many underserved populations have no access to the Internet, this requirement was lifted and audio-only appointments were permitted. In March of 2020, the state of California ordered insurance providers and Medi-Cal to allow audio-only telehealth appointments (APA, 2021). Also, initially telehealth was only authorized by CMS to clients who had a prior relationship with the provider. Again, this restriction was lifted so that new clients needing services could obtain them via telehealth.

Orientation to the Technology

Practitioners should give an orientation to clients about what telehealth is and how it is to be provided. This orientation can include reviewing intake paperwork, obtaining informed consent, explaining emergency protocols, and teaching clients how to physically use the equipment and/or telehealth software platform (Crowe, 2017). Orientation to the technology can include walking clients through the use of links; sending screen shots about entering URLs or using links to access

the virtual waiting room and entering the virtual appointment room; explaining privacy precautions and emergency protocols; and explaining the importance of lighting, audio, and connectivity.

Video Etiquette

A client will rely on the clinician to know how to use videoconferencing equipment and may need guidance about video etiquette as well. There are some basic rules for videoconferencing (George, 2020; Hart, 2020; Mendoza, 2020):

1. Mute yourself when not speaking.
2. Be on time or log on a few minutes before the appointment.
3. Ensure that the technology works correctly. Practice beforehand to make sure you do not have any problems.
4. Choose the proper software and hardware for telehealth services. Have a back-up plan for contact if the software and/or hardware fails.
5. Wear work-appropriate clothing and expect clients to wear what they would to an office visit.
6. Position the camera so that the client has the feel of direct eye contact..
7. Have the right lighting. The clinician and client need to be able to see each other clearly.
8. Plan for unexpected distractions during the appointment. For example, if dogs start barking because someone is at the front door, how does the practitioner handle this in the middle of an appointment?
9. Take into account the possibility of lag time in visual and audio transmission. Allow for sufficient time to receive and express information without overlap or interruption.
10. Use a direct, wired connection rather than Wi-Fi, if available.
11. Have all the materials needed for the appointment downloaded prior to the appointment. Many software platforms have a screen-sharing function that allows a practitioner to show the patient what is on the computer screen. When clinicians use the screen-sharing function, it is important that they know the clients will be able to see *everything* on the screen.
12. Choose an appropriate virtual background that is not distracting.

Multicultural Considerations

Using technology to interact can be a complicated endeavor when working with patients who are members of different cultures. Technology presents greater risks for misunderstandings and miscommunication between providers and their patients (Johnston et al., 2018). Johnston and colleagues (2018) provide several examples of ways that practitioners can convey cultural humility while using technology. A clinician can

1. adapt clinical style and process to accommodate different communication styles;
2. wear proper attire and have an appropriate room setup for direct in-home videoconferencing;
3. be aware of different understandings and uses of voicemail, return calls, and texts;
4. be aware that patients may not understand text message abbreviations such as LOL (laughing out loud) or SMH (shaking my head); and

5. understand that there are different understandings and expectations regarding the immediacy of response to emails.

There are benefits to cross-cultural telehealth service provision. Telehealth services provide increased access to care and can be used to reach a wide range of diverse populations (Johnston et al., 2018). Telehealth allows providers to offer services to diverse age groups, settings, communities, and environments. Individuals from underserved and marginalized communities can have access to services that were previously inaccessible. Telehealth practitioners can provide outreach, education, and community engagement in creative ways to address the needs of communities. They can target specific populations through an array of culturally-specific platforms. Also, because of local limitations related to distance and availability, patients using telehealth services will possibly have access to greater choices of clinicians and may choose to connect with a clinician from a similar cultural background (e.g., ethnicity, sexual orientation) if they wish, or they may deliberately choose a clinician from a different background if so desired. Finally, technology now provides greater access to translation services. Videoconferencing platforms, as well as text-based, mobile, and voice recognition services, can help bridge language barriers that can inhibit service provision.

However, there can be challenges to cross-cultural telehealth. Communities whose members are underserved or remote may be reluctant to try services with unfamiliar technologies. There may be limited connectivity where broadband services are not available (O’Dowd, 2018).

RISK MANAGEMENT IN DOCUMENTING ENCOUNTERS

Many ethical risks occur in the documentation or lack of documentation of clinician encounters. Essentially, documenting telehealth encounters is the same as recording in-person encounters; however, more contextual documentation is prudent, such as where the patient was during the encounter, or if there was someone else involved in the appointment, either intentionally or unintentionally. Four features need to be considered for risk management and documentation (explained in [Figure 3](#)):

1. content,
2. language,
3. credibility, and
4. access.

Figure 3. Documentation Strategies for Risk Management

Content	Language	Credibility	Access
Should have a clear, readable structure.	Use easily understood language.	Provide evidence for statements and outcomes.	Write for an audience.
Balance between too much and too little information.	Avoid repetition.	Avoid spelling and grammatical errors.	Remember that personal (shadow) notes are not confidential.

Include sufficient detail to enable service delivery.	Avoid defamatory or dehumanizing language.	Provide timely documentation.	Be familiar with legal, regulatory, and healthcare facility mandates governing release of records.
Avoid excessive detail, over-documentation or extraneous information.	Use clear, unambiguous and specific wording.	Acknowledge and notate errors.	Provide security for records, physically and electronically.
Use separate notes when seeing couples or families.	Do not use casual language or excessive professional jargon.	Do not speculate without substantiation.	Ensure and monitor patient access to records as requested.

(Edelson, 2018; Wheel Team, 2018)

ETHICAL ISSUES IN TELEHEALTH WITH CHILDREN, COUPLES, AND GROUPS

Working with Children

Engaging children and teens in treatment in person can be challenging enough, and the element of virtual engagement can increase frustration for both child and clinician. The U.S. Department of Health and Human Services Office for the Advancement of Telehealth (OAT) has demonstrated the effectiveness of using technology for children with special healthcare needs (Wasem & Puskin, 2000). Telehealth now includes teleplay therapy, which was employed occasionally before the pandemic and is now recognized as a viable approach. Filial therapy may be easily adapted to the online environment and is a collaborative way to encourage a child's engagement. However, adapting play therapy to a virtual environment raises both ethical and clinical questions.

What is teleplay therapy and what is it not? According to Fazio-Griffith and colleagues (2020),

Teleplay therapy refers to the use of a systematic approach to play therapy using play and play therapy interventions in a virtual context by a professional mental health practitioner expressly trained in play therapy. Teleplay would refer to use of the systematic approaches to play therapy and use of play therapy interventions; the difference in teleplay is that the clinician has not been specifically trained in play therapy.

The terms “teleplay” and “teleplay therapy” are often used interchangeably. There is a scarcity of research literature regarding clinical and ethical practice of teleplay, or supervision of teleplay, primarily because it is so new (Mullen, 2021; Straus & O’Neil, 2020). Play therapy and

supervision of teleplay require attention to the ethical situations that can come up when working exclusively with children and/or adolescents. A variety of ethical concerns can make their presence known during the play therapy process, which, in turn can influence the supervision process. Ethical issues salient in teleplay therapy primarily speak to clinician competence, record keeping and confidentiality.

Working with Couples and Families

In a scholarly article in the rare peer-reviewed literature regarding telehealth and couples and family counseling, Wrape & McGinn (2018) reviewed the unique clinical, ethical, and practical considerations of using telehealth to provide couples or family therapy. The authors categorized these areas of concern into five domains:

1. confidentiality/privacy,
 2. safety,
 3. managing multiple patients in an appointment,
 4. therapy process, and
 5. logistics for treatment planning.
- (Wrape & McGinn, 2018)

The usual privacy and confidentiality concerns are magnified when providing couples or family therapy.

Having multiple members participate meant that some common methods for increasing privacy (i.e., the use of headphones) are not readily available. ... If members are connecting from different locations, there is the possibility that someone else may be present outside the view of the screen without the other family member's knowledge. (Wrape & McGinn, 2018, p. 297)

Additionally, therapists' awareness of this possibility may inhibit their willingness to provide open and honest feedback. The possibility may also contribute to the avoidance of certain areas of discussion.

Couples and families sharing the responsibility for their own privacy and confidentiality should be clearly indicated and stipulated in an informed consent for telehealth. Documenting any inadvertent potential confidentiality risks (i.e., other family members walking in and out of the room in which the couple is participating in the video telehealth appointment) is further protection and a solid risk-management strategy.

Safety is another ethical and clinical consideration that is heightened in couples or family counseling. Even just having to sit closer together to be seen simultaneously on the screen could make for uncomfortable scenarios. In an office setting the therapist can interview partners separately to assess for safety or ask one to take a "time-out" in the waiting room or walk around the parking lot to cool down if tensions escalate. The same physical separation may not be so easily enforced in a telehealth session. Wrape and McGinn (2018) recommend that therapists establish where couples are at the beginning of each session in case police might have to be called. Some therapists ascribe to the view that this modality is contraindicated when severe violence or substance abuse is present and will refuse to treat couples and choose to work exclusively with

one individual or the other. Others offer the assessment that some intervention – particularly during the isolation of the pandemic in which domestic violence has reportedly increased – is safe to provide in certain situations (e.g., it is the only help the couple will receive) where the therapy is not escalating the situation. These decisions about telehealth in families where there is violence must be made in consultation with experts on family violence intervention.

Managing multiple patients in a session is another concern inherent to couples and family therapy, both when conducted in person and online. Imagine four people in family therapy crowded together on a couch where they cannot sit comfortably in view of the camera. If emotions get intense, will the physical proximity become problematic? Will an angry teenager leave the appointment and lock himself in his bedroom? This type of escape might not happen in an in-person appointment, particularly when the angry adolescent needs a ride home.

Couples may also split their attention in session, as one may be answering children's homework questions or another might be folding laundry, which would not happen in person. Situations like these can be curtailed with limit-setting and a mutual expectation that the session should be treated no differently than an in-person session, to the extent that this is possible. Wrape and McGinn (2018) see such examples as teachable moments in which problem-solving and communication skills can be assessed or practiced as couples work to set the parameters demanded of the therapy process.

Certain elements of the conjoint therapy process are altered dramatically, if not totally missing, in a telehealth platform. Subtle interpersonal or body language can easily be missed. The intimacy and vulnerability evoked in particular marital therapy approaches (e.g., imago therapy, emotion-focused therapy, Gestalt therapy) require attention to mind-body connections and body awareness, which is much more difficult to observe and use through a screen. The techniques of structural family therapy or transformative systemic therapy – such as joining, positioning, or posturing – are also not easily accomplished via video. Additionally, family-based (i.e., in-home) therapy is severely limited by telehealth. Therapists cannot as easily provide in vivo parenting or communication guidance when much of the interaction is taking place off-screen. Conversely, techniques such as reenactments could translate well to a virtual platform where participants can “perform” for the camera.

Finally, it is not as easy to administer objective outcome measures through quantitative assessments to assist in treatment planning, review, and evaluation via telehealth, compared with paper copies that may be used in an office setting. Clinicians need to find creative ways to collect this important information.

Working with Groups

When employing telehealth with groups, a breach of confidentiality can easily take place. A group member might attend from an insecure location where others can see or hear group members. Another possibility is that members might record or take a picture of the group or leader and use the information for unethical or illegal purposes (Whittingham & Martin, 2020). A separate signed informed consent spelling out do's and don'ts of participating in a group via telehealth is a necessary safeguard.

Group members must have the technological means to attend the group. This includes being on a secure Internet connection, rather than public or free Wi-Fi. The clinician and group members should keep the video on and do their best to be attentive and engaged. Phones or computers should be put on airplane mode to minimize interruptions. If the privacy of the patient's

location is an issue, wearing headphones or keeping the volume low can prevent sound from traveling to another room (Whittingham & Martin, 2020).

It is necessary to follow any group-established policy regarding a member, or an entire group, that becomes disconnected. If the group agrees, this may include having a member call in for the remainder of the session. Clinicians and clients must adhere to the group policy about how to handle a breach in confidentiality, such as a nonmember bystander witnessing the group or someone walking into a room while the group is meeting. For more information, the American Group Psychotherapy Association (AGPA; n.d.) gives specific tips on using technology for group therapy, which includes a quick-start guide for facilitating virtual groups, at <https://www.AGPA.org>.

STANDARDS PERTINENT TO TELEHEALTH

To keep up with the ever-changing landscape of cybertechnology in healthcare, standards have emerged in three areas:

1. regulatory law: government regulations, either through legislation or through licensing boards;
2. codes of ethics: standards promulgated by national professional associations (e.g., ACA, APA, NASW, AMA); and
3. standards of professional practice: best practice standards or guidelines adopted by professional groups and associations.

(Reamer, 2018a)

Several states have adopted telehealth legislation. In the absence of legislation, licensing jurisdictions have also established standards, as their mission is to protect the public. The APA, NASW, and ACA all have codes of ethics that have enforceable rules and aspirational guidelines for best practice. Categories relevant to telehealth include those dealing with competence, privacy, confidentiality, conflicts of interest, boundaries, social justice, practice settings, self-determination, and supervision. In addition, the NASW has revised its *Code of Ethics* and, in collaboration with the Association of Social Work Boards (ASWB), the Clinical Social Work Association (CSWA), and the Council of Social Work Education (CSWE), has established specific standards and guidelines to address the use of technology in clinical care (NASW, ASWB, CSWE, & CSWA, 2017).

Standards of care are meant to guide professional behavior and provide a basis for adjudicating sanctionable offenses or lawsuits. Standards regarding telehealth have emerged in most healthcare professions. The *NASW, ASWB, CSWE, & CSWA Standards for Technology in Social Work Practice* (2017) includes a total of 55 standards integrated into four sections:

1. Provision of Information to the Public,
2. Designing and Delivering Services,
3. Gathering, Managing, and Storing Information, and
4. Social Work Education and Supervision.

The American Medical Association (AMA) and APA have also published standards specific to the use of cybertechnology. In addition, the American Psychiatric Association has

developed an extensive and evolving “telepsychiatry toolkit” to inform psychiatrists about legal, financial, and ethical use of remote or distance psychiatry (American Psychiatric Association, n.d.b).

Practicing Across State Lines

Practitioners generally cannot practice across state lines. As of this writing, no permanent federal provisions allow mental health professionals to practice teletherapy over state lines; clinicians must register or be licensed in their patient’s state to provide teletherapy. The general directive is that services can be provided only to a client who is currently residing in the state where the clinician is licensed. Therefore, a client must be receiving services while physically located in a state where the clinician is licensed and the clinician has to be licensed in the state where the clinician is physically located while delivering services.

It should be noted that CMS temporarily loosened the within-state restriction for telehealth for individuals using Medicare, Medicaid, and the Children’s Health Insurance Program during the COVID-19 emergency (HHS, 2021).

A frequently asked question is, What if the client or clinician is temporarily out of state on vacation or business? What if the clinician and client are in two different states, but the clinician is licensed in both? Can services be provided? No clear guidance exists, and some states specify, while others do not. It is a risk to do so and safely handled by providing only short-term consultation (Zencare, 2021). To be on solid ground, clinicians should check the licensing board and relevant legislation in the state where they practice or where the client resides. On April 3, 2020, Governor Gavin Newsom signed an executive order loosening restrictions for telehealth, including the practice of telehealth across state lines (American Speech-Language-Hearing Association, 2022).

Telehealth Training

Most states, including California (Tran-Lien, n.d.), have not required training in telehealth, but it is a good idea to make sure your liability insurance covers you for telehealth. Furthermore, according to California Business and Professions Code 4980.395(a), on or after July 1, 2023, applicants for licensure as marriage and family therapists, educational psychologists, clinical social workers, and professional clinical counselors will have to show proof of having completed a minimum of three hours of training or coursework in the provision of mental health services via telehealth.

The AAMFT *Code of Ethics* (2015) addresses the provision of online therapy or supervision in Standard VI. In particular, Standard 6.1 concisely outlines the steps MFTs should take before commencing therapy or supervision services through electronic means. The standard was quoted in Part I of this course in relation to multiple relationships, but is worth quoting again:

Prior to commencing therapy or supervision services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that technologically-assisted services or supervision are appropriate for

clients or supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform clients or supervisees of the potential risks and benefits associated with technologically-assisted services; (c) ensure the security of their communication medium; and (d) only commence electronic therapy or supervision after appropriate education, training, or supervised experience using the relevant technology.

Telehealth, along with clinical supervision via telehealth, currently take center stage in the delivery of healthcare services, and its permanence in the field seems highly likely. Ensuring ethical and effective practice requires awareness, training, and a multi-layered level of competence.

PART V. PREVENTING MEDICAL ERRORS: BEST PRACTICES FOR MENTAL HEALTH PROFESSIONALS

A landmark 1999 report by the Institute of Medicine (now the National Academy of Medicine), *To Err Is Human: Building a Safer Health System*, brought attention to the issue of preventable medical errors. This report focused primarily on medical settings. According to the report, between 44,000 and 98,000 Americans were dying each year as a result of medical errors. A subsequent report published in 2012, found that approximately 200,000 Americans die from preventable medical issues, including facility-acquired conditions, and that millions may experience errors (Andel et al., 2012).

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 healthcare 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. The federal government has also focused on medical errors, with Congress funding patient safety research through the Agency for Healthcare Research and Quality (AHRQ; see <https://www.ahrq.gov>).

To Err Is Human has brought about changes in the practice of health care. More than a decade ago, The Joint Commission, the group that provides accreditation to U.S. hospitals and other healthcare facilities, began requiring hospitals to implement a number of safety practices. These National Patient Safety Goals have been reviewed annually, and include mandates for behavioral health settings (The Joint Commission, n.d.a). Some of these behavioral health goals are

- **Entry to care, treatment, or services:** Having a screening procedure for the early detection of risk of imminent harm to self or others.
- **Environment of care:** The organization establishes and maintains a safe, functional environment; areas used by individuals served are safe, clean, and comfortable.
- **Emergency management:** The organization has a written Emergency Management Plan that describes the response procedures to follow in the event of an emergency.
- **Human resources management:** The organization determines how staff function within the organization; all staff who provide care, treatment, and services possess a current license, certification, or registration, in accordance with laws and regulations and organization policy.
- **Infection prevention and control:** The organization identifies risks for acquiring and spreading infections.
- **Information management:** The organization protects the privacy of health information.
- **Leadership:** Leaders implement changes in existing processes to improve the performance of the organization.
- **Life safety:** The organization provides and maintains building features to protect individuals from the hazards of fire and smoke.
- **Medication management:** The organization safely controls medications brought in by individuals served, their families, or prescribers.
- **Performance improvement:** The organization collects data to monitor its performance.
- **Record of care, treatment, and services:** The organization has a written policy that requires timely entry of information into the record.
- **Rights and responsibilities of the individual:** The organization respects the cultural and personal values, beliefs, and preferences of the individual served.

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. Two principles commonly found in the ethical codes of counselors, social workers, and psychologists are “beneficence and nonmaleficence.” Simply put, these codes state that clinicians strive to do good and “do no harm” to those with whom they work. The APA (2017a) *Ethical Principles of Psychologists and Code of Conduct*, for example, puts beneficence and nonmaleficence together in the same General Principle, A, which 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.” The Principle goes on to outline the areas that could potentially jeopardize psychologists’ ability to help those with whom they work.

This section of the 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.

LEARNING OBJECTIVES

Upon completion of this course, the learner will be able to:

23. Define patient safety goals and medical errors in behavioral health.
24. Explain how root cause analysis analyzes medical errors.
25. Identify medical errors common in mental health.

DEFINITION OF MEDICAL ERRORS

In behavioral health, medical errors are mistakes made by mental health professionals within the normal work of their practice and which result in harm to the patient. All errors constitute a failure in service delivery and have consequences for people at a time at which they are especially vulnerable (National Academy of Sciences, n.d.). 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 when a client threatens self-harm.

Corey and colleagues (2018) suggest that one framework for studying errors is to break them down into two basic types: 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 not reporting child abuse.

The Joint Commission (2019) defines a **patient safety event** as an event, incident, or condition that could have resulted or did result in harm to a patient. This event may be the result of a defective system or process, a system breakdown, or human error. The four categories of errors are:

1. adverse events,
2. no-harm events,
3. close calls, and
4. hazardous or unsafe conditions.

The Joint Commission refers to the most acute events as *sentinel events* (Joint Commission, n.d.b). The organization defines a sentinel event as a patient safety event “not primarily related to the natural course of the [patient’s] illness or underlying condition” that “reaches a [patient] and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)” (Joint Commission, 2021). 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.

Examples of sentinel events include: An individual served dies from suicide within 72 hours of being discharged from a behavioral healthcare setting that provides around-the-clock care; prescribed medication results in a loss of function or death; any 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.

Although these examples refer to inpatient settings, a better idea of medical errors that impact mental health professionals can be gleaned from malpractice data. Most of these malpractice suits are similar to those in other fields because 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 & Vasquez, 2016). The list is presented in descending order of frequency.

- sexual violations,
- incompetence in developing or implementing a treatment plan,
- 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, and
- breach of contract.

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

ROOT CAUSE ANALYSIS

The Joint Commission requires that all organizations investigate sentinel events, whether they are reported or not. Further, if the Joint Commission becomes aware of a sentinel event, the organization must submit an analysis or action plan within 45 business days of the event. *Root cause analysis* (RCA) is a retrospective approach to analyzing errors that has its basis in industrial psychology. As the name suggests, RCA 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 RCA 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 U.S. Department of Veterans Affairs' National Center for Patient Safety (2021) states that the goal of an RCA is to determine

1. What happened?
2. Why did it happen?
3. How can it be prevented from happening again?

The use of RCA tools generally reveals three types of causes:

1. *Physical causes* – Tangible causes, such as material items failing in some way. An example of this would be a psychiatric medication causing an adverse reaction.
2. *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.
3. *Organizational causes* – A system, process, or policy that mental health professionals use to make decisions or do their work is defective. An example would be an organization's policy that delays the reporting of child or elder abuse.

The remainder of this learning material will use RCA to analyze clinical vignettes depicting mental health medical errors.

COMPETENCE

Mental health professionals can avoid many medical errors. There is a direct relationship between minimizing medical errors and maintaining professional competence. Competence implies that the treating clinician has the appropriate knowledge to assess and diagnose, as well as 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 and Vasquez (2016) list incompetence in developing or implementing a treatment plan as a leading cause of malpractice suits. At the most basic level, competence means that clinicians 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 but 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 the proper skills through reading and consultation. Often the former approach ensures a greater degree of safety for the client.

An important factor, along with knowledge and skills, is emotional competence. Clinicians need to be aware of their own personal problems that may interfere with their ability to provide care (APA, 2017a; NASW, 2021).

The final area related to maintaining competence is conscious effort on the part of practitioners to further their education. It is important that mental health professionals keep up with changes in the field and within their scopes of practice.

Case Example

Dr. 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 Dr. Jones that when her depression has been bad, she has coped by bingeing and purging. Dr. Jones is not familiar with treating bulimia, and initially tells Lisa that she will refer her to another therapist. Lisa resists, and Dr. 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.

How can it be prevented from happening again?

The therapist will receive training and supervision in any specialized psychological issues with which she is not familiar. The therapist will educate herself on local resources for making referrals when her clients need specialized care.

Discussion

Sections in the ethics codes for the APA, NASW, and NBCC can be applied to this vignette. For example, according to APA (2017a) Standard 2.01, on the boundaries of competence,

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience. ...

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

The case of Dr. Jones and her client Lisa 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, many disorders require specialized knowledge and skill. Dr. Jones was unaware of the dangers of frequent purging and failed to require the client to be medically monitored.

Case Example

Dr. Bill 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 gelatin desserts and, following the bankruptcy of the Humvee dealership in which he had invested most of his retirement savings, he had become depressed and found himself eating more and more. He probably would have experienced no ill effects other than mild weight gain if his local supermarket had not run out of whipped topping. He always bought tubs of topping 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 refrigerator in his office and every client was offered a large helping of gelatin dessert 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 bizarre, 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.

Root Cause Analysis

What happened?

Dr. Bill was providing therapy while impaired by a substance. Dr. Bill was implementing interventions with no evidence base.

Why did it happen?

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

How can it be prevented from happening again?

He should remain in treatment for his depression and substance use. He should receive regular consultation regarding his care of clients in the form of individual or peer supervision.

Discussion

All professional codes of ethics address personal problems and conflicts, as well as impaired practitioners. Related to this vignette, Dr. Bill and his colleagues engaged with various directives from ethical codes. The NASW (2021) *Code of Ethics* Standard 2.08 concerning the impairment of colleagues, for example, states

(a) 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.

(b) Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment

should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

Concerning a practitioner's own impairment, Standard 4.05 says,

(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 (Edge & Lemetyinen, 2019; Martela & Riekkii, 2018; Soto et al., 2018.)

Although a full discussion of multicultural competence is not possible in this learning material, clinicians may familiarize themselves with issues related to multicultural competence by referring back to the discussion in Part I of the course, as well as the section in Part IV on multicultural considerations as they relate to telehealth, and by reviewing any of the sources in the Reference section, including Corey, Corey, and Corey (2018); Dune, Caputi, and Walker (2018); Martela and Riekkii (2018); and Soto and colleagues (2018).

What is cultural competence? According to Sue and colleagues (2019), who have published widely on multicultural competence, cultural competence involves the possession of cultural knowledge and skills of a particular culture to deliver effective interventions to members of that culture. A culturally competent counselor possesses

- **Cultural awareness and beliefs:** The provider is sensitive to her or his personal values and biases and how these may influence perceptions of the client, the client's problem, and the counseling relationship.
- **Cultural knowledge:** The counselor has knowledge of the client's culture, worldview, and expectations for the counseling relationship.
- **Cultural skills:** The counselor has the ability to intervene in a manner that is culturally sensitive and relevant.

Sue and colleagues (2019) further state that many problems encountered by marginalized clients actually reside externally to them (such as bias, discrimination, and prejudice). Such clients should not be faulted for encountering these obstacles, nor for the emotions they experience as a consequence. This concept is at the heart of their affirmative approach to counseling.

A number of important aspects are involved in providing culturally competent care. Among these are cultural self-assessment, engagement, multicultural assessment, cultural analysis, employing cultural thinking when providing psychopharmacy and testing, fostering empowerment and culturally-specific healing, and developing multicultural consciousness (extending cultural competence beyond the clinical encounter).

In addition to providing culturally competent care, it is also important to consider competence with regard to other groups. For example, clinicians need to look closely at the provision of nondiscriminatory services and be aware of issues connected with sexual diversity, socioeconomic diversity, and practices with diverse age groups. Thus, medical errors connected with lack of cultural competence can occur in client assessment, understanding, or intervention.

The APA (2017b) published *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality*. These 10 guidelines can be easily applied to all mental health professionals, who should

- **Guideline 1:** Recognize that identity and self-definition are fluid and complex, with a dynamic interaction between the two. Appreciate that intersectionality is shaped by the multiplicity of an individual's social contexts.
- **Guideline 2:** Recognize and understand that as cultural beings, mental health professionals hold attitudes and beliefs that can influence perceptions of and interactions with others, along with their clinical and empirical conceptualizations. Mental health professionals strive to move beyond conceptualizations rooted in categorical assumptions, biases, and formulations based on limited knowledge about individuals and their communities.
- **Guideline 3:** Strive to understand the role of language and communication through engagement that is sensitive to the lived experience of the individuals, couples, families, groups, communities, and organizations with which they interact and to understand how they bring their own language and communication to these interactions.
- **Guideline 4:** Endeavor to be aware of the role of the social and physical environment in the lives of clients, students, research participants, and consultees.
- **Guideline 5:** Aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression. Mental health professionals should seek to address institutional barriers and related inequities; disproportionalities; and disparities of law enforcement and criminal justice administration, as well as educational, mental health, and other systems as they seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services.
- **Guideline 6:** Seek to promote culturally adaptive interventions and advocacy within and across systems, including prevention, early intervention, and recovery.

- **Guideline 7:** Examine the assumptions and practices of mental health as a profession within an international context, whether domestically or internationally based, and consider how this globalization has an impact on the psychologist’s self-definition, purpose, role, and function.
- **Guideline 8:** Be aware of how developmental stages and life transitions intersect with the larger biosociocultural context, how identity evolves as a function of such intersections, and how these different socialization and maturation experiences influence worldview and identity.
- **Guideline 9:** Aim to conduct culturally appropriate and informed research, teaching, supervision, consultation, assessment, interpretation, diagnosis, dissemination, and evaluation of efficacy as they address the first four levels of the *Layered Ecological Model of the Multicultural Guidelines* (as described beginning on page 10 of APA, 2017b).
- **Guideline 10:** Strive to take a strength-based approach when working with individuals, families, groups, communities, and organizations that seeks to build resilience and decrease trauma within the sociocultural context.

(APA, 2017b, pp. 4-5)

Case Example

Dr. 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 Dr. Todd that his father has seemed increasingly depressed since Sam’s mother died. 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.

Although it is difficult to get Mr. Chang to open up, he does comment to Dr. Todd that the only time he 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. Dr. Todd recommends that Mr. Chang consult with a psychiatrist for medication.

Root Cause Analysis

What happened?

Dr. Todd diagnosed Mr. Chang with a severe mental illness.

Why did it happen?

Dr. Todd did not understand the customs or thought processes of a Chinese-American client.

How can it be prevented from happening again?

Dr. Todd should take steps to educate himself when working with a client from a culture with which he is unfamiliar.

Discussion

Dr. Todd and his clients would be better served if he took steps to implement the APA's Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality.

Informed Consent

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. Failure to obtain informed consent is in itself a medical error. Additionally, acquiring informed consent aids in reducing the possibility of errors in diagnosis and treatment planning. Beyond all this, informed consent is an essential aspect of establishing the professional relationship. When done effectively, it helps promote client autonomy by engaging in a collaborative process and helps to reduce the likelihood of exploitation or harm (Corey et al., 2018; Beckett et al., 2017).

Although informed consent provides clients with information to make decisions about the treatment process, the amount of information clinicians choose to share may vary from clinician to clinician and will be 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 professional ethics codes provide minimum standards for what must be communicated to clients pertaining to informed consent for therapy, assessment, supervised treatment, and research. The codes require that clients be provided with information on the limits of confidentiality, fees, and the process of therapy. They also require that clinicians clarify their roles with all clients and that trainees inform clients that they are being supervised. Medical errors may occur when the informed consent process is unclear.

Case Example

Carolyn, a 42-year-old woman diagnosed with bipolar disorder, has been working with Dr. Snyder, a clinical psychologist, for the past five years. Dr. Snyder has recently become concerned because she is seeing signs in Carolyn 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 so stressful.

Dr. Snyder 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. Dr. Snyder 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?

Dr. Snyder did not fully assess a client's decisional capacity and Dr. Karlin did not obtain informed consent for the recommended medication change.

How can it be prevented from happening again?

The therapist and psychiatrist will engage with the client about her medication and the suggested changes.

Discussion

In this case, both Dr. Snyder and Dr. Karlin made errors via multiple ethical infractions, including breaking confidentiality (contacting the client's brother without explicit consent to discuss changing medications), unauthorized disclosure of information, and the obvious infractions to autonomy and informed consent for the medication changes.

All professional codes of ethics address informed consent. Here, Section 10.1 of the APA code (2017a) is relevant:

(a) When obtaining informed consent to therapy ... psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers.

Health Insurance Portability and Accountability Act (HIPAA)

Providers should also be aware of federal statutes contained in HIPAA. Part I of this course discussed HIPAA in detail; the current discussion is meant to provide a summary of the main provisions of HIPAA. Human services and mental health professionals have been among the health care professionals least affected by HIPAA because their codes of conduct already provide strict ethical provisions regarding confidentiality and informed consent. Nevertheless, it is important to be familiar with HIPAA's main components.

The U.S. Department of Health and Human Services has made exhaustive reference material available on their website (<https://www.hhs.gov/hipaa/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 record keeping are among the most stringent in the nation, and most practitioners 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.

The components of HIPAA are

- **portability standards** that ensure the continuity of healthcare,
- **privacy standards** that govern the disclosure of protected health information, and
- **security standards** that protect the development and maintenance of health information.

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; and
- securing client records containing individually identifiable health information so that they are not readily available to those who do not need them.

Case Example

Kelly, a registered nurse, is seeking counseling because of substance use issues. She is referred to her employee assistance program (EAP), which engages the services of 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 because of her treatment prognosis. She says 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 ethics board and likely seeking legal action.

Root Cause Analysis

What happened?

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

Why did it happen?

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

How can it be prevented from happening again?

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

Discussion

The NASW *Code of Ethics* (2021) includes Standard 1.03, which is relevant to this situation:

- (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.

Standard 1.07, Privacy and Confidentiality, has more to say on the subject:

(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. ...

(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 others. 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.

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 this information will be used. Standard 1.07 would suggest that only limited information be provided to third parties in situations where there is concern by the treatment professional.

Confidentiality

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 that are ordered by the court as part of a legal proceeding. There are also specific limits based on treatment settings, such as when 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 NASW (2021) Standard 1.07(b), above, 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.

Case Example

Manny Wright has been seeing Fred and Wanda for couples counseling for about a month when Wanda brings up the topic of sexual intimacy. Fred was 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 works individually with Fred, teaching him some relaxation techniques to help him overcome the anxiety he experiences even when contemplating sexual intimacy. Fred and Wanda become comfortable with a program of successive approximations of intimacy and they are soon regularly enjoying sexual relations.

Fred next reports that Wanda has expressed a wish for more variation in their lovemaking. Manny then introduces Fred to the Indian book Kama Sutra that describes various sexual positions Fred and Wanda might try. Because Fred is much too shy to attempt any of the sexual positions in the office with Wanda, Fred and Manny come up with an idea where Fred practices positioning himself on a 6-foot-tall Barney doll in Manny's office. At Fred's request, Manny captures pictures or video on Fred's iPhone so he will have them for a reference at home.

All is well until Fred's iPhone is stolen and Manny receives a panicked phone call from Fred who has been alerted by friends who have seen his video with Barney on YouTube. Fred later receives a letter from his parents saying that they are very disappointed and that they raised him better than that.

Root Cause Analysis

What happened?

Confidential patient information was made public.

Why did it happen?

Recording the session made the need for confidentiality especially important.

How can it be prevented from happening again?

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

Discussion

Manny has an obligation to inform Fred of the real threats to his privacy before recording the session and storing private data on an insecure device. NASW (2021) Standard 1.07(l) is relevant to this situation:

- (l) 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 Example

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 Taylor 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 situation should this behavior continue. Melvin works hard to stop, and is able to discontinue the sexting.

Unfortunately, Melanie has not deleted the compromising photographs from her cell phone, and when one of 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

What happened?

Confidential patient information was made public.

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.

How can it be prevented from happening again?

Obtain consent before intervening.

Discussion

Standard 1.07 in the NASW (2017a) code is once again relevant:

(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 Example

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, Jim, who has obsessive-compulsive disorder (OCD). Jim is a high-powered executive at a local financial services firm. He 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 photograph 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 shares the story with her husband, Carl, who works for a local financial services office. Carl is struck by the coincidences and sneaks into Jim's office. He finds a picture of Jim-Jim in Jim's top drawer.

When Jim arrives at the office that day, he is serenaded by a rousing chorus of "Rockabye Baby."

Root Cause Analysis

What happened?

Confidential patient information was made public.

Why did it happen?

The therapist did not protect confidential patient information.

How can it be prevented from happening again?

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

Discussion

Once again, NASW (2021) *Code of Ethics* Standard 1.07 is relevant:

(u) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information.

Mandatory Abuse Reporting

Another serious medical error involves failing to report suspected 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 (Child Welfare Information Gateway, 2019b).

Mandatory abuse reporting is discussed fully in Part I of this course.

Reporting child abuse does raise some ethical concerns with regard to confidentiality. 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 Example

Mandy is a 15-year-old girl who comes to Tori Halloway for an evaluation at the request of her probation officer. Mandy has been ticketed a number of times for running away from home, curfew violations, and a minor-in-possession-of-alcohol charge. Mandy is dressed in baggy black clothing, has short hair dyed black, and is wearing black lipstick and fingernail polish. Her appearance and speech are dramatic. Tori notices cuts on Mandy's arms, which Mandy says are from her pet cat.

Mandy lives with her mother and stepfather, who are her primary custodians. During the interview, Mandy states that her stepfather frequently gets drunk and makes sexual advances toward 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 reports that her stepfather supplied her with the vodka she and her boyfriend were caught with, resulting in her minor-in-possession charge. Later in the interview she states 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 stepfather and would do anything to break them up. Her mother explains that Mandy's stepfather holds Mandy accountable for her behavior and expects her to help with household chores and to be respectful toward adults. She goes on to state that Mandy wants to live full-time with her father who has no rules, allows her to drink, lets her 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. As it happens, Mandy has been on the computer with her boyfriend when the stepfather enters her room, and the boyfriend is able to record the stepfather's words and actions from Mandy's Webcam. The boyfriend calls 911 and the police arrest the stepfather.

Root Cause Analysis

What happened?

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

Why did it happen?

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

How can it be prevented from happening again?

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

Discussion

Standard 1.07 of the NASW (2021) *Code of Ethics* also contains a section that is relevant to this situation:

(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 others. 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 I of this course for information on duty to protect laws.

There is variability in the interpretation of duty to warn and duty to protect cases, and 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 clients express ill intentions toward another, although acting out these intentions often remains 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 precariously beside the criteria permitting an exception to confidentiality” (p. 474), placing mental health professionals in tenuous positions.

Suicidal Risk Response

Of all the medical errors discussed in this section of the course, one of the most serious is the failure to properly identify a client's risk of suicide. Suicide was also among the sentinel events referenced by The Joint Commission.

There is a strong connection between mental illness and suicide. Ninety percent of people who die by suicide have a diagnosable and potentially treatable psychiatric disorder at the time of their death (American Foundation for Suicide Prevention, n.d.a, 2020; Blådvik, 2018). Psychiatric comorbidity increases the risk for suicide, especially when substance abuse or depressive symptoms coexist with another psychiatric disorder or condition.

Progression of Suicidal Ideation

Often there is a transition that takes place along the continuum from ideation to plan to attempts. Individuals may first think about suicide and then transition from seriously thinking about suicide to making a plan, and many of these planners move from a plan to an attempt. The connections between suicidal ideation and attempts – as well as completed suicide – is an important topic. Although it was previously thought that depression alone was predictive of suicide attempts, newer research suggests that the lethargy associated with depression may serve as a protective factor against suicide attempts. In fact, lower levels of depression may be more highly correlated with suicide attempts (Rogers et al., 2016). Some of the continuing study of suicide looks at specific populations, such as older adults, members of the LGBTQ community, and autistic persons.

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 suicide being a common problem, it is a source of extraordinary stress for many treatment providers. Pope and Vasquez (2016) 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 enact 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, and
- hospitalizing clients only after considering drawbacks as well as benefits and communicating caring.

Risk Factors for Suicide

A number of factors may increase risk or have been found to be statistically related to the presence of suicidal behaviors. The statistically related factors do not necessarily impart a causal relationship, but rather they serve as guidelines to help the clinician 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 *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action* (Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012):

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, especially access to a firearm
- 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 they avoid asking direct questions about suicide for fear of “putting ideas” into clients’ heads.

However, it is important to take the first step of asking 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 attempted suicide?

The next step is to 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 intervention 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 Example

Dr. McLean had been treating Vincent for six months for severe depression following a hospitalization for an overdose of 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 parents' double suicide had been rekindled after Vincent's best friend had killed himself two weeks before.

The previous week, Dr. McLean 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, Dr. McLean was pleased to note a dramatic change in Vincent's outlook on life. Whereas during the previous week Vincent had been despondent and sad, this week he seemed much calmer and more composed. He even brought Dr. McLean a 44-magnum pistol, just like Dirty Harry used. Dr. McLean took this as a good sign. He had mentioned in passing that he was a Clint Eastwood fan and that he had always wanted a gun like that. Dr. McLean would simply take the value of the pistol off 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. Dr. McLean had been working with him to become more engaged socially and not to engage in procrastination and avoidance. Vincent stated that he'd been busy visiting and calling people, tying up loose ends, and making things right. He said, "I'd let so many things go when I was so depressed." He had even met with his lawyer to update his will.

Now, while Dr. McLean is discussing the case with one of his trainees, she recognizes Vincent's warning signs of suicide and queries Dr. McLean about them. Dr. McLean realizes he has missed them and calls the police, who arrive to find Vincent intoxicated and preparing to shoot himself with one of his many loaded weapons.

Root Cause Analysis

What happened?

The clinician did not recognize the warning signs of suicide in a client.

Why did it happen?

The clinician misperceived his client's symptoms, interpreting them as signs that his client's depression was improving.

How can it be prevented from happening again?

The clinician must be retrained on the warning signs of suicide, suicide risk assessment, and suicide intervention.

Discussion

Because the consequences of suicidal ideation can be so severe, every therapist should be thoroughly familiar with the signs and symptoms of suicide. The American Foundation for Suicide Prevention (n.d.b) lists the following warning signs:

A person might talk about

- killing himself or herself,
- feeling hopeless,
- having no reason to live,
- being a burden to others,
- feeling trapped, or
- unbearable pain.

Behaviors that may signal risk, especially if related to a painful event, loss, or change, include

- increased use of alcohol or drugs;
- looking for a way to end one's life, such as searching online for methods;
- withdrawing from activities;
- isolating from family and friends;
- sleeping too much or too little;
- visiting or calling people to say goodbye;
- giving away prized possessions;
- aggression; and
- fatigue.

People who are considering suicide often display one or more of the following moods:

- depression,
- anxiety,
- loss of interest,
- irritability,
- humiliation/shame,
- agitation/anger, or
- relief/sudden improvement.

According to the American Association of Suicidology (n.d.), the following behaviors are acute risks, even though a particular individual may not make them so explicit or obvious:

- threatening self-harm or suicide or talking about wanting to hurt or kill oneself,
- seeking access to means,
- starting to talk or write about death, dying, or suicide, when the person does not usually discuss such topics.

- Other warning signs listed by the American Association of Suicidology include
- increased alcohol or drug use,
- expressing a feeling of having no reason to live or no sense of purpose,
- anxiety, agitation, insomnia or sleeping all the time,
- expressing the feeling of being trapped or like there's no way out,
- hopelessness,
- withdrawal from friends and family and society in general,
- ragefulness and revenge seeking
- recklessness and engaging in risky activities (seemingly without thinking),
- changing mood dramatically, and
- giving away prized possessions or seeking long-term care for pets.

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. Despite the inclusion of these criteria in the *DSM*, study of medical illness is not covered in many psychology, counseling, or social work programs.

According to Grace and Christiansen (2007), "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 client's presenting psychological symptoms." These authors 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. This questionnaire consisted of 10 case studies in which a patient seeks treatment for psychological problems that in actuality result from hidden medical illnesses. The study findings suggested that "non-medical" mental health providers were at greater risk of not recognizing these masked medical illnesses in their clients. On the basis of these findings, the authors proposed collaborative and educational approaches to minimize this risk and improve patient care.

In his definitive text, *When Psychological Problems Mask Medical Disorders: A Guide for Psychotherapists*, James Morrison (2015) 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 lability. Clearly, these symptoms may also be the result of a mental disorder.

Morrison (2015) 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 (2015) notes that it is easier to detect a medical issue in an existing client who presents with a personality or behavior change because clinicians can compare these symptoms to a prior baseline. He also recommends that clinicians remain vigilant when clients discuss new physical symptoms or symptoms do not fit the

working diagnosis or when a client has symptoms that do not resolve despite appropriate treatment. Morrison (2015) 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 their discussion of mental disorders secondary to general medical conditions, Chuang and Forman (2006) provide 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, and
- waxing and waning mental status.

Chuang and Forman (2006) also provide a comprehensive listing of medical conditions that result in psychological symptoms. They divide these conditions into categories of symptoms that result from:

- medical and toxic effects (e.g., alcohol- or drug-related psychological 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
- a miscellaneous category (e.g., systemic lupus erythematosus, 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 for new clients is a good professional practice recommendation.

It is also helpful to be aware that some medical conditions may result in increased risk for suicide. Some of these conditions are diseases of the central nervous system (epilepsy, tumors, Huntington’s chorea, Alzheimer’s disease, multiple sclerosis, spinal cord injuries, and traumatic brain injury), cancers (especially head and neck cancers), 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 Example

Joe is a 72-year-old man who has been in therapy with David Wepfer for about a month, dealing with estrangement from his children. Since age 18, Joe has abused alcohol, and he experiences great guilt over the times he used to beat his children when he came home drunk.

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

David explains to Joe that he is suffering from conversion disorder and that he obviously has lost the use of the arm that he used to hit his children. Joe mumbles his appreciation and tries to exit through a closet. David guides him to the elevator. David later learns that a cabbie has driven Joe to the emergency room where he is being treated for a stroke.

Root Cause Analysis

What happened?

David's patient had a stroke and David misdiagnosed the symptoms.

Why did it happen?

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

How can it be prevented from happening again?

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

Discussion

The NASW (2021) *Code of Ethics* Standard 1.04, on the subject of competence, is relevant to this situation:

- (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 that care can be coordinated between the therapist and the client's physician. This will enable the therapist to consult with, and refer any medical concerns to, the physician.

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. Segal and Coolidge (2001) explain the 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 also helps professionals to better organize their diagnostic thinking, such as allowing them to accurately probe for symptoms. Third, differential diagnosis presents an interface with the legal arena, especially in cases in which issues of competency may be called into question. Fourth, accurate differential diagnosis helps facilitate appropriate treatment, such as influencing the type of medication or therapy that may be needed. This accuracy leads to the 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 to be able to identify whether a patient meets the diagnostic threshold for the illness. Although most clinicians know the diagnostic criteria for many mental disorders, it is always helpful to review them rather than risk misdiagnosis resulting from inadequate use of diagnostic criteria. It may be helpful to have a working hypothesis, rather than to formulate an opinion prematurely.

The tendency toward misdiagnosis may be higher in the treatment of ethnic minority groups. As mentioned in the section of this course on multicultural competence, this tendency may lead to inappropriate treatment interventions. In 2001, Surgeon General David Satcher issued the report *Mental Health: Culture, Race and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General*, 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 demonstrating that 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, discomfort with mental health assessment and treatments, discomfort with a racially or ethnically 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 Example

Roseanne 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 Tory a 21-year-old African American mother of two children. Tory tells Roseanne 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. Tory states that she really needs the housing and hopes that Roseanne will approve her for this.

Although Roseanne tells Tory that she is only completing the intake assessment to assign her to the right therapist, and does not have anything to do with housing recommendations, Tory states that she knows “the truth here.” Tory responds to questions evasively, or with one-word answers. When asked about her motivation for treatment, Tory answers that she “doesn’t see how talking to an uppity doctor will help,” and asks why Roseanne is taking so many notes and who she is reporting their conversation to.

Roseanne notes the body language Tory displays, her reticence to answer questions, and symptoms of “paranoia,” anger, and emotional distance, and diagnoses Tory with likely paranoid schizophrenia. She refers Tory to a therapist and for a medication consultation.

Root Cause Analysis

What happened?

The social work intern misdiagnosed the client because of a lack of multicultural competence and inexperience.

Why did it happen?

The social work intern did not prepare the client appropriately for the intake assessment and does not appropriately respond to common questions about the purpose and procedures of the intake assessment. The social work intern then inappropriately assessed the client.

How can it be prevented from happening again?

The social work intern needs appropriate supervision and also needs experience conducting intake assessments and working with diverse populations.

Discussion

The relevant NASW (2021) Standard is 1.05, which covers cultural competence and social diversity:

- (a) Social workers should demonstrate understanding of culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.
- (b) Social workers should demonstrate knowledge that guides practice with clients of various cultures and be able to demonstrate skills in the provision of culturally informed services that empower marginalized individuals and groups. Social workers must take action against oppression, racism, discrimination, and inequities, and acknowledge personal privilege.
- (c) Social workers should demonstrate awareness and cultural humility by engaging in critical self-reflection (understanding their own bias and engaging in self-correction); recognizing clients as experts of their own culture; committing to life-long learning; and holding institutions accountable for advancing cultural humility.

Overdiagnosing

In addition to the concerns listed above, many clinicians are aware of the tendency toward overdiagnosis. This problem may be the result of thresholds that are too low. There is also concern about so-called “diagnostic trends.” Although systematic study is needed, diagnostic trends, which often do not match the standards listed in the *DSM*, do occur. For example, there is an upsurge of incidences of many childhood illnesses, including autism, attention-deficit disorder, and pediatric bipolar disorder.

It is important that treatment professionals complete a comprehensive differential diagnosis. 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, or other groups, in order to make an accurate diagnosis and assess treatment needs.

Case Example

Tim Lyons, a newer social worker, is working with the Keller family. The parents are presenting for support with recent difficulties they’ve been having with their five-year-old son Aidan. Since he has started kindergarten, Aidan 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, Tim witnesses one of Aidan’s outbursts. Tim is unprepared for the intensity of Aidan’s crying and shocked at the amount of time it takes to soothe him. This reminds Tim of the outbursts he has seen in the past from manic patients. Tim has been reading about pediatric bipolar disorder and feels that Aidan may have this condition. He tells the Kellers that a child psychiatrist should assess Aidan, but that it is likely that he is bipolar and needs medication.

Root Cause Analysis

What happened?

The social worker inappropriately assessed the child.

Why did it happen?

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

How can it be prevented from happening again?

The social worker needs to practice within his area of competence.

Discussion

The NASW (2021) Standard 1.04 is relevant to this situation:

(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 relates to the financial aspects of providing therapy services. It can also be the basis of medical errors. Conflicts over billing, payment for services, and collections, are common catalysts for triggering a Board complaint or malpractice suit.

Standard 1.13(a) in the NASW (2021) *Code of Ethics* addresses payment for services in this way: “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.”

Standard 1.17 (cited below) addresses termination of services and specifies the circumstances under which it is ethical for social workers to terminate services for nonpayment. It is ethical to terminate treatment because of nonpayment of fees (Treloar, 2010). Many circumstances affect a client’s ability to pay, include a change in or loss of insurance coverage. Although 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 prevent 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 next case illustrates some of the complexities of the financial aspects of treatment.

Case Example

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 at Kevin’s 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 is surprised when Vera arrives at the next session wearing a Black Eyed Peas T-shirt, and enthuses about the “awesome” weekend away she and a friend have just had. The two flew to a concert in Chicago, stayed in a hotel, and partied 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 call from the hospital informing him that Vera has been admitted following a serious suicide attempt. Kevin states that he is no longer her therapist and refuses to discuss the situation further.

Root Cause Analysis

What happened?

The therapist was unclear about financial responsibilities and terminated the client without warning and without facilitating an appropriate referral.

Why did it happen?

The therapist 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.

How can it be prevented from happening again?

The therapist should familiarize himself with the relevant ethical standards related to fee arrangements and termination.

Discussion

The NASW (2021) *Code of Ethics* Standard that is relevant for this situation is 1.17 sections (b) and (c) which specifically state:

(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.

SUMMARY

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 preventing medical errors; retrospectively employing root cause analysis 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 and of medical conditions that may be masked by psychological symptoms.

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