Sequence XII

NAVIGATING CHALLENGING CONVERSATIONS

ETHICS AND RISK MANAGEMENT

THE TRUST

Agenda

- Introduction - The Trust Risk Management Model
  - Challenging Conversation 1: The Possibly Impaired or Unethical Colleague
  - Challenging Conversation 2: A Micro-Aggression
  - Challenging Conversation 3: How Could You Write That About Me?
  - Challenging Conversation 4: A Question of Duties

LUNCH

  - Challenging Conversation 4: A Question of Duties (continued)
  - Challenging Conversation 5: A Conflict of Interest & A Demanding Attorney
  - Challenging Conversation 6: The Peripatetic Patient
  - Challenging Conversation 7: Obsessive Love
- Summary and Recommendations

Learning Objectives

- Describe at least five basic principles of ethics and risk management, as applied to several specific clinical situations that frequently arise in professional practice.
- Identify three risk factors and warning signs of distress/impairment in ourselves and our colleagues, and list three primary interventions for managing professional distress/impairment. Also delineate two factors to consider when preparing for a conversation with a potentially impaired colleague and for deciding the appropriateness of a formal or informal ethical resolution.
- Describe two methods for effectively engaging in challenging conversations regarding race and ethnicity with colleagues, supervisors/supervisees, and patients/clients.
- Define the Information Blocking Rule and explain two strategies for ethically managing risk related to this rule.

Learning Objectives (continued)

- Identify three types of immunity provisions that protect psychologists who make mandated child abuse reports and list three steps psychologists can take to minimize their risk in these situations.
- Apply at least two risk management strategies for decreasing risks when involving collaterals in treatment and/or providing conjoint psychological services.
- List four broad categories of factors to consider when determining whether to provide cross-jurisdictional telepsychological services.
- Discuss four strategies for ethically and safely managing patients/clients who exhibit stalking, threatening, or harassing behaviors.

THE TRUST

The Trust Risk Manageme

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  - (800) 477-12

The Trust Risk Management Team

Leisl Bryant, Ph.D., ABPP

Julie Jacobs, J.D., Psy.D.

Marc Martinez, Ph.D., ABPP

Joe Scroppo, Ph.D., J.D.

THE TRUST

Advocate Emeritus:

Eric Harris, Ed.D., J.D.

Jeffrey Younggren, Ph.D., ABPP

Dan Taube, J.D., Ph.D.

INTRODUCTION

THE TRUST RISK MANAGEMENT MODEL

Joys and Sorrows of Practice

- Assessment, treatment, consulting, research, and teaching can all be deeply gratifying
- We serve people, whether through advancing understanding, clarifying areas of dysfunction, providing care, supporting colleagues and supervisees, or leading others, among other roles

These roles and gratifications come along with risks and challenges:

- Challenging patients/clients
- Challenging situations
- Psychologist vulnerabilities
- Hazards of practice

Patient/Client Vulnerabilities

- Patient/Client Characteristics
  - Traumas, past and present (PTSD, childhood maltreatment, domestically violent relationships, assaults, sex trafficking, DID, recovered memories)
  - Substance dependence
  - Suicidal ideation and attempts
  - Potential violence toward others
  - Cluster B personality traits or disorders (people with borderline, narcissistic, or antisocial characteristics)
- Patient/Client Circumstances
  - Child custody conflicts
  - Requesting third-party evaluations from treating clinicians; patient involvement in unrelated lawsuits
  - Child custody-related cases
  - Third-party evaluations (e.g., disability evaluations, fitness of duty, emotional support animal letter requests, etc.)

Psychologist Vulnerabilities

Context/situational dimensions more likely to create risk for **clinicians**:

- Act as primary ***supervisors***
- Become or are ***isolated***
- Experience ***personal*** losses, health compromises, life challenges
- Experience excessive positive or negative counter-transference
- Work with attractive or wealthy patients
- ***Uncertainty/ambiguity***

Psychologist Vulnerabilities

Inherent dimensions more likely to create risk for **clinicians in uncertain situations**:

- Judgement/decision making biases, such as:
  - Confirmation
  - Availability
  - Representativeness
  - Anchoring
  - Affect heuristic (emotional state)
- Personality traits (e.g., greater narcissism)

Potential Consequences

For professionals, risks include:

- Licensing board complaints
  (high incidence, high consequence)
- Malpractice suits
  (low incidence, high consequence)
- Ethics complaints
  (no insurance coverage, public expulsion, reports to licensing boards)
- Negative online reviews
- Insurance audits

Risk Management Model

B = Breathe and slow down

E = Exercise cultural humility

S = Solid informed consent process

A = Access routine consultation

F = Follow a structured decision-making process

E = Ensure effective self-care

R = Record rationale and have good record keeping strategies

BE SAFER

CHALLENGING CONVERSATION 1

THE POSSIBLY IMPAIRED OR UNETHICAL COLLEAGUE

Vignette 1

Dr. Chun

Dr. English

- One of the most difficult challenges psychologists face
- APA CAP Monograph (2006):
  - Learning of a colleague's sexual involvement with a patient was one of the most stressful events reported by psychologists
  - Knowledge of an impaired behavior by a colleague is almost as stressful and disturbing as having a suicidal patient/client
- Also, one of the areas psychologists receive little training in
- And not often discussed openly
- Hard to see or think about in ourselves or others

We are ALL vulnerable

- Brene Brown, DSW (2012):
  - Vulnerability is not weakness… it is emotional risk, uncertainty, and exposure
  - Shame about vulnerability undermines emotional health in many ways, including being related to addiction, depression, aggression, and other psychological and social ills
  - Shame – and dysfunction – grow in the context of secrecy

It is critical to create and foster an atmosphere in which we can compassionately and non-punitively discuss and address these realities

Sobering Statistics

Guy, Poelstra & Stark, 1989

- 74.3% of surveyed psychologists acknowledged experiencing distress at some time in their work
- Of this number, 36.7% indicated their personal distress resulted in a decreased quality of patient care
- 4.6% acknowledged delivering inadequate care as result of personal distress

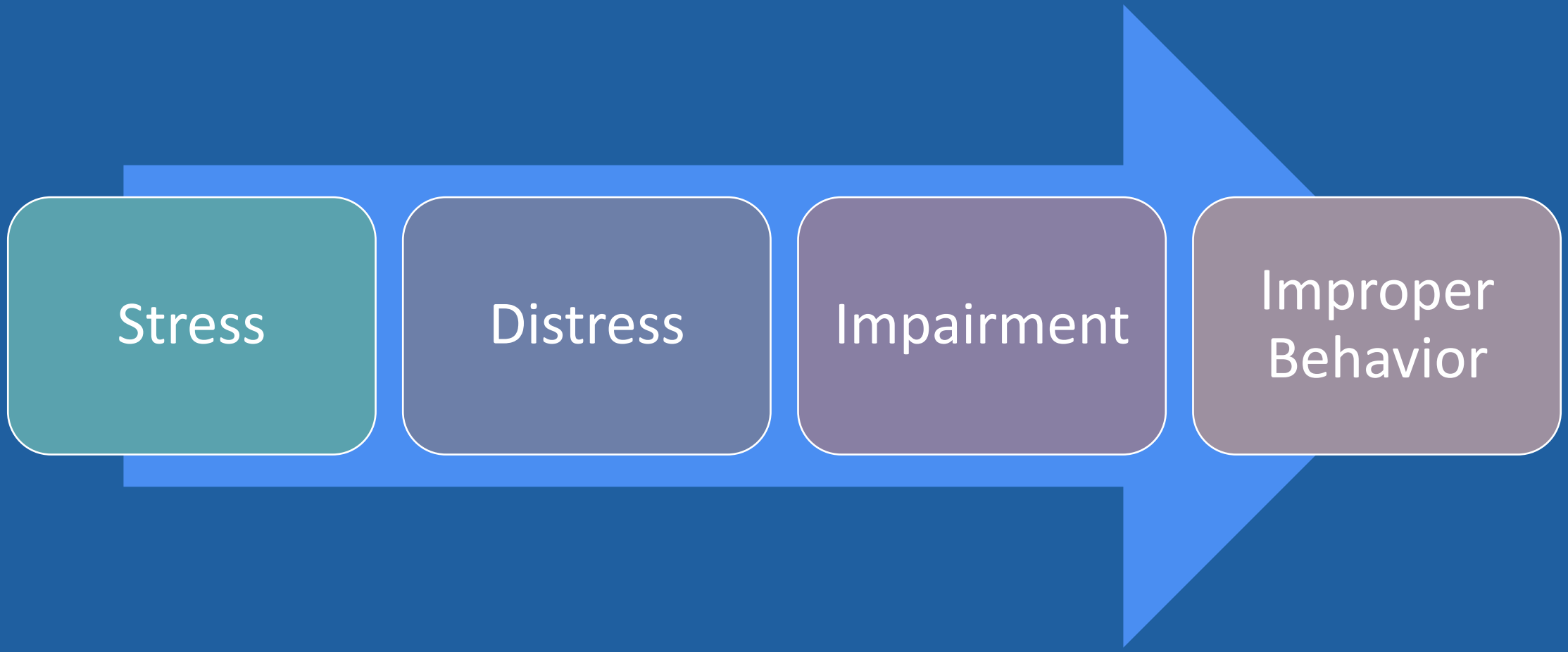
Pope, et al., 1987

- 85% of surveyed psychologists believed working when too distressed to be effective was unethical
- Over half of psychologists surveyed (59.6%) acknowledged having worked when too distressed to be effective
- About 1 out of every 15 or 20 respondents (5.7%) acknowledged having done therapy while under the influence of alcohol

Additional

- Laliotas and Grayson, 1985: Impairment prevalence in psychologists at 5-15%
- Cushway and Tyler, 1994: In a sample of British clinical psychologists, 75% reported moderate or severe stress as result of their job
- VandenBos and Duthie (1986): 69% of psychologists knew colleagues experiencing emotional difficulties, but only 36% approached the colleagues about these concerns.

Stress – Distress Continuum



(APA Board of Professional Affairs Advisory Committee on Colleague Assistance, 2008)

What Do We Mean?

Distress

- Universal definitions of ‘distress’ and ‘impairment’ do not yet exist
- The subjective emotional state or reaction experienced by an individual in response to ongoing stressors, challenges, conflicts, and demands (Barnett, Johnston, & Hillard, 2006)
- Munsey (2006): “…an experience of intense stress that is not readily resolved…[that affects] well-being and functioning, or [disrupts] thinking, mood and other health problems that intrude on professional functioning.”
- Normative intermittent experience
- Often precedes impairment and is considered a beginning warning sign
- No bright lines

What Do We Mean?

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- OAC Ann 4731-16
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- Impairment has also be
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remain quite vague

Colleague Assistance Programs

- Involve cooperation between psychology regulatory/licensing boards and professional associations to promote professional growth and rehabilitation of

Virginia Colleague Assistance Program

- "…any physical, psychological, or interpersonal condition that results in a reduction of work performance by the impaired psychologist and for which the impaired psychologist is not receiving adequate treatment yet continues providing services at an inadequate level."

What Do We Mean?

Impairment

- Munsey (2006): Impairment is "a condition that compromises the psychologist's professional functioning to a degree that may harm the client or make services ineffective" (p. 35)
- A few other important distinctions:
  - Some terms often used interchangeably (e.g., distress, burnout, impairment)
    - Burnout = "… terminal phase of therapist distress" (Baker, 2003, p. 21)
  - Distress itself is not impairment
  - Distress, burnout, or some other stress-related condition (e.g., vicarious traumatization, secondary traumatic stress) becomes impairment at the point at which it "adversely alters the psychologist's occupational functioning or results in the provision of substandard care" (Smith and Moss, 2009)
  - Impaired practice can also be differentiated from negligent practice (e.g., failing to follow laws and professional codes or practicing outside one's competence)

Hazards of the Work

(Norcross & Vandenboss, 2018)

Patient Behaviors

- Hostile transference
- Suicidal statements/attempts
- Anger toward therapist
- Severe depression
- Apathy, lack of motivation
- Premature termination
- Passive-aggressive behavior
- Being litigious
- Ethics or licensing complaints
- Patient violence (threats/assaults)
- Terminally ill patients
- Intense resistance
- Severe psychopathology

Working Conditions

- Organizational politics
- Managed care
- Onerous paperwork
- Excessive workload
- Scheduling constraints
- Work overinvolvement
- High expectations with low control
- Compliance w/ excessive regulations
- Exclusion from administrative decisions
- Low salary
- Lack of administrative support
- Time pressures and deadlines
- Isolation
- Lack of routine feedback

Hazards of the Work

(Norcross & Vandenboss, 2018)

Emotional Depletion

- Boredom/monotony of work
- Physical exhaustion/fatigue
- Difficulty leaving it at work
- Inevitable need to relinquish patients
- Identifying with patient pathology
- Compassion fatigue/secondary traumatization
- Repeated emotional strain
- Paucity of therapeutic success
- Doubts about career choice
- Activation of preexisting psychopathology

Therapeutic Relationships

- Responsibility for patients
- Difficulty in working with disturbed patients
- Lack of gratitude from patients
- Countertransference
- Developing a pathological orientation
- Loss of authenticity in relating with patients
- Constraints of the '50-minute hour'

Personal Disruptions

- Financial concerns
- Illness/disability
- Aging and retirement
- Death of loved one
- Marriage/divorce
- Pregnancy/parenthood

Miscellaneous stressors

- Idealism regarding clinical outcomes
- Difficulty in evaluating progress
- Doubts about efficacy of treatment
- Public stigma against mental disorders

Why Does It Matter? APA Ethics Code

- Principle A: Beneficence and Nonmaleficence: "Psychologists strive to be ***aware of the possible effect of their own physical and mental health on their ability to help those with whom they work***."

- Standard 2.03: Maintaining Competence: "Psychologists undertake ongoing efforts to develop and maintain their ***competence***."

Standard 2.06: Personal Problems and Conflicts:

"(a) Psychologists refrain from initiating an activity when they ***know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner***…

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they ***take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related activities***."

Standard 3.04: Avoiding Harm:

"Psychologists take reasonable steps to ***avoid harming*** their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable."

Why Does It Matter? (Barnett, et al., 2007)

- Failure to adequately attend to one's own psychological wellness and self-care can place the psychologist at risk for impaired professional functioning
  - And thus, risk for harm to patients/clients
- An ongoing focus on self-care is essential for the prevention of burnout and for maintaining one's own psychological wellness
- Ethical mandate that dictates self-care responsibility, as self-care or the lack thereof directly impacts the lives of those we are assigned to help and assist
- Ethical responsibility to those we serve to be informed about the stressors we face and to practice self-care that directs itself at minimizing the symptoms of those stressors

"**Self-care** is not a narcissistic luxury to be fulfilled as time permits; it is a *human requisite*, a *clinical necessity*, and an *ethical imperative*."

(Norcross & VandenBos, 2018, emphasis added, p. 15)

The Stakes Are High

- Distress
- Burnout
- Secondary traumatic stress/vicarious traumatization
- Compassion fatigue
- Errors in judgment
- Impaired competence
- Failure to meet legal and ethical obligations
- Harm to clients
- Licensing board complaints and/or lawsuits

How Do We Recognize Distress/Impairment In Ourselves and Each Other?

- Unable to acknowledge the possibility one may experience distress
- Ignoring the signs of distress or assuming one can simply push through them
- Experiencing significant life stressors and minimizing their impact

- Physical signs (disturbed sleep/eating/concentration, headaches, stomachaches, lethargy, exhaustion, recurring colds/illness)
- Emotional signs (sadness, prolonged grief, anxiety, depression, agitation, mood swings)
- Isolation

How Do We Recognize Distress/Impairment In Ourselves and Each Other?

- Overworking, not taking breaks, less enjoyment of one's work, missing meetings, avoiding certain people in the workplace, tardiness
- Boredom, disinterest, easily irritated, feeling overwhelmed, cynicism
- Wishing patients would not show up or daydreaming during sessions

- Self-medicating, overlooking personal needs/health
- Seeking emotional support or nurturance from clients
- Family/friends say you work too much (50- to 60-hour weeks), irritability with family/partner
- Violating boundaries

Another Look At Statistics

VandenBos & Duthie, 1986

- 69% of surveyed psychologists knew of colleagues experiencing active emotional difficulties
- Yet, only 36% of those psychologists approached their colleagues about their observations and concerns

Skorina, Bissell & DeSoto, 1990

- Although a majority of psychologists who abuse alcohol report being impaired as a result at work, only 22% were confronted by their supervisor or employer

Good, Thoreson, & Shaughnessy, 1995

- 43% of surveyed psychologists knew of a male psychologist with a substance abuse problem, and 28% knew of a female psychologist with a substance abuse problem
- But, only 19% of those surveyed approached their colleague about their substance abuse.

Thoreson, Budd, and Krauskopf, 1986

- 33% of those surveyed knew of a colleague misusing alcohol
- Only 12% were willing to intervene

Pope, et al., 1987

- 14% believed it is always unethical or unethical in most circumstances to file an ethics complaint against a colleague

Koocher and Keith-Spiegel, 2016

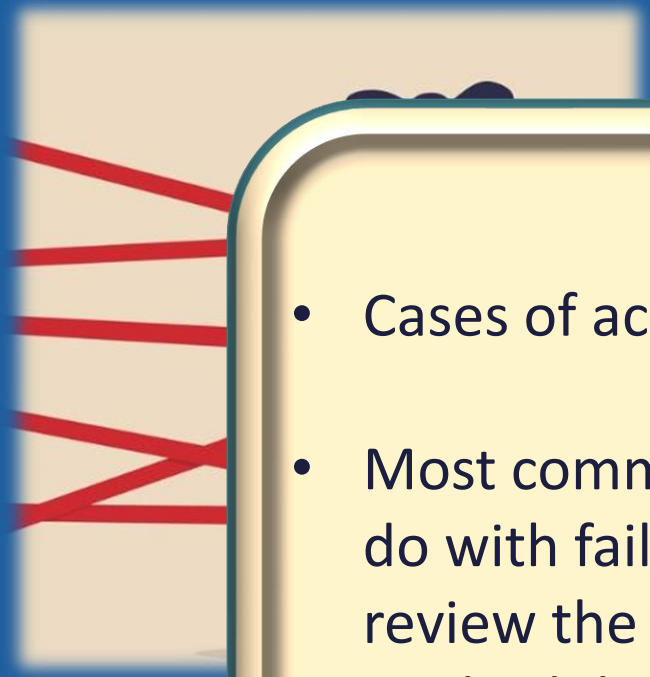
- "…peer colleagues stand in the best position to intervene, to attempt to minimize any harms, and to help ensure that the [unethical or impaired behavior] will not likely reoccur." (p. 587)

Barriers to Intervening

(Smith and Moss, 2009)

- Lack of awareness of warning signs for distress and impairment
- Not all signs are easily observable by others (e.g., lower energy, decreased concentration and confidence vs. isolation, irritability, failure to complete work tasks)
- It can be difficult to distinguish the line between a colleague's distress and possible impairment
- Floyd, Myszka, and Orr (1998): When study participants were asked what prevented them from expressing concern about a colleague:
  - 43% indicated they did not think the behavior would impair the colleague's professional functioning
  - 26% worried the intervention would cause an adverse outcome
  - 22% were unsure of their professional responsibility to intervene
  - 19% were concerned about potential consequences to themselves (e.g., retaliation)
  - 13% were concerned it would result in harm to the colleague

Additional Barriers



- Fear of being seen as a "tattletale"

- Cases of actual retaliation are not common
- Most common mistakes that lead to legal consequences have to do with failing to consult HR, follow organizational policies, or review the Americans with Disabilities Act (ADA) for its applicability to the situation

- Addit
  - Ga cissism
  - As a profession we are rarely encouraged to express doubts or concerns about ourselves
  - Rationalization of our behaviors (e.g., others are doing it; the harm was unintentional; no one will find out; I'll just do it this one time)

Education

Awareness

Prevention

SO, WHAT DO WE DO?

Primary Intervention Strategies

Primary Interventions

Education

- Specific training on:
  - Personal and professional characteristics that increase vulnerability to impairment
  - Warning signs of distress/impairment
  - Self-care/wellness behaviors

Awareness

- Of risk factors and hazards
- Of ourselves and each other
  - Even when psychologists become aware of concerns in their own lives, they often neglect their own needs and engage in inadequate self-care (APA, 2000)

Prevention

- Ensuring a healthy lifestyle with a focus on well-being and promoting ongoing wellness and self-care
- Self-care is the most important preventative

Self-Awareness

- Linked with many benefits (Rokach & Boulazreg, 2020)
  - Ability to manage countertransference during sessions
  - Increased interpersonal engagement with clients
  - Allows clinicians to be more aware of their own biases and/or stereotypes
  - Multiple studies show that psychologists identify self-awareness as a valuable means of preventing burnout

- Rupert & Kent, 2007: Study of 595 psychologists
  - Maintaining self-awareness was the second highest ranked “career sustaining behavior”

Self-Awareness/Self-Assessment Limitations

- Inherent fallibility of hu
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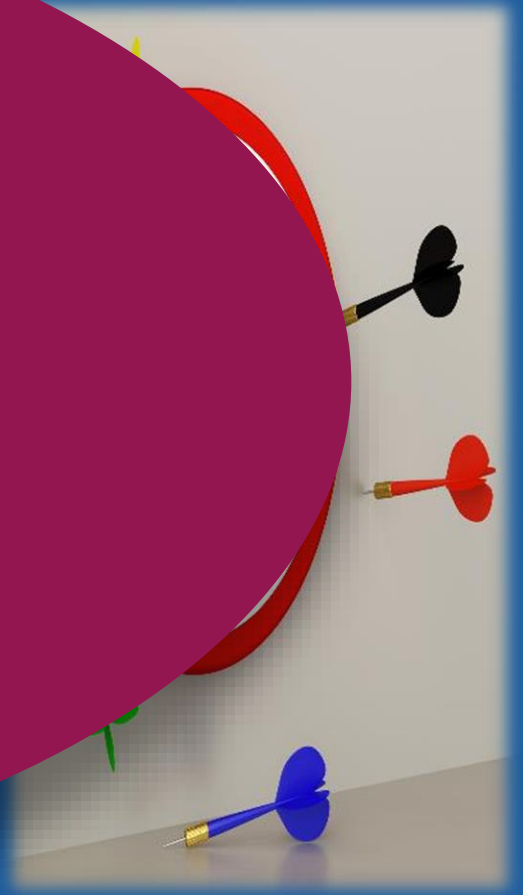
  most
  (Kruger &
- Those who
  least able to be
  appropriately to it (John
- Competence is context specific and vulnerable to decrements when the individual is experiencing distress

There are three things extremely hard:
steel, a diamond, and to know one's self.
—Benjamin Franklin, (1750)



What's the Solution?

(John

Johnson, et al. (2012) Proposed a Reformulation of Ethics Code

"Standard 2.03, Maintaining Competence: Psychologists undertake ongoing efforts to develop and maintain their competence. *Psychologists maintain regular engagement with colleagues, consultation groups, and professional organizations and routinely solicit feedback from these sources regarding the competence for work in specific roles and with specific populations.*"

"Standard 2.06, Personal Problems and Conflicts: *(c) When psychologists become aware that a psychologist colleague is experiencing problems that may lead to interference with professional competence, they offer care and support, and collaborate with that colleague in assessing competence and determining the need to limit, suspend, or terminate their work-related duties.*"

Competence Constellations

(Johnson, et al., 2012, p. 566)

- Defined as: "…a psychologist's network or consortium of individual colleagues, consultation groups, supervisors, and professional association involvements that is deliberately constructed to ensure ongoing multisource enhancement and assessment of competence."
- Composition and quality of constellation are important

- Rokach & Boulazreg, 2020: Effective way to improve self-care and decrease burnout
- Allows for:
  - Feedback without fear of serious repercussions
  - Constructive criticism in a safe space
  - Sharing of self-created self-care strategies
- Benefits to clients
- Benefits to clinicians

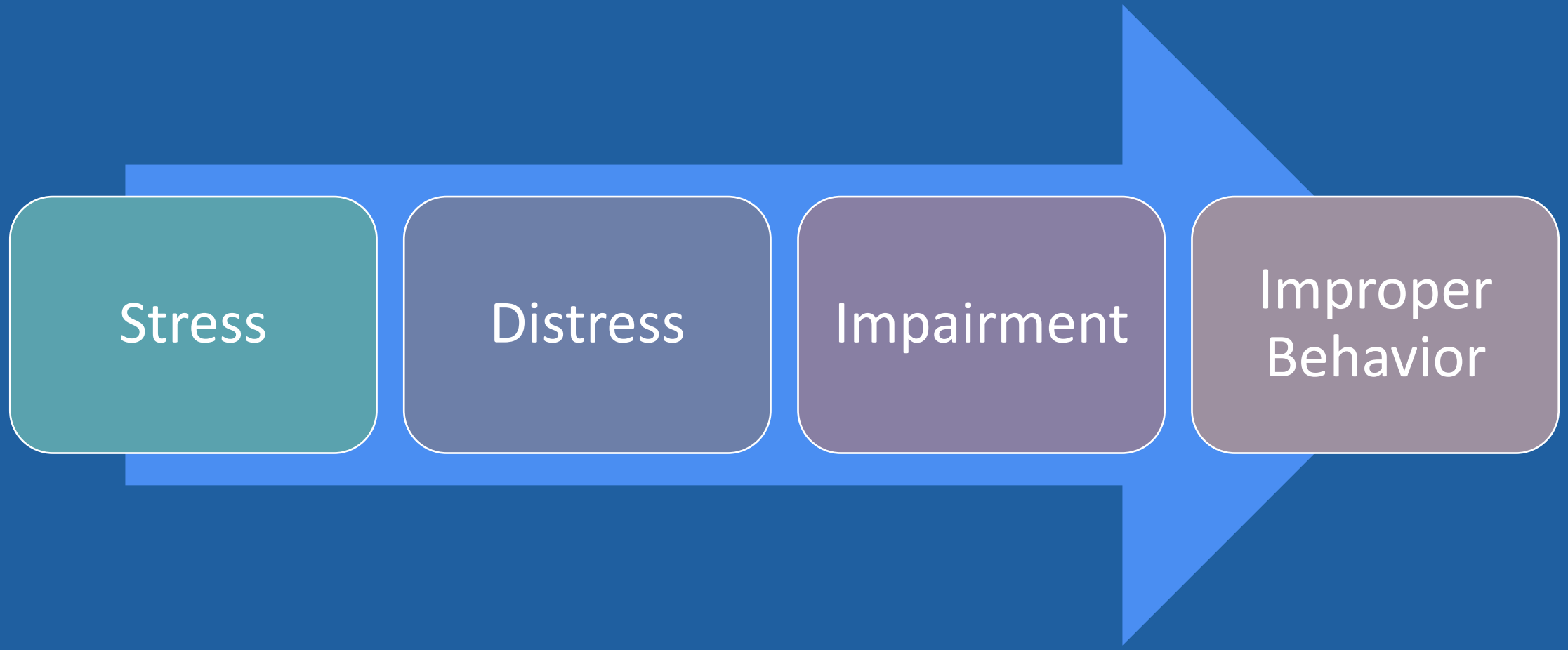
Need for Collective Care/Communities of Care

- Self-care is often defined as taking action to improve and protect one's well-being and happiness
  - But this is limited in scope and may also be culturally bound (Euro-centric, individualistic)
- Other perspectives bring in the idea that self-care is not about personal improvement, but is **a responsibility we have to each other**

- *"Shouting self-care at people who actually need community care is how we fail people."*
  -- Nakita Valerio

- *"The wellness we relentlessly seek is only possible through a practice of radical responsibility that goes beyond self-help to collective care."*
  (Kelly, 2022)

Stress – Distress Continuum



(APA Board of Professional Affairs Advisory Committee on Colleague Assistance, 2008)

Prevention and a Broader Continuum Concept

HOW DO WE INTERVENE WITH COLLEAGUES?

SECONDARY INTERVENTION STRATEGIES

General Guidance

- Keep in mind that every situation is different
  - There is no cookie-cutter approach to these situations
  - No specific process that will be appropriate for every single situation
  - It will need to be case specific, nuanced, and often flexible and changing with events as they occur

- Consultation is VERY helpful in these cases
  - As is role-playing conversations or potential language for difficult conversations

- Review ethics code
- Know relevant state law(s) and any organization/institutional policies
- Is there a colleague assistance program available?

APA Ethics Code

- Earlier versions of the code mandated informal resolution first
- Current code allows the psychologist to decide the most appropriate response
- Though inaction is not an option

Informal Resolution

1.04 Informal Resolution of Ethical Violations

"When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by:

- bringing it to the attention of that individual,
- if an informal resolution appears appropriate
- and the intervention does not violate any confidentiality rights that may be involved" (emphasis added).

APA Ethics Code

Formal Resolution

1.05 Reporting Ethical Violations

"If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution…, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities.

This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question" (emphasis added).

State Law and Potential Mandated Reporting of Impaired Colleague(s)

Connecti

(b) (1) Any health care professional … person may, file a petition

Statute 65-4923: Repo… provider, or a medical… directly involved in th… knowledge that a hea… reportable incident, s… employee shall report…

(5) This subsectio… negate the physician-… privilege or the social… Kansas statutes.

…nia

…r or colleague who has …n active addictive disease …treatment, is diverting a …lly incompetent to carry out …use to be made a report to …y who acts in a treatment …approved treatment program is …requirements of this subsection. …suant to this section in good faith …e immune from any civil or criminal liability arising from such report.

BE AWARE

of these mandated reporting obligations if practicing teletherapy in other states

Informal or Formal Resolution: How Do I Decide?

- Consult
- Factors to consider
  - Overall advantages and disadvantages
  - The suspected individual's personal characteristics
  - The quality of your evidence
  - Your relationship and status vis-a-vis the possible colleague of concern
  - About your institution (if there is one)
  - Apparent nature of the act in question
  - Your personal sources of support
  - Your own welfare

(Koocher & Keith-Spiegel, 2016)

When Might Informal Resolution Be Inappropriate?

Examples

- If an informal resolution seems unlikely and significant harm has already occurred (or is likely to occur)
- If threats have been made for physical harm, retaliation, or legal action for harassment or slander
- If a colleague appears generally or broadly incompetent as result of insufficient training or emotional impairment with very little insight or recognition of their shortcomings
- If the alleged unethical behaviors are extremely serious

Preparing to Approach a Colleague Informally (Koocher & Keith-Spiegel, 2016)

1. Identify the relevant ethical principle(s) or law(s) that apply to the suspected breach of professional ethics
   - Differentiate between offensive personal styles and unpopular/widely divergent views versus violation of law or ethics

2. Reflect thoughtfully on your own motivation to engage in (or avoid) a confrontation with a colleague
   - Ensure your own personal issues are not impacting your judgment
   - Consult

3. Consider any cultural issues that may further elucidate or impact the situation

4. Assess the strength of the evidence
   - Direct observation of the unethical behavior
   - A colleague's intentional or unintentional disclosure of an ethics violation
   - Direct observation of suspicious, but not clearly interpretable behavior
   - Receiving a credible secondhand report
   - Casual gossip

5. Consider your relationship with suspected colleague

6. Consult with a trusted colleague who has demonstrated sensitivity to ethical issues

7. Avoid easy outs
   - Passing the information off to other colleagues and assuming this discharges one's responsibility (it doesn't)
   - Engaging in anonymous actions (e.g., sending an anonymous letter to the offending colleague)

Tips for the Difficult Conversation Itself (Koocher & Keith-Spiegel, 2016)

- Schedule the meeting in advance, being careful to avoid a menacing or punitive tone
  - An office setting is usually best
  - Meeting in person is better than by phone or email/text/letter
- Set a constructive and educative tone
  - Avoid taking on the role of an accuser or 'penance dispenser'
  - View the conversation as a collaborative effort of colleagues solving a problem together

- When directly addressing the allegation, remain calm and self-confident
  - Anticipate that your colleague may become emotional
  - Use nonthreatening, possibly even soothing language; expressing confusion and/or asking for clarification
  - Avoid accusations and instead seek explanations, understanding

Tips for the Difficult Conversation Itself (Koocher & Keith-Spiegel, 2016)

If you are ever approached by a concerned colleague:

- Be grateful for the warning about how others perceive you
- Try to be open-minded
- Openly and honestly work toward a positive outcome for all that does not necessitate review by outside evaluators

behalf of…"

- If your colleague becomes threatening or abusive, attempt to steer them to a more constructive state or end the conversation

Formal Resolution Considerations

- Reporting to state licensing board (mandated by law in some states)
- Mandated reporting (e.g., minor/vulnerable adult)
- Reporting related to danger to others (e.g., potential patients/clients)
- Possible organizational/facility mandates to report impaired functioning of an employee
- Filing complaint with professional association's ethics committee (e.g., APA)

*****Always consider issues of confidentiality prior to making any report/complaint*****

High Price of Turning Away

- Harm to patients/clients
- Harm to the profession
- "Moral distress" (Austin, et al., 2005) and feelings of having 'shirked' one's duty may be felt for years to come
  - 40% of scientists in a large NIH study who knew of wrongdoing and did nothing continued to feel misgivings about their own inaction years later
  - Most of those who did not act failed to do so because they were not sure what to do

- The unresolved misconduct of others may create liability for you
  - E.g., vicarious liability in some circumstances; harm to your organization; your own ethics violation for failing to uphold Standard 1.04 and 1.05; violation of state law(s)
- Failure to act can lower professional self-esteem and negatively impact how we think of ourselves as human beings

Additional Resources

- APA Advisory Committee on Colleague Assistance
- State Psychological Associations
  - Ethics Committee
  - Colleague assistance programs in some states
- Your professional liability insurance carrier
  - The Trust's Advocate 800 Program consultation service
- The Trust's webinars on self-care

CHALLENGING CONVERSATION 2

A MICRO-AGGRESSION

Vignette 2

Dr. Leader, Director

Supervisor Y

Two Methods for Engaging in Challenging Conversations About Race

- Additional skills are needed to "do no harm"
- How do we respond to disagreement and a wide range of people, opinions, prejudices, aggressions (macro and micro) in our workplaces, among patients, and among colleagues?
- Two Sample Methods
  - Dr. Amanda Kemp's *Holding Space for Transformation*
  - Professor Loretta Ross' *Calling In*

Dr. Kemp's Method

- "**Holding space for transformation**…"
  - "… gives you a way to have conversations across the color line... it shifts the conversation from being a debate, with winners and losers, to being more of a journey, a discovery of [lack of awareness], assumptions, connections, and compassion."
    (Dr. Amanda Kemp, TEDx Wilmington)
  - Unconditional love and unconditional acceptance while standing on the ground of your values (Niyonu Spanns and Dr. Kemp, 2018)
- A straightforward set of steps to de-escalate and shift hostile/reactive interactions to more productive ones
- Allows for *responding* as opposed to *reacting*

Dr. Kemp's Five Steps

1. **Check in With Yourself (Body, Mind, Spirit)**

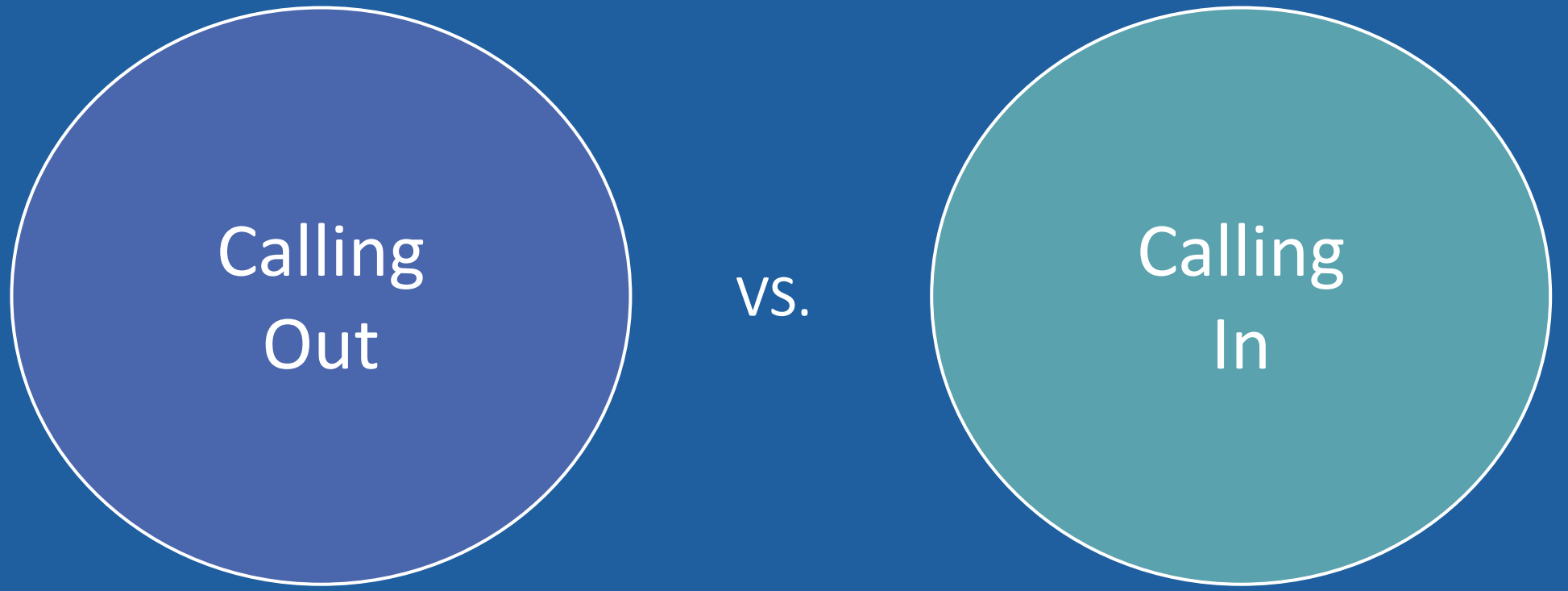
2. **Hold Space for Transformation**
   - Setting an intention to extend

3. **Lean In (Without Correcting or Overpowering)**
   - Ask questions, listen
   - Try to get to values and feelings to understand why

4. **Plant a Seed**
   - "Would you like to hear what it's like for me?"
   - If so, be brief and heartfelt

5. **Reflect on Your Experience**
   - Acknowledge your responses
   - What emotions/physical sensations did you experience during the conversation?
   - What do you need now?

Professor Loretta Ross' Approach



When discriminatory actions, statements, and policies occur

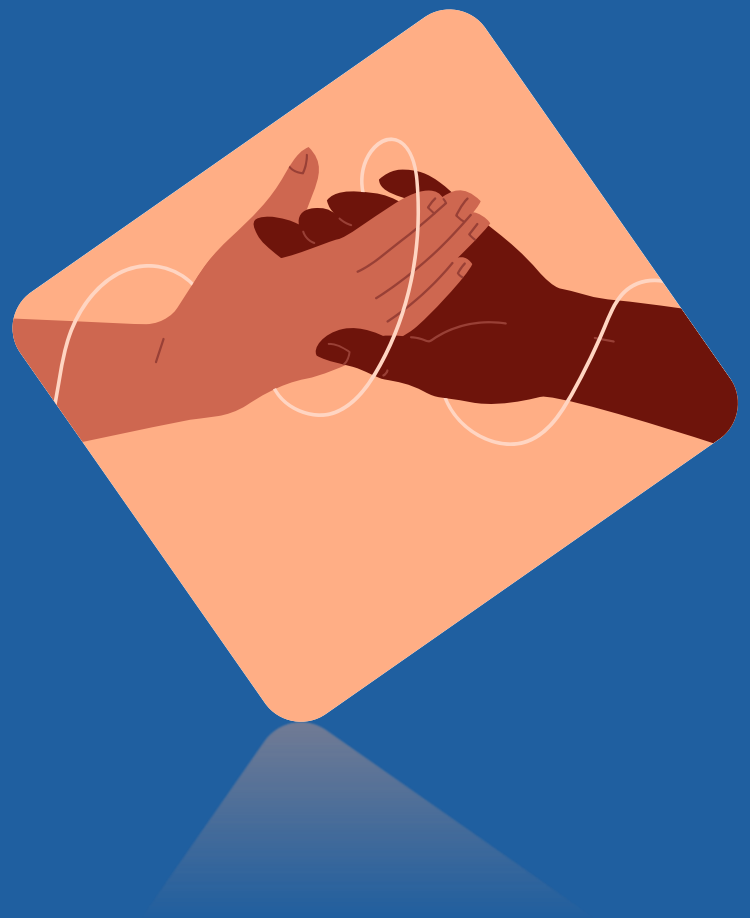
Professor Loretta Ross' Approach

- As noted in her article *Speaking Up Without Tearing Down***:
  - The "call out" culture that has emerged in recent years, largely from social media, can be toxic (2019)

- As Dr. Ross puts it:
  - "Calling out happens when we point out a mistake, not to address or rectify the damage, but instead to publicly shame the offender. In calling out, a person or group uses tactics like humiliation, shunning, scapegoating or gossip to dominate others."

**https://www.learningforjustice.org/magazine/spring-2019/speaking-up-without-tearing-down

Professor Loretta Ross' Approach



- "Calling in," on the other hand, is:
  - "…speaking up without tearing down. [It]... can happen publicly or privately, but its key feature is that it's done with love. …[W]e can patiently ask questions to explore what was going on and why the speaker chose their harmful language."*
- In this way, Dr. Ross's approach is similar to Dr. Kemp's
- Explicit recognition that:
  - This willingness to explore is sometimes not going to be productive
  - Calling out is not always unwarranted

*https://www.learningforjustice.org/magazine/spring-2019/speaking-up-without-tearing-down

Professor Loretta Ross' Approach

- Specific limits to calling in include:
  - The person injured is not required to help the person who offended understand or explore (i.e., is not required to do "involuntary emotional labor.")
  - It is not likely to work for those people who purposefully harm or attack others with racist/hate speech

- In that circumstance, calling out may be more effective—particularly when it's a person in power who is ignoring and unresponsive to attempts to "call in"
- It is not that calling out is "bad" or "wrong," it just may be more or less effective at times
- As Professor Miguel Gallardo notes, "It might be the best response, but we do not want to stay there permanently if we are going to make meaningful change." (personal communication)

Vignette 2

Dr. Leader, Director

Supervisor Y

Method for Developing/Maintaining Cultural Humility

(Adapted from Sue et al., 2019)

1. Increase awareness and acceptance of difference
2. Self-awareness regarding one's own cultural/personal identities
3. Understanding the dynamics of difference
4. Knowledge of a client's/family's culture and contextualized history
5. Adaptation of skills/interventions
6. Finally, recognize and work at reducing our own biases, stereotypes, racism and prejudices

Approaches Continued…

- These approaches - making space for transformation, calling in, and addressing one's own biases, racism, and prejudice - are valuable tools we can use to become more effective in this kind of challenging conversation
- Parallel, simultaneous foci:
  - Doing our own work
  - Developing skills in managing highly conflictual situations and systems

- These are core components of professional skills for the provision of psychological services — as well as addressing, at times, intense disagreements among colleagues, supervisees, supervisors and others
- Potentially more practical and effective than cutting off or shaming clients/patients, colleagues, or trainees

Ethics, Risk Management, and Diversity, Equity and Inclusion

- These approaches promote and provide avenues for *translating ethical values into action*
- We want to emphasize the need for *continuing life-long exploration, self-reflection, and development of humility and cultural sensitivity*
- These approaches are examples of methods that enhance access and probably the effectiveness of our services within and to people of color and traditionally marginalized communities

- That reduces risks of harm to members of these same communities
- And thereby, to us as practitioners (risk management) by doing good, culturally and ethically grounded, clinical work and serving the best interests of the patient/client

CHALLENGING CONVERSATION 3

HOW COULD YOU WRITE THAT ABOUT ME?

The CURES Act and Information Blocking Rule

VIGNETTE 3

Dr. Jay

Mr. O

Information Blocking Rule (also know as the Open Notes Rule)

- Documentation is a key risk management strategy:
  - "If it isn't written down, it didn't happen" is an axiom most of you have heard many times
- It is also crucial for continuity of care and reimbursement

- HIPAA, as well as many states, have long required access to records in a limited amount of time
- It has been **no more than 30 days** for HIPAA-covered entities for some two decades (with a current Office of Civil Rights, DHHS proposal to shorten it to 15 days)

- The prior requirements allow access to virtually the whole clinical record (e.g., billing, email, texts, messaging through a portal, legal documentation)
- Some exceptions, including what HIPAA termed "psychotherapy notes"

Open Notes Rule

- Dr. Jay faces a change resulting from “The Cures Act”
- The law passed in 2016 and took effect April 5, 2021
- One purpose of the statute directly affected mental health services
- That is, the provisions promoting and requiring greater ease of digital information system exchange and access
- Long awaited issuance of regulations by the DHHS Office of Department of Health and Human Services’ Office of the National Coordinator for Health Information Technology (ONC)

Open Notes Rule

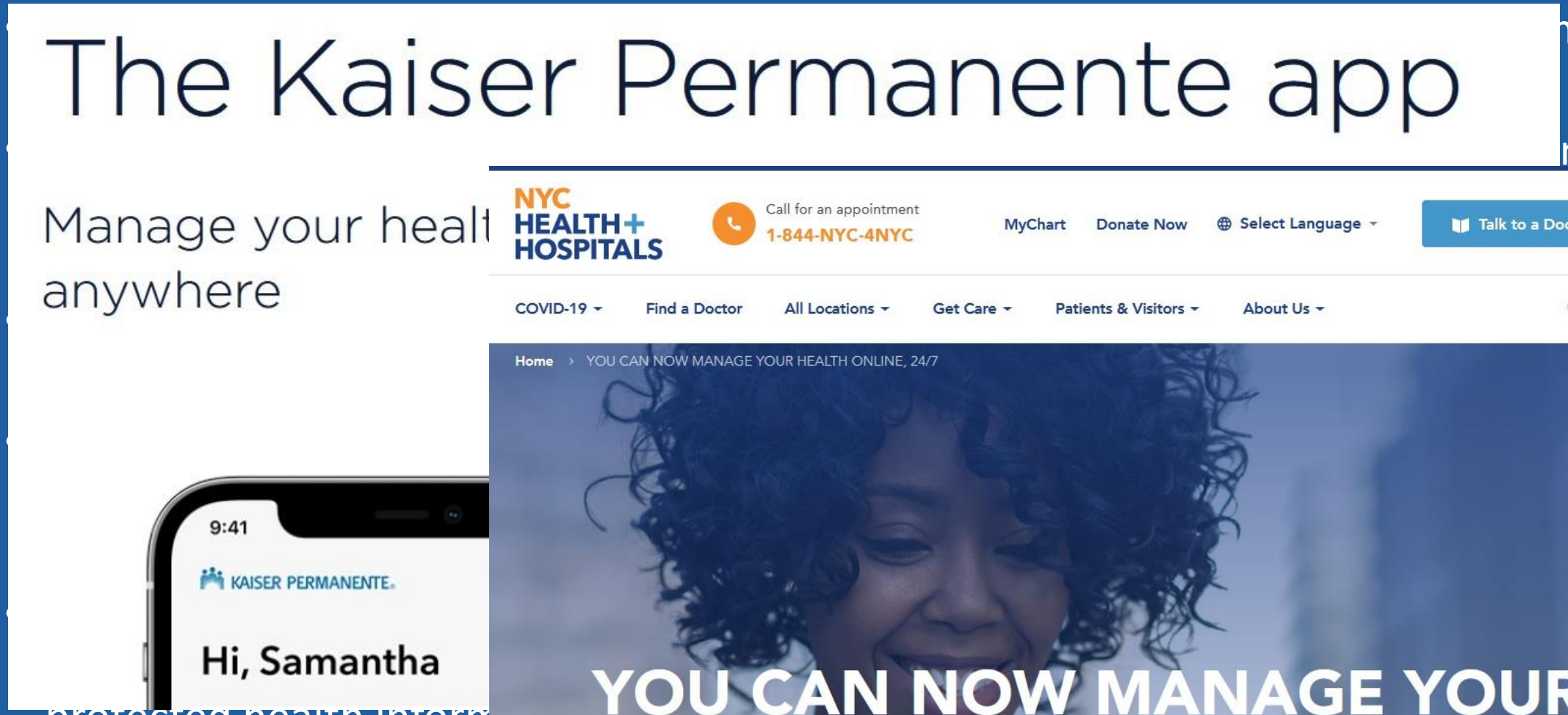
- The relevant portion of these regulations focuses on what has been called "Open Notes" (though that's not quite accurate – it's broader than that)
- Essentially, the **purposes** of the Information Blocking Rule are to facilitate:

- Immediate access to records, through a variety of means (with some exceptions)
- E.g., apps, tablets, Internet

- Ease of transferability of records
- E.g., when the patient/client changes providers

- "Interoperability" – EHRs talking to each other
- To benefit safety, treatment and the coordination and transfer of care

Open Notes Rule



Open Notes Rule

- Importantly, **the rule does not make big changes in the nature of the content that patients now have access to under most state laws and HIPAA**—it changes ***the timing*** and ***method of access***
  - That is, the usual access rules that patients (with some limited exceptions) have access to all their clinical records remain the same

- What has changed:
  - The expectation that patients will have access to the typical electronic health information instantaneously (e.g., online portal/app access is required as soon as the record is completed)
  - Patients/clients can use their smartphones with apps and go online from almost anywhere one can get reception

What Information Do Patients/Clients Have Access to under HIPAA and the Open Notes Rule?

- The rule created a somewhat different definition of **“electronic health information”** (EHI)
- It is similar to HIPAA’s definition of a **“designated record set”**

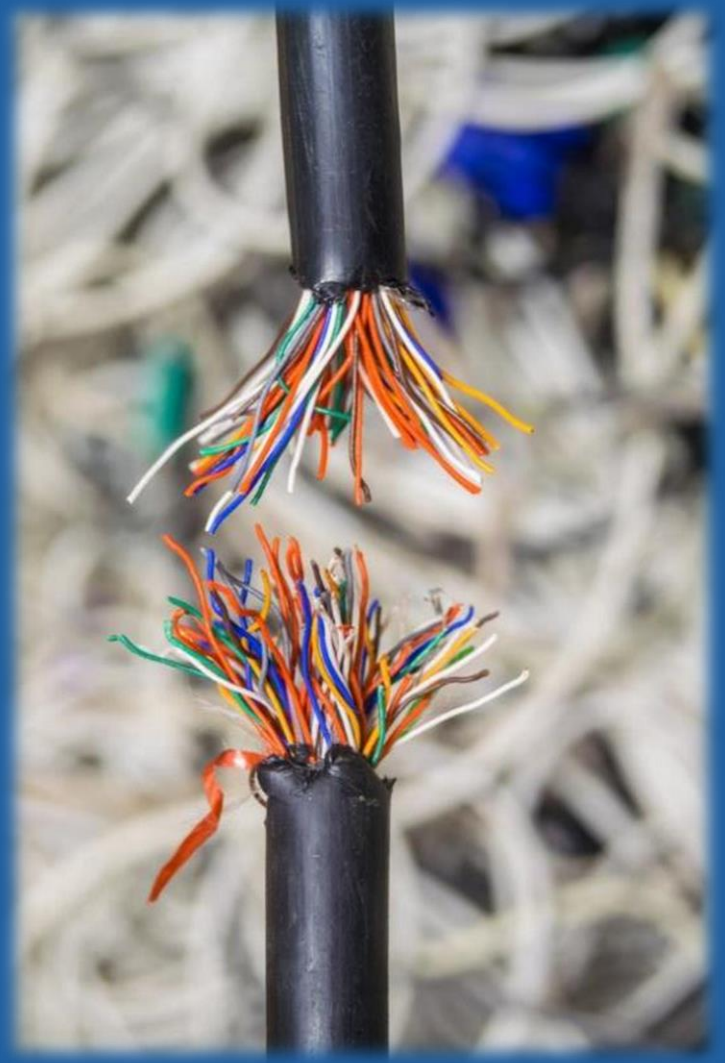
What in the blazes is a "designated record set?"

Under HIPAA, a designated record set is any of the following kinds of information used, collected, disclosed or maintained by the provider/facility (what HIPAA calls covered entities):

- Medical records
- Billing records
- Records about insurance payment and claims, enrollment, health plan claim(s) decisions

- ***If* this information is used to make decisions about an individual's care**
- **This means: If a provider relies on records to make treatment determinations, those records are available to the patient/client**

Open Notes Rule



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USCDI v3 Summary of Data Classes and Data Elements

Allergies and Intolerances
- Substance (Medication)
- Substance (Drug Class)
- Reaction

Assessment and Plan of Treatment
- Assessment and Plan of Treatment
- SDOH Assessment

Care Team Member(s)
- Care Team Member Name
- Care Team Member Identifier
- Care Team Member Role
- Care Team Member Location
- Care Team Member Telecom

Clinical Notes
- Consultation Note
- Discharge Summary Note
- History & Physical
- Procedure Note
- Progress Note

Clinical Tests
- Clinical Test
- Clinical Test Result/Report

Diagnostic Imaging
- Diagnostic Imaging Test
- Diagnostic Imaging Report

Encounter Information
- Encounter Type
- Encounter Diagnosis
- Encounter Time
- Encounter Location
- Encounter Disposition

Goals
- Patient Goals
- SDOH Goals

Health Insurance Information
- Coverage Status
- Coverage Type
- Relationship to Subscriber
- Member Identifier
- Subscriber Identifier
- Group Number
- Payer Identifier

Health Status/Assessments
- Health Concerns
- Functional Status
- Disability Status
- Mental/Cognitive Status
- Pregnancy Status
- Smoking Status

Immunizations
- Immunizations

Laboratory
- Tests
- Values/Results
- Specimen Type
- Result Status

Medications
- Medications
- Dose
- Dose Unit of Measure
- Indication
- Fill Status

Patient Demographics/ Information
- First Name
- Last Name
- Middle Name (Including middle initial)
- Name Suffix
- Previous Name
- Date of Birth
- Date of Death
- Race
- Ethnicity
- Tribal Affiliation
- Sex
- Sexual Orientation
- Gender Identity
- Preferred Language
- Current Address
- Previous Address
- Phone Number
- Phone Number Type
- Email Address
- Related Person's Name
- Related Person's Relationship
- Occupation
- Occupation Industry

Problems
- Problems
- SDOH Problems/Health Concerns
- Date of Diagnosis
- Date of Resolution

Procedures
- Procedures
- SDOH Interventions
- Reason for Referral

Provenance
- Author Organization
- Author Time Stamp

Unique Device Identifier(s) for a Patient's Implantable Device(s)
- Unique Device Identifier(s) for a patient's implantable device(s)

Vital Signs
- Systolic Blood Pressure
- Diastolic Blood Pressure
- Heart Rate
- Respiratory Rate
- Body Temperature
- Body Height
- Body Weight
- Pulse Oximetry
- Inhaled Oxygen Concentration
- BMI Percentile (2 - 20 years)
- Weight-for-length Percentile (Birth - 24 Months)
- Head Occipital-frontal Circumference Percentile (Birth- 36 Months)

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Open Notes Rule

What is excluded from the records to which patients/clients have access?

1. Psychotherapy notes
2. “Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.”
3. Whether other HIPAA exceptions to designated record set inclusion apply remains to be seen

Open Notes Rule

- Let's return to psychotherapy notes for a moment
- "PSYCHOTHERAPY notes mean notes recorded (in any medium) by … a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record."
- So, psychotherapy notes are not the same as a clinical record
- "A CLINICAL record includes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of … diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date."

Open Notes Rule

- Aside from a psychotherapy note, is there any other information that can be withheld from a patient without triggering an assumption that we are "information blocking"?
- Yes, there are eight exceptions
- Three of these are likely most relevant to our work in clinics and practices:
  - Preventing harm
  - Privacy
  - Infeasibility

Preventing Harm Exception to Patient/Client Record Access

- To be allowed to block access we must have a ***reasonable belief that [preventing access] will substantially reduce a risk of harm to a patient or another person that would otherwise arise from the access…***
- ***The lack of access can't be any broader than necessary to*** substantially reduce the risk of harm
- It must be based on a specific type of risk (e.g., concern over heightening suicidality)
- The decision to restrict access must focus on protecting against that particular risk
- The decision is based on your facility policy or provider judgment about this patient's/client's particular facts and circumstances

Privacy Exception

- **Precondition not satisfied**: If a [provider] is required by a state or federal law to satisfy a precondition (**e.g., a patient must sign an authorization to release**) prior to providing access … to EHI, the [provider] may choose not to provide access, if the precondition has not been satisfied under certain circumstances.

- **Respecting an individual's request not to share information**: A [provider] may choose not to provide access, exchange, or use of an individual's EHI **if doing so fulfills the wishes of the individual**, provided certain conditions are met.

Infeasibility Exception

What is meant by "infeasibility?"

1. **Uncontrollable events**, such as technological outages, labor strikes, public health emergencies, and the like
2. **Inability to separate out the requested information** from information that is not accessible (not likely)
3. And likely more relevant to small practices, "**infeasibility under the circumstances**," which could include, among other things, expense to the practitioner (e.g., access would require expenditures beyond the technological or financial resources of the provider)

Clinical Concerns

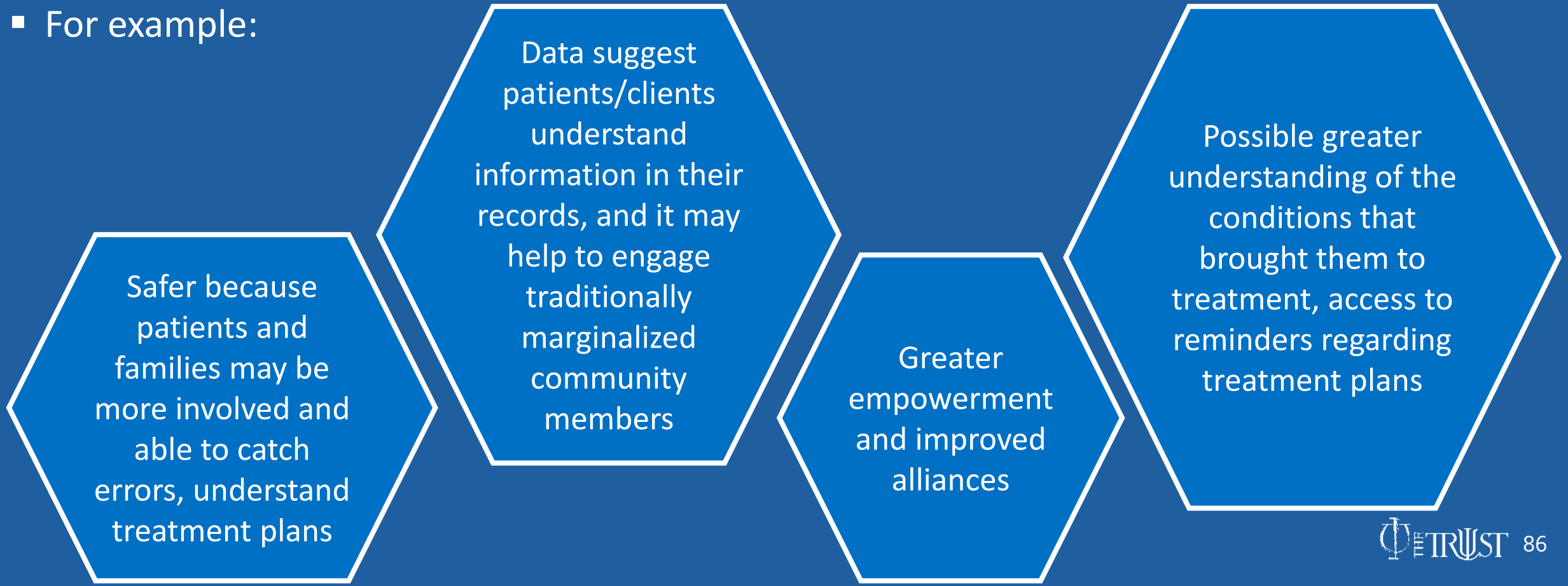
- Concerns over near-instantaneous access to clinical records were voiced, especially by psychotherapists, and those conducting psychological/psychiatric evaluations
- These worries include:
  - The impact of reading notes on patients/clients who distrust systems/providers (e.g., someone who has a psychotic disorder and believes people are intentionally mislabeling them)
  - How does one include diagnoses, mental status evaluations, neuropsychological assessments and descriptions without sometimes undermining the alliance, increasing patient/client distress, and causing psychological harm to some of those to whom we provide services?
  - Remember, relationship disruption and psychological distress do not meet the “harm” standard under the Information Blocking Rule or under HIPAA. These rules impose a physical harm standard before access can be denied

Open Notes Rule

- The question then becomes, if patients/clients will have virtually instantaneous access to records, how does one address the concerns voiced along the way, and that many MHPs have?
- There are at least two general approaches to addressing this concern, and these approaches are not necessarily independent of one another or conflicting:
  1. **Modifying how we craft our records** in keeping with transparency with our patients/clients
  2. Engaging in **collaborative record keeping**

Changing Our Record Keeping Habits

- The “OpenNotes” project has been in existence for at least 10 years (see https://www.opennotes.org/onc-federal-rule/)
- Its proponents have been arguing for some time that sharing notes with patients/clients has a number of benefits (https://www.opennotes.org/effects-of-opennotes-faqs/)
- For example:



Open Notes Rule

- The OpenNotes organization makes the following suggestions to providers regarding how note-taking can change and improve to reduce the potential for some of the anticipated negative outcomes to arise:
  - Briefly define medical terms when feasible.
  - Patients may benefit from the list of common abbreviations on Medline Plus, where they may also look up medical terms or diagnoses.
  - Incorporate lab or study [test] results into your notes to give patients the full picture.
- Include educational materials or links to trusted content for your patients.
- Be mindful of sensitive topics, and remember patients always have rights under HIPAA to access their records.
  https://www.opennotes.org/effects-of-opennotes-faqs/

The OpenNotes Project Also Suggests

- Avoid abbreviations. For example, “SOB” does not mean “shortness of breath” to most patients!
- Avoid language that may seem judgmental, such as “noncompliant” and “unreliable.” ***These observations are better off documented behaviorally, rather than using an adjective to describe a patient (e.g., “Patient reports he did not take the medications as suggested.”)*** [emphasis added]
- Avoid copying and pasting information into a note. Both patients and clinicians often take umbrage at such practice.
- Use plain language; see some helpful examples at: https://www.opennotes.org/wp-content/uploads/2016/02/Klein_notes-tip_toolkit.pdf
- Sign notes in a timely manner. https://www.opennotes.org/effects-of-opennotes-faqs/

Scenario

Ms. “B” — a patient with a borderline diagnosis

Sample note: Ms. B’s condition remains about the same as it was during our last visit. She feels the medication helps somewhat, but I have shared my concerns with her that her continued use of marijuana and alcohol likely interferes with the ability of the medication to help. She recognizes her frustration and unhappiness, however, and was open to discussing a referral for dialectical behavior therapy. I think this could be very helpful for her. I also raised the question of AA. We agreed to see how she felt after a week of going without alcohol, and if she can do this, we will consider a medication referral to help her with her moods. While she has her ups and downs at her job as a receptionist, she does feel her boss is supportive, and that’s encouraging.

APA Suggestions

APA Services (2021) has also made some suggestions, which differ slightly from OpenNotes. These include, among other things:

- Writing ‘lean’ records. That is, keeping the information to a minimum and using psychotherapy notes (as defined in HIPAA) to allow more detail for providers
- Document with the expectation that patients will read it without your knowledge or ability to [explain context]
- In the context of group, family or couples treatment, have a clear informed consent process for explaining what will be provided in the records
- Keep separate records (e.g., for group members) when it is in your policy to do so
- Let patients/clients know that they can ask to have parts of the record unavailable to others (have and communicate a policy in that regard)

Collaborative Record-Keeping

Increasing transparency and trust

Increasing engagement

Avoiding misunderstandings and misinterpretations

Allows for clarification and discussion in-the-moment

Increasing the efficiency and accuracy of the records

- The second approach to addressing concerns about Open Notes has been termed "collaborative record-keeping"
  - The ***central idea*** in this method is that the clinician engages in ***documentation WITH the patient/client present and involved***—typically at the beginning and/or end of the session
  - The patient/client input and perspective becomes an integrated part of the record (Dicarolo & Garcia, 2016; Matthews, 2020; Stanhope et al., 2013)
  - The presumed benefits are…

Collaborative Record-Keeping (continued)

- The focus is on the clinician's and patient's/client's evaluation/assessment, goals and patient/client progress
- It is an approach that dovetails well with patient/client in-session feedback models (e.g., PCOMS system—the Partners for Change Outcome Management System)
- It is also in keeping with models of person/family-centered care models that focus on patient/client control and choice in services

Introducing Collaborative Record-Keeping to Patients/Clients

"I'd like to try something today that you may find helpful. Research shows that when therapists and clients write notes together, it can improve understanding and collaboration. I'd like to try that right before the end of the session."

Sample Notes:

- "At the beginning of our session, we talked about how, when you are feeling down or depressed, you stop reaching out to friends and family…Did I understand that correctly?" (if so, then write the note)
- "Is this right? 'Joe has been feeling better and wants to stop taking his medications. I suggested he be sure to talk to his psychiatrist before doing that'."
- "I know you've been having a hard time sleeping, so let's go over the suggestions I've made today…" (review and enter into the note)

Open Notes Rule

- Of course, no system or set of steps is perfect
- Some patients/clients may find it uncomfortable, or object to note-taking along with the clinician in-session (note how important the clinician's training and comfort level can be in fostering engagement in this kind of process)
- In an emergency, or a patient/client who is floridly manic patient/client, it may not be possible

- But, when combined with the idea of creating notes with the ***intent that these records will be seen*** (transparency), collaborative record-keeping offers a way to help address some of the potential problems with immediate and unfiltered access to records—which has been happening, and is going to happen in many systems, notwithstanding objections many clinicians have raised

What do the data show about these two approaches?

- The research on **Open Notes**/quick patient access to records is nascent, and methods have not been rigorous
- Still, findings suggest negative outcomes are infrequent, and related to how notes are framed (i.e., perceived negative wording), not apparently access itself
- In studies of collaborative recording-keeping, between 80% and 95% of behavioral health patients found it helpful and involving, and over 75% wanted to continue
- Qualitative data from another study found that therapist comfort level with such an approach was a factor in determining whether it was helpful and effective
- Further, one small study suggested it enhanced the alliance

Conclusions

Loving-Kindness for Clinicians

Anti-Burnout Card Deck, Warren, Abblett & Willard, 2018

- Changes in record-keeping styles and the use of collaborative documentation are two potential approaches

CHALLENGING CONVERSATION 4

A QUESTION OF DUTIES

Vignette 4

Mr. Worried

Ms. Unconcerned

Clara

A Step Back in Time

- Cases involving criminal prosecution of parents for abusing their children date back to the 1600s in the U.S., and child welfare began to garner more attention in the late 1800s
- But it was not until 1962 that public awareness and concern was galvanized

A Step Back in Time

- Kemp et al. (1962) study: Demonstrating physical medical evidence of intentional bone breakage in children who had been brought to ERs by their parents
- A confluence of factors, including a model statute proposed by the U.S. Children's Bureau soon after the study, led to mandated reporting laws in almost all American jurisdictions by 1967

- In 1978, Congress passed the Child Abuse Prevention and Treatment Act (CAPTA), with financial incentives for states that enacted laws in keeping with Federal standards for reporting, prevention, and intervention

A Step Back in Time

- States not required to impose mandated reporting standards on professionals
  - But were financially incentivized to do so
- As a result, there has been increasing consistency among states regarding the general structure of required reporting statutes
- BUT these statutes are NOT uniform

- Notwithstanding some thoughtful and bracing critiques of the effectiveness of mandated reporting in curbing child maltreatment (Newberger, 1983: Melton, 1994), as well as concerns about inequitable applications of such laws against traditionally marginalized communities, these mandates are in force today throughout the country

Current Status

- The legislation evolved over the years, but retains some relatively consistent elements:

1. Almost all **list** those **professionals mandated to report**, including mental health professionals
2. All have a **low threshold for reporting**
   - (i.e., "reason to believe," "reasonable suspicion," "reason to suspect," etc.)

   This level of "proof" is lower than "probable cause" standards for law enforcement to intervene
3. Almost all provide **some immunity from civil and/or criminal liability** when MPHs make a mandated report, and **penalties** (primarily misdemeanors) **for failing** to make such reports when the reporter had or should have had the requisite reason to believe abuse had occurred

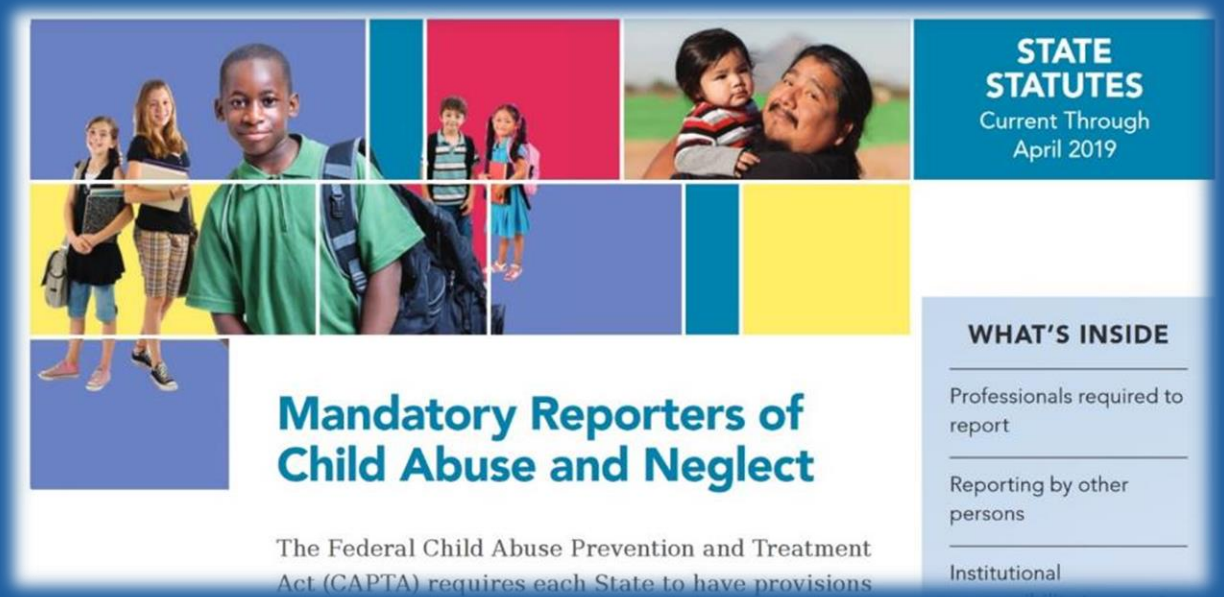
Current Status

These protections for reporting, and punishments for failure to report, developed in part because:

- Clinicians' traditionally strong confidentiality rules and related reluctance to disclose information
- Clinicians' concerns about the negative impact on provider-patient relationships, treatment effectiveness, and willingness of patients to disclose information

- Some larger systems' (e.g., schools, hospitals, juvenile centers) institutional reluctance to making reports
- Concerns over potential legal retribution against those professionals and community members who make these reports (i.e., liability)

Current Status



- As a result, Federal model legislation and states encouraged the use of a kind of "carrot and stick" approach:
  - Immunity provisions to protect practitioners from legal liability when they fulfill their duties to report
  - Punishment for failure to report

Immunity Clauses

Good Faith

- Variously worded as such or requiring that reports are not made "maliciously" or "in bad faith"
- This puts the burden on the mandated reporter to demonstrate they were reporting in good faith

Presumptive

- Includes a legal **presumption that the reporter acted appropriately**
- Places the burden on those who sue or prosecute to prove it was made in bad faith
- Provides an additional barrier to successful suits in some 17 jurisdictions

Unqualified Immunity

- AKA "quasi-judicial immunity" laws
- Do not require even "good faith" by the mandated reporter to invoke immunity
- **Highly protective** of required reporters
- Only a handful of states have this standard

Examples of Good Faith Immunity Clauses (the most common)

Texas Family Code § 261.106. A person acting in good faith who reports or assists in the investigation of a report of **alleged child abuse or neglect, or who testifies or otherwise participates** in a judicial proceeding arising from a report, petition, o
abuse or neglect**, is im**
liability that might othe
...A person who repor
neglect of a child or w
malicious purpose in re
neglect is not immune

Florida Ann. Stat. § 39.203(1) Any person, official, or institution participating in good faith in any act authorized or required by the reporting laws or reporting in good faith any instance of child abuse, abandonment, or neglect to the department or any law enforcement agency **shall be immune from any civil or criminal liability that might otherwise result by reason of such action**.

Example of Presumed Good Faith (second most common)

Illinois Comp. Stat. Ch. 325, § 5/9. Any person, institution, or agency that, under the reporting laws, participates in good faith in making a report or referral…—and except in cases of willful or wanton misconduct—shall have immunity from any liability, civil or criminal, that otherwise might result by reason of such actions; For the purpose of any proceedings, civil or criminal, the good faith of any persons required to report or refer, or who are permitted to report, cases of suspected child abuse or neglect shall be presumed….

Example of Unqualified Immunity (least common)

Maryland Fam. Law § 5-708
Any person who makes or participates in making a report of abuse or neglect under §§ 5-704, 5-705, or 5-705.1, or participates in an investigation or a resulting judicial proceeding, **shall have immunity from civil liability or criminal penalty**

New Jersey Ann. Stat. § 9:6-8.13
Anyone acting pursuant to the reporting laws in making a report under the reporting laws shall have immunity from any civil or criminal liability that might otherwise be incurred or imposed. Any such person shall have the same immunity with respect to testimony given in any judicial proceeding resulting from such report.

A Rare Bird

- **And, unusually, at least one state (California) provides *reimbursement*** for the successful defense of a lawsuit for making a child abuse report:

Cal Penal Code §11172(d)(1)"The Legislature finds that even though it has provided immunity from liability to persons required or authorized to make reports pursuant to this article, that immunity does not eliminate the possibility that actions may be brought against those persons based upon required or authorized reports. In order to further limit the financial hardship that those persons may incur as a result of fulfilling their legal responsibilities, it is necessary that they not be unfairly burdened by legal fees incurred in defending those actions. Therefore, a mandated reporter may present a claim to the Department of General Services for reasonable attorney's fees and costs incurred in any action against that person on the basis of making a report required or authorized by this article if the court has dismissed the action upon a demurrer or motion for summary judgment made by that person, or if he or she prevails in the action…not [to] exceed an hourly rate greater than the rate charged by the Attorney General of the State of California at the time the award is made and shall not exceed **an aggregate amount of fifty thousand dollars."**

No Guarantee

- Immunity **does not guarantee** protection of professionals from suit, licensing board complaints, and other negative events
- There are a number of cases of professionals being sued for making required reports
  - **BUT**, by far **the most common outcome is that courts determine good faith immunity applies, and the cases are dismissed early in the process** (e.g., summary judgment motions)

There are dozens of such cases across the country

Here are three examples:

Immunity Case Example 1

Awkerman v. Tri-County Orthopedic Group, P.C.

(143 Mich. App. 722, 373 N.W.2d 204, 1985)

- Orthopedic surgeons treated a child for multiple bone fractures.
- They ruled out "brittle bone disease" and made a child abuse report, after which the child was removed from his mother by CPS.
- The child was later diagnosed with this disorder, and the child was returned home, and the CPS case was dismissed.
- The mother then filed suit, alleging, among other things, that the original physicians were liable for the erroneous child abuse report.
- The court held that good faith immunity applied, and those claims were dismissed on summary judgment motion.

Immunity Case Example 2

Chaney v. Corona
(103 S.W.3d 608, 2003 Tex. App)

- Involved a teacher who allegedly hit a student in the eye with a chair. The principal consulted with her supervisor and was told to make a CPS report, which she did.
- The parents sued the teacher, and the teacher sued the principal. The principal filed for summary judgment.

- The principal argued the case against her should be dismissed because of good faith immunity, but the lower courts initially ruled against her.
- On appeal, the Texas Supreme Court overturned the lower courts' rulings, and dismissed the case against the principal because she reported to CPS in good faith.

Immunity Case Example 3

Rine v. Chase

(309 A.D.2d 796, 765 N.Y.S.2d 648)

- Note: New York State has a presumption of good faith for mandated reporters.
- A clinical social worker was providing therapy to the children of two divorcing parents. On the basis of statements made by the children, he reported to CPS a reason to believe the father had abused the children.
- CPS determined that the reports were unfounded.
- The father sued the therapist for defamation and malicious prosecution. The trial court dismissed the claims.
- The father appealed, and the appellate court upheld the lower court's dismissal.

When Does Immunity Fail?

- The above decisions and numerous others across the U.S. are representative of the majority of cases interpreting state immunity provisions for mandated reporters
- **Of course, there are exceptions to this typical trend**—both in states with the standard good faith immunities (e.g., Texas), and those few states where immunity does not even require good faith (e.g., California)

- In other words, under some circumstances, courts have permitted lawsuits to go forward, notwithstanding these immunity provisions.

When Does Immunity Fail?

Scroggs v. State (396 S.W.3d 1)

- Two people broke in, assaulted, and kidnapped a pregnant woman to take her to a hospital to force her to get a blood test because they believed she was using Oxycontin while pregnant, and had been involved in stealing it from one of the kidnappers.
- When stopped by police at the hospital, they reported their concerns about the unborn child being exposed to drugs.

- In partial defense of their actions at their criminal trial, they said they were going to report to CPS, but wanted to have the pregnant woman get a blood test to prove her innocence before doing so.
- **They claimed immunity** from criminal actions under good faith abuse reporting law. **Note, though, they had committed numerous crimes prior to telling the police, and had not reported to CPS. Not surprisingly, the court refused to grant them good faith immunity.**

When Does Immunity Fail?

Cuff v. Grossmont Union High School Dist.
(221 Cal. App. 4th 582, 164 Cal. Rptr. 3d 487)

- A father involved in a custody battle took his sons to see a school counselor and reported that his ex-wife had abused them.
- The counselor made the required report, and then gave the father a copy of the written report she had submitted.

- Giving the report to the parent, though, was contrary to CA reporting law requirements for confidentiality.
- The mother sued the school and counselor. The trial court dismissed the case, accepting an immunity argument. But on appeal, the Appellate Court ruled that the school and counselor were not immune because they acted in violation of the reporting statute.

Administrative (Licensing Board) Consequences for Reporting

- It is difficult to find any documentation of complaints resulting in discipline by State Boards of Psychology for professionals who have made mandated reports
- Among the seven Trust Risk Management Team members, with almost 110,000 consultation calls completed by the Team, ***only one could recall a single instance*** of a board complaint that was sustained against a provider for making a report

When Are Mandated Reporters Liable?

- Many states classify ***failures to make a mandated report*** **as "unprofessional conduct"** in the licensing laws of professionals
- Most states have **misdemeanor penalties** for ***failing to report*** by mandated reporters (with a handful penalizing anyone who fails to do so)
- Some permit private **civil actions** (malpractice) for such failures, but this is not permitted in all states

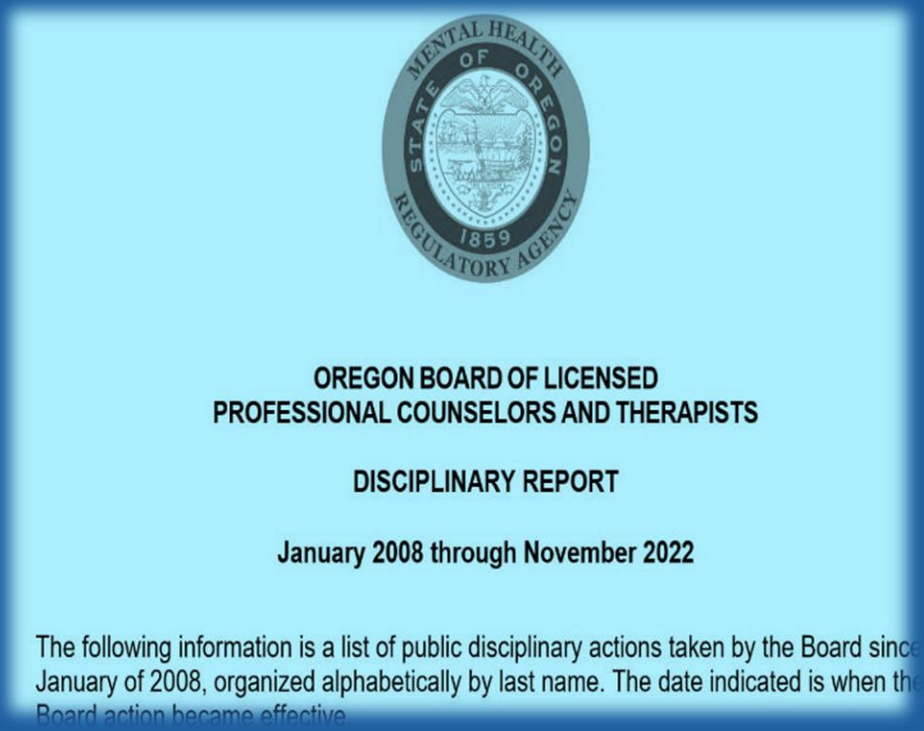
Example of Criminal Prosecutions for Failure to Report

State v. Brown
(140 S.W.3d 51, 2004 Mo. LEXIS 101)

- A nurse was informed by paramedics about suspicious bruising on the back and face of a 2-year-old child who had been airlifted to her hospital.
- She did not make a child abuse report. The child was released and, 4 days later, died due to massive head injuries.
- The nurse was prosecuted for failure to report child abuse (a misdemeanor in MO). The trial court dismissed the case, accepting the argument that the law was unconstitutional. The Missouri Supreme Court overturned that decision and sent the case back to the circuit court for the nurse to be criminally tried.

Discipline for Failure to Report

- Unlike complaints for making a report – which are extraordinarily rare – complaints and Board disciplinary actions against licensed professionals for a **failure to report** can be found in a number of states:



OREGON BOARD OF LICENSED
PROFESSIONAL COUNSELORS AND THERAPISTS

DISCIPLINARY REPORT

January 2008 through November 2022

The following information is a list of public disciplinary actions taken by the Board since January of 2008, organized alphabetically by last name. The date indicated is when the Board action became effective.

- See, for example:
  - Texas Psychology Board Updated Disciplines, August 2019 (http://www.tsbep.texas.gov/files/agencydocs/Discipline_2019August.pdf)
  - Oregon Board of LPCs and Therapists Disciplinary Report 2008-2019 (https://www.oregon.gov/oblpct/Documents/Discipline_List.pdf)

Civil Liability for Failure to Report

Some states allow civil lawsuits by guardians and others for a mandated reporter's failure to report abuse or neglect.

Landeros v. Flood (17 Cal.3d 399, 1976)

- Involved a physician who treated an 11-month-old infant at an ER for spiral fractures and multiple bruises. There was plentiful evidence she had been physically abused.
- The physician did not report the abuse and released her to the mother after treatment.
- The infant was later seen by another physician after suffering additional severe trauma caused by her caretakers. A report was made, the child was removed from the home, and the caretakers were prosecuted.
- A Guardian Ad Litem sued the original physician on behalf of the injured child, and the CA Supreme Court permitted a private civil action in malpractice against the physician who had failed to report, based in part on the reporting statute's requirements.

Despite These Protections, There Are Some Risks to *Making* Child Abuse Reports

- Even if the professional wins, suits against professionals for reporting are not a walk in the park (and there have been a number)
- There can be a negative impact on the treatment relationship and possibly on a patient's willingness to seek treatment in the future (see, e.g., Rokop, 2003)
- Parents, caretakers and patients can retaliate through negative online reviews, or harass professionals in other ways (e.g., phone, email, in-person)

- Legal retaliation for an abuse report against a clinician can also occur, in the guise of a claim of incompetence, bias or multiple relationship
- Employer retaliation against mandated reporters is possible (though employers can face legal repercussions for such retaliation)

What Can a Psychologist Do? Steps to Address Risk

- Importantly, current statutory structures create a **CLEAR mandate to REPORT, *with legal protections when one does so, and potentially significant risks when one does not***
- So, despite the risks of reporting, **The Trust Risk Management Team is unanimous in our perspective that a report must be made when the statutory conditions are met**
- But spurious and vengeful complaints and adverse actions can and do happen
- So, the question becomes: **How to minimize the risks, while complying with the legal requirements?**

What Can a Psychologist Do? Steps to Address Risk

- If at all possible, ***engage the patient*** (e.g., a parent) in the process. There are times when it won't be possible, but making efforts to inform, communicate, and educate can help reduce damage to the alliance (though note exceptions; e.g., Rokup, 2003)

- Have a good understanding of the conditions under which a mandated report is required (knowledge of the law), and what one is required to do—and NOT required to do (remember CA case: *Cuff v. Grossmont Union High School Dist*., 221 Cal. App. 4th 582, 164 Cal. Rptr. 3d 487, 2013)
- Be aware of varying state laws if doing teletherapy

What Can a Psychologist Do? Steps to Address Risk

Because child abuse reporting requirements are generally clear…

- As are the structural **protections and punishments** laws that provide for mandated reporters

…The risks involved with **NOT** **reporting are significant**

- Some risk of completing a report exist, nonetheless
- Recognizing the patients/clients and situations where those risks are elevated is an important step
- **Increased attention to traditional risk management methods can help address these situations more effectively**

CHALLENGING CONVERSATION 5

A CONFLICT OF INTEREST & A DEMANDING ATTORNEY

Vignette 5

Ms. Torn

Dr. Lee

Individual Therapy

Couples Therapy

Ms. Loyal

Differentiating Collateral vs. Conjoint Services

- Before diving into other aspects of this scenario, a first step is to consider whether Ms. Loyal was a collateral participating in Ms. Torn's individual treatment or if this was a conjoint couple's treatment

- Factors in determining collateral status include:
  - Whether there is a person who is clearly identified as the focus of treatment; that is, is there a person you believe is receiving the treatment and to whom you owe primary fidelity/loyalty?
  - Whether the additional person(s) are intended to be a patient(s)/client(s)
  - Whether the relationship is intended to be the focus of services

Differentiating Collateral vs. Conjoint Services

Ms. Torn initially asked Dr. Lee to have her wife, Ms. Loyal, come to her individual sessions. They then asked for couple's therapy and Dr. Lee agreed.

Mr. Stuck calls and seeks services because he can't seem to disengage from arguments with his fiancé. He wants help to bring her in to talk about their conflicts and work on problem-solving in their relationship.

Notice the different nature of such a treatment relationship if, instead, Ms. Torn had been struggling with a longstanding depression. Dr. Lee asked Ms. Loyal to attend two sessions to provide information and enlist her support because Ms. Torn struggled to describe her day-to-day functioning and increase her behavioral activation.

What if it's Conjoint Treatment, Rather than Collateral?

- Conjoint services are time-honored—couples and family therapy have a long history, and there's substantial empirical literature on the effectiveness of different types of conjoint treatment
  (see, e.g., Gottman, 2010; Johnson, 2018)
- Additional challenges come when clinicians shift from one type of service (e.g., individual treatment for Ms. Torn), to a multi-person service (e.g., couple's treatment for Ms. Loyal and Ms. Torn)
- Is this prohibited?
- Risky?

Is the Shift from Collateral to Conjoint Permitted?

- Arguably, there is no specific prohibition in the Ethics Code regarding treating a couple after working with an individual couple member:
  - Still, we believe it could violate existing sections and discourage it, notwithstanding some current criticism asserting that such is an outdated view
  - Consultation and case-by-case analysis is strongly recommended
- Treating an individual after working with the couple may perhaps be less fraught; though there are ethical, clinical and legal implications

But consider APA Ethical standards related to:

- Standard 10.02(a), defining and clarifying who is the client
- Multiple relationships (3.05)
- Conflicts of interest (3.06)

Risk Management Question
What could go wrong?

Differentiating Collateral vs. Conjoint Services

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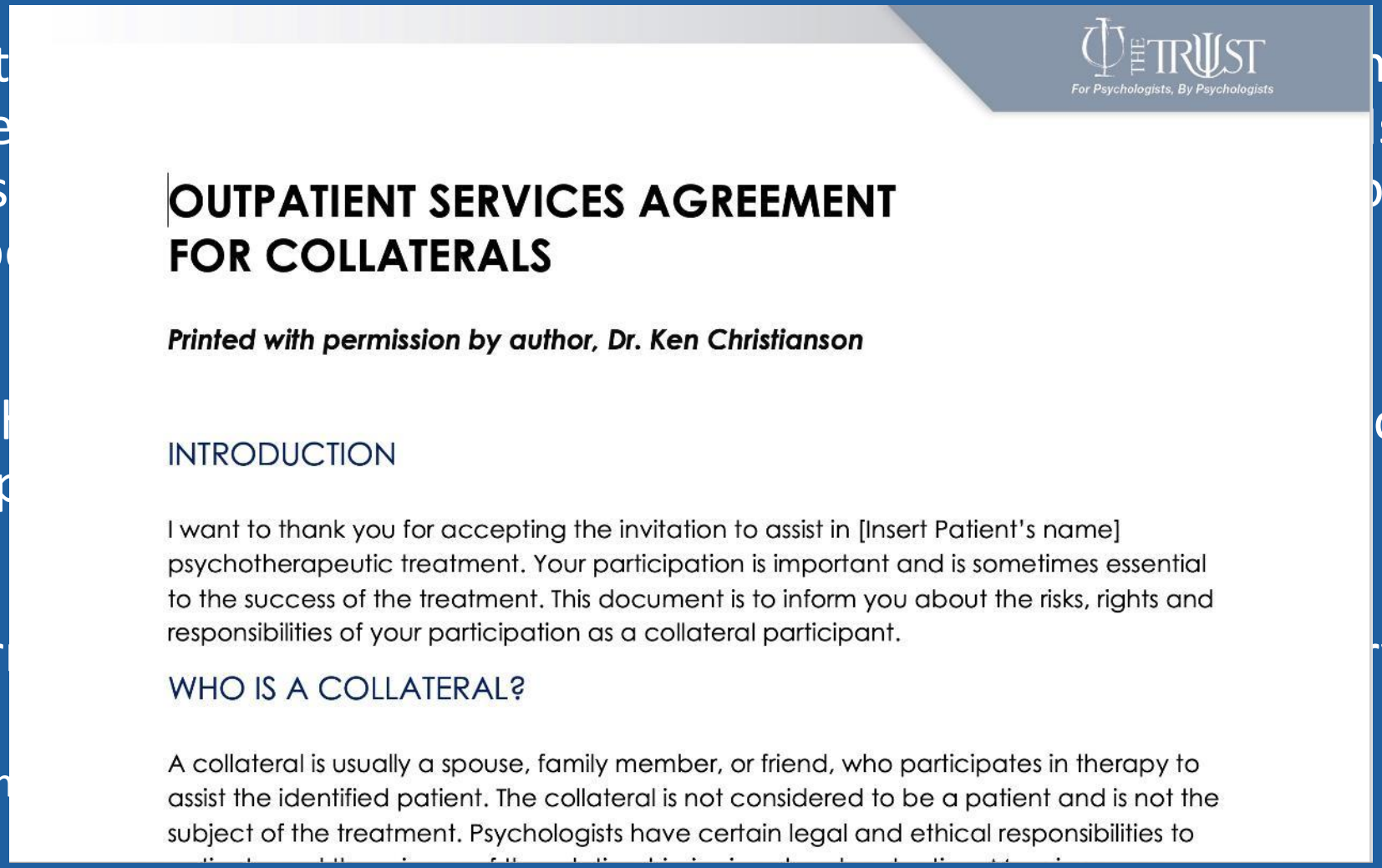


THE TRUST
For Psychologists, By Psychologists

OUTPATIENT SERVICES AGREEMENT FOR COLLATERALS

Printed with permission by author, Dr. Ken Christianson

INTRODUCTION

I want to thank you for accepting the invitation to assist in [Insert Patient's name] psychotherapeutic treatment. Your participation is important and is sometimes essential to the success of the treatment. This document is to inform you about the risks, rights and responsibilities of your participation as a collateral participant.

WHO IS A COLLATERAL?

A collateral is usually a spouse, family member, or friend, who participates in therapy to assist the identified patient. The collateral is not considered to be a patient and is not the subject of the treatment. Psychologists have certain legal and ethical responsibilities to

Relevant Ethical Considerations

Multiple Relationships APA Ethics Code Standard 3.05 (2017)

- 3.05 (a) A multiple relationship occurs when the psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with

3.06 Conflict of Interest

Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to

(1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists

or

(2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

A Multiple Relationship/Conflict of Interest Analysis

- Is it a multiple relationship or conflict of interest?
  - Are you or have you been in another professional or other relationship with a client or person closely related to a client?
- Could this relationship or interest adversely impact your objectivity, competence or effectiveness?
  - How seriously?
  - How probable is the impact?

A Multiple Relationship/Conflict of Interest Analysis

- Can you reasonably foresee the multiple relationship or conflict causing harm to, impairment of/or exploitation of the client?
  - How serious?
  - How likely?
- What are the potential benefits to the client of your entering into the relationship?
- What alternative arrangements to the multiple relationship of conflict of interest are available for the client?
  - Potential for equivalent benefit
  - Problems for client in accessing them

A Multiple Relationship/Conflict of Interest Analysis

- Are you required to enter the conflict because of legal or institutional obligations?
  - Have you made reasonable attempts to persuade the institution that an exception is warranted?
- At what point in the relationship did you discover the conflict?
  - Does this change your answers to the previous questions?

- If there is an adverse outcome, what is the risk of a licensing board complaint?
  - Is there a patient or situation with high-risk characteristics?
- If there is a licensing board complaint, how well will you be able to defend yourself?
  - Is the benefit worth the risk?

Other Significant Issues: Informed Consent

- Provide clear informed consent including what is confidential and what exceptions there are
- Any children who might be involved (e.g., in a family therapy or a reunification treatment) are entitled to developmentally appropriate informed consent/assent
- It is important for all members—children included—to know who has access to confidential information/records

APA Ethics Code Sections (2017)

Standard 10.02: When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset:

- which of the individuals are patients and clients, and
- the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the service provided or the information obtained.

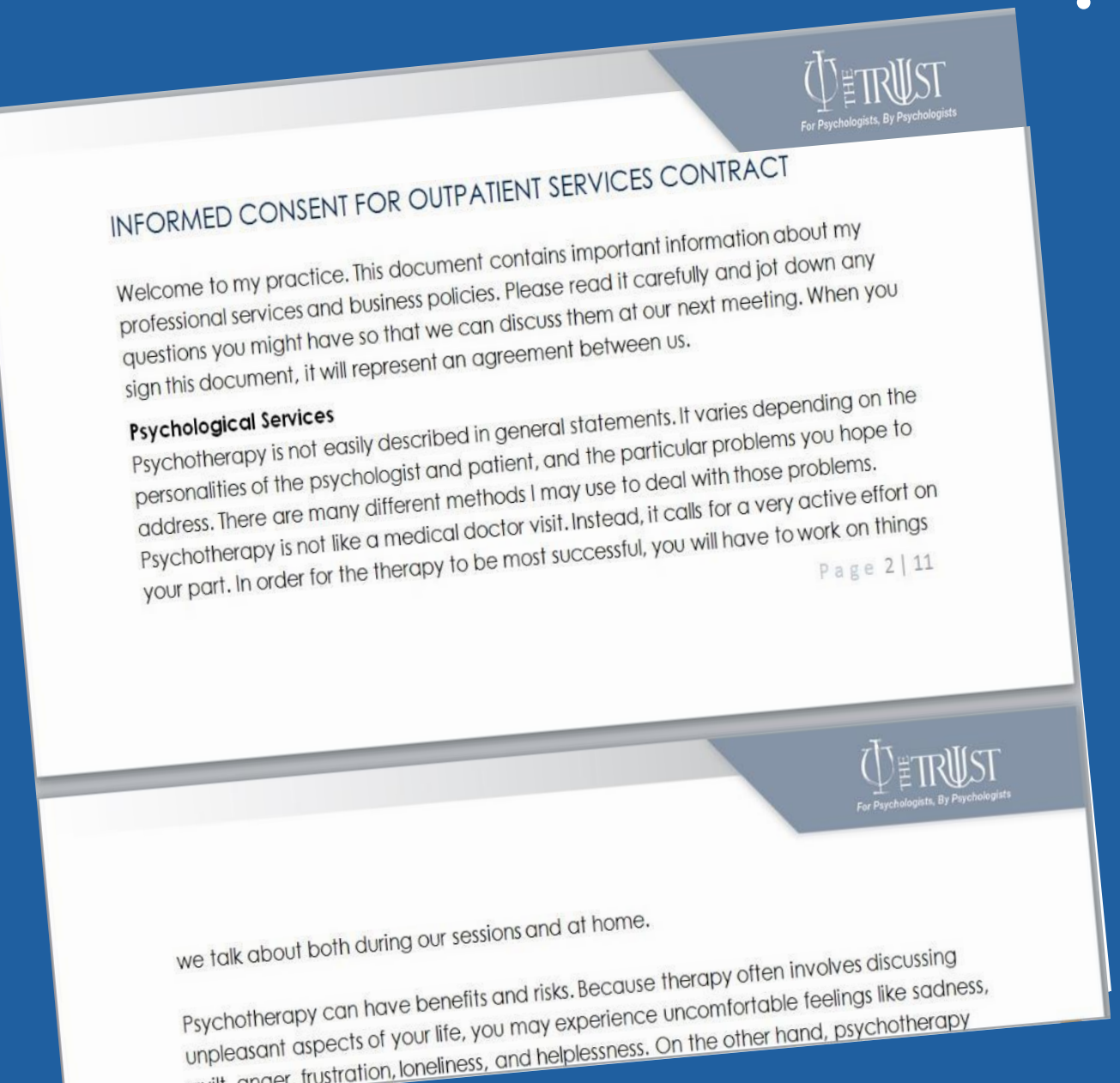
- If it becomes apparent that psychologists may be called upon to perform potentially conflicting roles (such as family therapist and then witness for one party in a divorce proceeding), psychologists take reasonable steps to clarify, and modify, or withdraw from, roles appropriately.

Standard 5.01: Psychologists discuss with persons … with whom they establish a … professional relationship … the relevant limitations on confidentiality, including limitations where applicable in … marital or family therapy….

APA Ethics Code Sections

- **APA Ethical Standard 3.10** (2017) requires obtaining informed consent of the individual or individuals using language that is reasonably understandable (3.10 (a))
- For persons who are legally incapable of giving informed consent (e.g., school-age children), psychologists nevertheless:
  - provide an appropriate explanation,
  - seek the individual's assent,
  - consider such person's preferences and best interests, and
  - obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

Informed Consent



- Raises the issue of engaging in informed consent with both members of the couple. For example:
  - Thinking through, first for Dr. Lee, and then discussing with Ms. Torn and Ms. Loyal, the potential impact of having worked individually with Ms. Torn on any potential couples work
  - Considering whether this conflict of interest would be likely to undermine the effectiveness of the new services (and that in one respect, multi-person treatments have inherent potential conflicts of interest)
  - Clarifying with Ms. Loyal and Ms. Torn what the potential risks and benefits would be from moving into couples treatment

Informed Consent

- Specifying, for both members of the couple, that ***the relationship*** has become the focus of treatment
- Explaining that ethically and legally, Dr. Lee would owe duties to both members of the couple, including such things as:
  - Minimizing harm to each (e.g., domestic violence; threats to self or others)
  - The nature of and access to records
  - How Dr. Lee would respond to legal demands for records
  - Whether Dr. Lee would (or would not) hold secrets (we'll get back to this point shortly)

Secret Keeping

- Another aspect of potential multiple relationships and conflicts of interest involves the long and ongoing debate about how to address secret keeping by clinicians in couple and family therapy

- Dr. Lee accepts Ms. Torn's initial demand to maintain the secret, notwithstanding her now owing a duty of fidelity to both members of this couple

Is Dr. Lee's approach permissible?

Is it safe?

Is it risky?

Secrets: To Keep or Not To Keep?

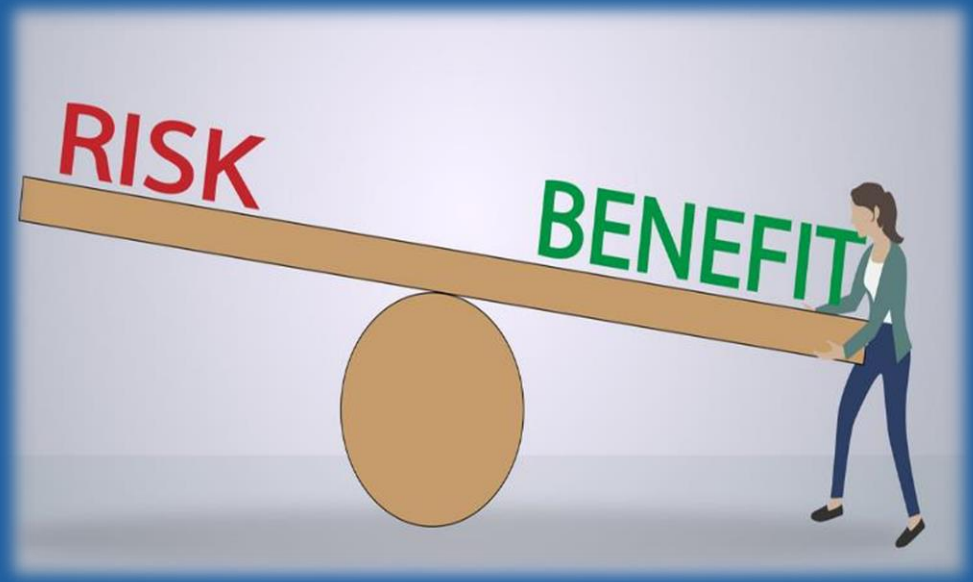
OR…?

There are essentially three positions that have been discussed regarding secret keeping, dating back some 40 years (Margolin, 1982):

- Keep secrets and attempt to navigate treatment, as Dr. Lee did
- Have a no secrets policy, inform partners ahead of time, and work with partners/family members to disclose; and if that's refused, provide important information that affects services and relationships
- An intermediate approach, which allows keeping – and disclosing – of secrets at the discretion of the clinician

Secret Keeping

- All of these approaches have benefits and risks
- But in our view, **the first and third positions** – keeping secrets and using clinical discretion – **are more risky** approaches:
  - Heighten potential for conflicts of interest
  - Higher potential for members of a couple or family being or feeling betrayed, becoming angry, ending treatment, and complaining



- Ultimately, clinicians must decide which balance of risks and benefits best suits their approach to treatment
- It is very important to decide – and inform – all members of the conjoint therapy about one's policy before beginning treatment
  - This should be included in your informed consent documents and discussed verbally

Couples and Privilege

Underlying bases for privilege:

- Confidentiality is an ethical and legal duty to protect privacy of patients/clients
- Privilege is a statutory exception to normal rules of evidence that any relevant and material evidence should be available to ensure the most just outcome
- Privilege belongs to the patient, but under certain circumstances, it can be asserted by the psychologist on the patient's/client's behalf

- Traditional view has been that privilege should be narrowly applied (i.e., if there is ambiguity of privilege, courts have seen the need for truth in the legal process taking precedence over privilege)

Couples and Privilege

- Privilege rules differ from state-to-state (e.g., patients only vs. all professional relationships)
- Some are modeled after lawyer-client privilege laws (e.g., compare Georgia to Illinois)
- Applies only to psychologists/MHPS or to others who are present to facilitate the treatment including family members and other collaterals
- Most protect couples treatment, but there are exceptions
- Psychologists should be familiar with state privilege rules, but should not attempt to give legal a[illegible]ice about application

Subpoena for Records/Testimony

- As you know, subpoenas are legal demands, usually issued by an attorney, seeking to establish a court's jurisdiction over a person or entity
- These instruments do demand a response, but NOT immediate disclosure of treatment information
- Court orders are issued by a judge who has determined that privilege does not apply
- Court orders and subpoenas require different responses
- When in do[illegible]t about which one you have, co[illegible]before you act

(a) Except as provided herein, in any civil

Couples and Privilege

General advice to psychologists treating couples

- When there's a subpoena for records or testimony:
  - Get **both members to provide authorization**

    OR
  - **Assert privilege** on the couples' behalf and let the court decide
  - NOTE: Different rules in some states require a different strategy (as discussed earlier re: Washington State)
- Though there are a variety of exceptions to privilege that might apply (e.g., if a member of the couple is suing someone and putting their own mental state at issue; if the conditions for privilege were not met during the services provided, etc.)
- It is not necessary for the clinician to determine whether such exceptions exist in a given situation

Couples and Privilege

If the situation is unclear, and one partner has not authorized disclosure, an exception to privilege may apply or an individual treatment patient has not clearly waived privilege:

- It is generally safer to assume privilege applies; assert privilege and have the client's attorneys and ultimately the court decide whether an exception exists

- Example: A provider received a subpoena and was aware the patient had introduced their mental state into issue in a lawsuit, thereby raising a potential exception to privilege (true in most states)
- The psychologist decided to release the records without speaking to the patient or getting legal counsel, and the patient made a licensing board complaint
- The Board disciplined the professional, who appealed the decision
- The Board's actions were upheld by a PA Commonwealth Court (*Rost v. State Board of Psychology*, 659 A.2d 626, 1995)

Collateral vs. Conjoint Services Summary

Care to Play?

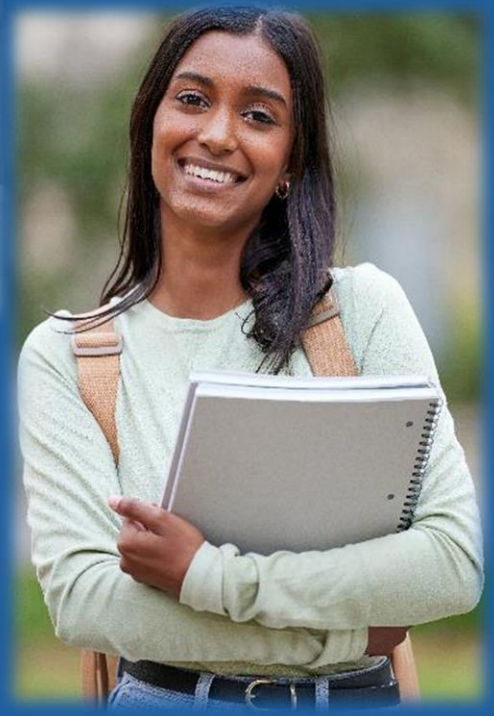
Anti-Burnout Card Deck, Warren, Abblett & Willard, 2018

CHALLENGING CONVERSATION 6

THE PERIPATETIC PATIENT

Expanding Mobility

Moving to a New State



College Students

Traveling Nurse or Other Professionals Traveling for Work

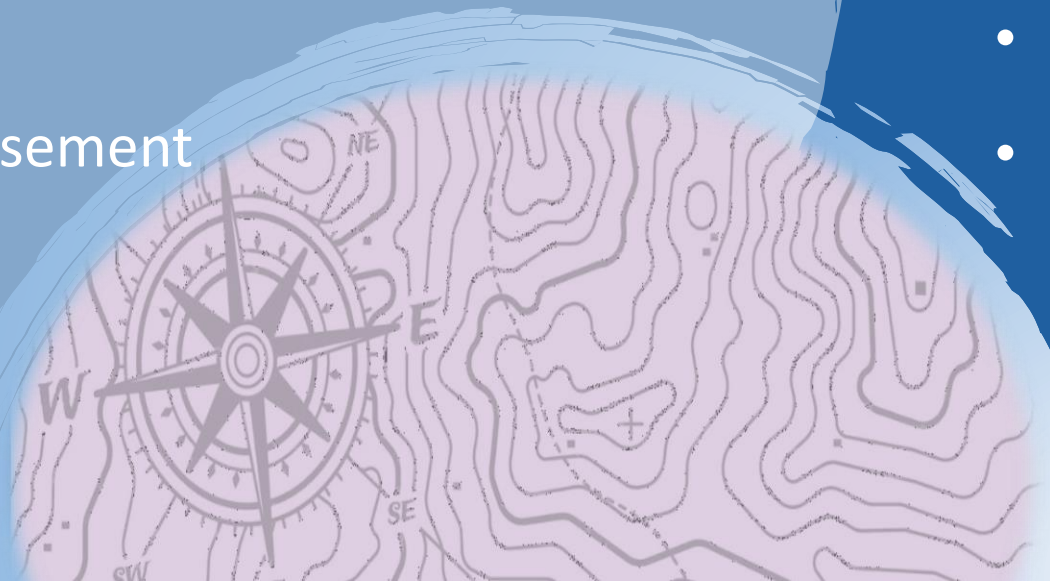
International Travel or Relocation

Digital Nomads

Navigating the Complexities

Telepsychology Basics

- Ethical standards and guidelines
- Competence
- Security and technology
- Informed consent
- Clinical suitability
- Safety planning
- Service reimbursement
- Documentation



Cross-Jurisdictional Considerations

- Regulatory
- Clinical suitability
- Safety planning
- Service reimbursement
- Documentation

State Specific Guidelines

- A

Maryland §10.36.10 Telepsychology:

A. Before engaging in the practice of psychology using telepsychology, a psychologist or psychology associate shall evaluate the client **to determine that delivery of telepsychology is appropriate** considering at least the following factors:

(1) The client's: (a) Diagnosis; (b) Symptoms; (c) Medical and psychological history; and (d) Preference for receiving services via telepsychology; and
(2) The nature of the services to be provided, including anticipated: (a) Benefits; (b) Risks; and (c) Constraints resulting from their delivery via telepsychology.

B. The client evaluation set forth in §A of this regulation **shall take place at an initial in-person session, unless the psychologist or psychology associate documents in the record the reason for not meeting in person.**

***** If practicing under PSYPACT, there are additional regulations to consider*****

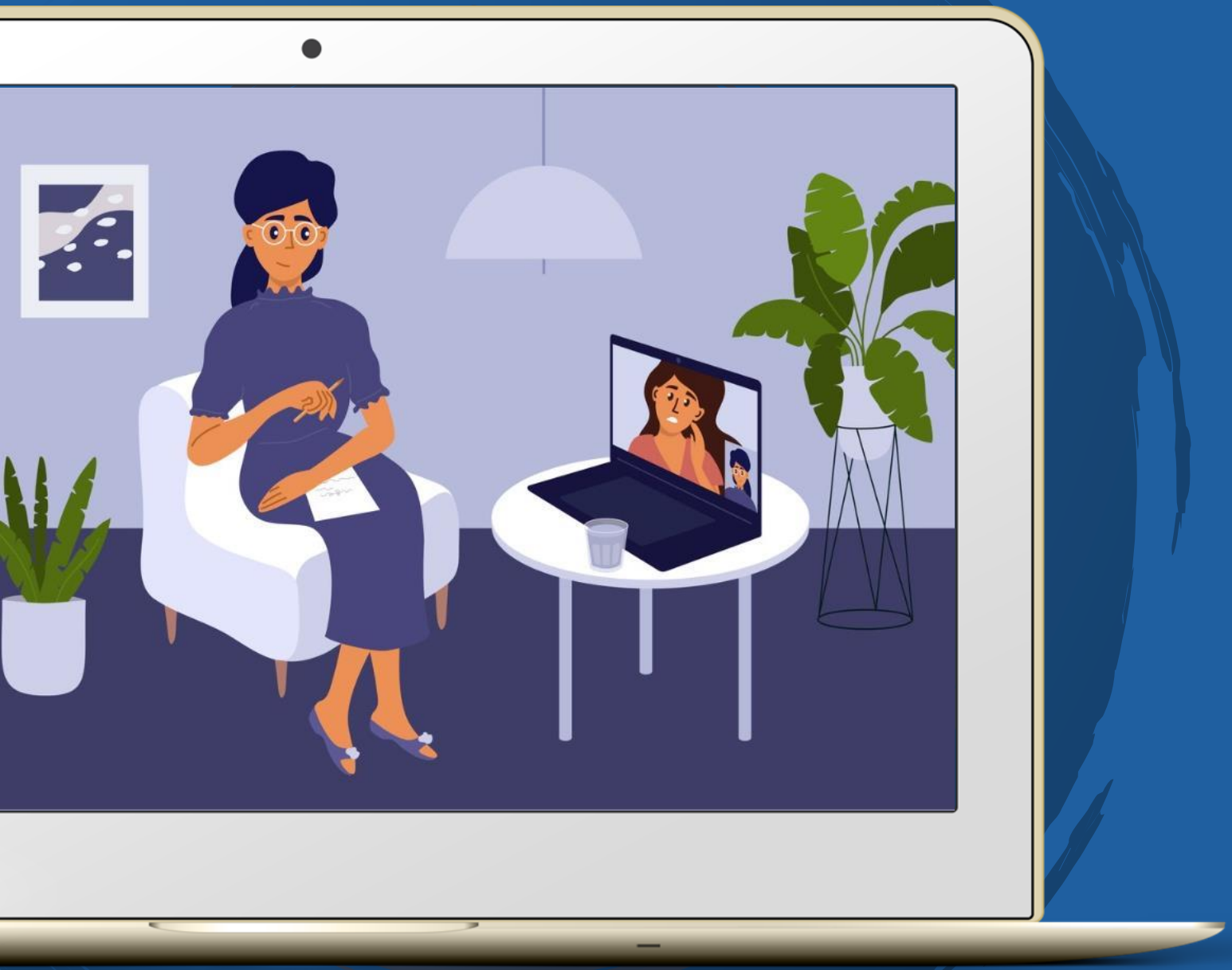
Security Risk Management

Regularly conduct a thorough security risk analysis of all devices

- What PHI could be developed, stored, sent or received on the device?
  - E.g., email, text, healthcare apps, contact lists, etc.
- What are the risks of compromise of those data?
  - E.g., loss, theft, viewing by unauthorized people, interceptions, etc.
- How likely are those risks, and what would be the impact if they occurred?
- What security controls/safeguards can be implemented?
  - E.g., secure email systems with device-based app; DO ENCRYPT YOUR DEVICES; secure remote erasure

DO NOT IGNORE Security Issues

- Promptly address vulnerabilities and add safeguards
- If not sure how to do so, contact an IT specialist



Where in the world?

Intrastate

Interstate

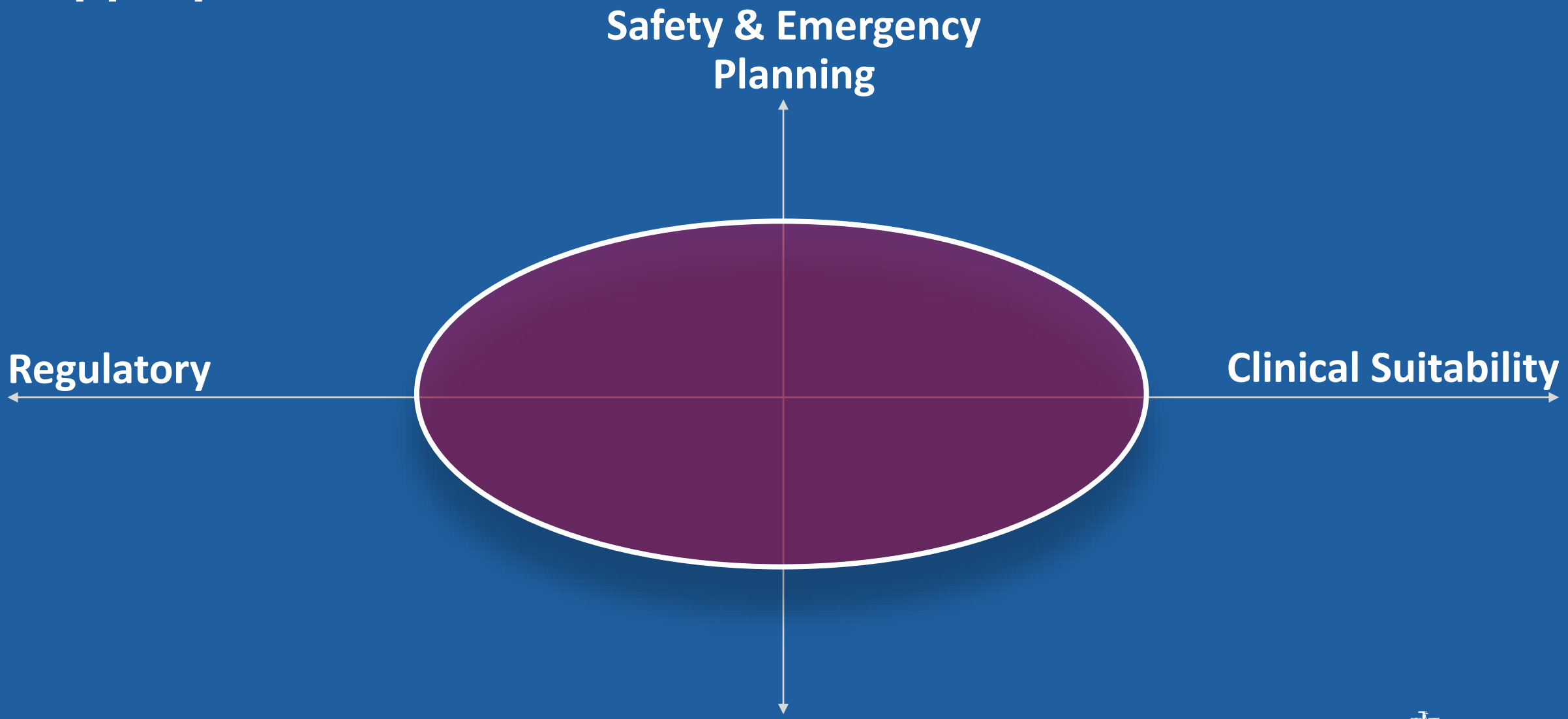
International

Jurisdictional Issues

In the U.S., the regulation of professions is assigned to the states, including:

- If licensed in the state, then there are few regulatory concerns (the professional is subject to any state requirements for telepsychology)
- But… what if your patient/client is in another jurisdiction (state or country)?
  - Where does a transaction/service take place? And thus, which state has jurisdiction over the transaction/service?
  - For example, if the provider is in Vermont and the client is in Alaska and they are using an Internet-based video chat program. Does the transaction occur:
    - *Where the patient/client is located?*
    - *Where the practitioner is located?*
    - *Where either of them resides?*
    - *In cyberspace?*
- Most states have taken the position that the transaction takes place in the **forum state—that is, where the patient/client is located**
- **BE AWARE: This is different if practicing under PSYPACT and PSYPACT has muddied the water a bit even for non-PSYPACT practice**

So How Do We Decide If/When Cross-Jurisdictional Telehealth Is Appropriate?



1. Regulatory Considerations

- Are you license
- If not, what i
  - Be aware

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§2912: Allow
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Michigan Public Hea
Code §333.16171: All
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and an adjoining state

Connecticut: Must petition the Board; case-by-case decision; MAY be able to practice by endorsement if can demonstrate one's license in another state is equal to or greater than the requirements for CT

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must be submitted PRIOR to beginning work in TX; allows for no more than 30 days

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ent/client permanently move

2. Clinical Suitability

- Patient/client suitability or clinical appropriateness is key to providing successful, ethical, and risk-managed remote care

- One must weigh the benefits vs. risks for each patient/client on a case-by-case basis, consider efficacy, and document rationale

- Key assessment areas:
  - Patient/client factors
  - Environmental factors
  - Length and purpose of treatment
  - Ongoing monitoring and decision-making

Assessing Clinical Suitability

Example **Patient/Client Factors:**

- Technological competence
- Clinical diagnosis
- Medical condition
- Language and other di
  variables
- Boundary concerns
- ER resources/supports
  location
- High-risk patients/clie
  - Fragile eating disorde
  - Domestic violence?
  - History or current no

Example Situ
Environmenta

- Discuss and underst
  parameters of patie
  remote situation
- Know the availabilit
  emergency, technic
  supports
- Be aware of any thr
  and confidentiality
- Risk of distractions
- Inability to control environment

Length and Purpose of Treatment:

- Lower risk with shorter term treatments or 'bridge sessions'

Ongoing Monitoring and Assessment:

- Regularly assess progress or lack thereof
- Take appropriate steps to adjust and/or re-evaluate the suitability of remote care
- If remote care is no longer beneficial or is harmful, discuss with patient/client and appropriately consider in-person services, transfer care or terminate

3. Safety & Emergency Planning

Even with low-risk patients/clients, one must be prepared for crises/emergencies

Steps:

1. **Identify and know how to access effective emergency resources in the patient's/client's local area:**
   - Where is the patient/client located? (Determine at the outset of each session)
   - How does the clinician efficiently and quickly access crisis services local to the patient/client?
   - Is there a psychiatric emergency team? How does one reach them when located in a distant community?
   - What patient/client local emergency health care services, DV services, etc., are available?

Safety Planning Steps (continued)

2. Create a plan to effectively address any lack of resources
3. Clearly discuss with patients/clients (and provide written instructions) what to do if there is an emergency
4. Ensure you have a secondary way to contact patient/client during an emergency
5. Be familiar with the laws and rules of the jurisdiction where the patient/client is located and any differences from your own jurisdiction

Safety Planning Steps (continued)

6. **Be aware of and consider any cultural issues with respect to safety and emergency planning**
7. **Address and document handling of any other safety concerns**
   - For example, is there DV in the home? Will a session increase risk of harm to the patient/client?
8. **Consider having a signed authorization on file allowing for and designating a specific person at the patient's/client's location that you can speak with in case of emergency**

4. Service Reimbursement

- Medicare coverag… s –
  including tele… tended;
  currently s…
- But stat… r
  expand… it
- The PH…
  May 1…
- Stay a…
- Call insu… or not
- Notify pa… coming and may happen relatively suddenly; cr… s possibility
- **BE AWARE…** audit… asing – **ensure you are in compliance** with provider documentation and medical necessity requirements (if in-network)

"Prediction is very difficult, especially if it's about the future."
Neils Bohr

Do

In a … ological services sho…

- …
- …
  - Anyone in the room v… ccur
- Develop a HIPAA Security … platforms and methods u…

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American Insurance Trust ▪ 111 Rockville Pike, Suite 700, Rockville, MD 20850-5109 ▪ (800) 477-1200 ▪ trustinsurance.com

INFORMED C…

This Informed Consent for Teleps… psychotherapy using the phone or t… have any questions. When you sign…

Benefits and Risks of Telepsychol…

Telepsychology refers to providing… technologies, such as video confere… that the client and clinician can eng… This can be helpful in ensuring co…

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INFORMED CONSENT FOR TELENEUROPSYCHOLGICAL [TELEPSYCHOLOGICAL] ASSESSMENT

This Informed Consent for Teleneuropsychological [Telepsychological] Assessment has important information in it. It focuses on completing your evaluation online or over the phone. Please read it carefully, and let me know if you have any questions. When you sign this form, it will create an agreement between us.

What is Teleneuropsychological [Telepsychological] Assessment?

It means using video chat, phone or similar online methods to do an assessment. The assessment process can include interviews, review of records, and, at times, testing. It is also called remote testing or assessment.

Documentation of Remote Services

- Documentation of whether, and to what extent, health insurance policies reimburse for remote care
- Other financial aspects of care (e.g., billing codes/charges specific to remote services, including CPT code modifiers, whether insurance reimburses for telephone only, texting, email)
- Documentation consistent with requirements for in-network providers (if you are one)
- Maintain copies of digital communications in the patient's/client's file
- The procedures used to securely delete digital tracks of communications and interactions, as well as records (when permitted by law or where none exists, practice standards)

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Risk Management Checklists

Intrastate

- ❑ Licensed in the state
- ❑ Know ethical standards and guidelines, state law and regulations
- ❑ Able to demonstrate competence in all 3 areas (technological, clinical, cultural)
- ❑ Secure systems and technology
- ❑ Assess and document clinical suitability and rationale
- ❑ Teletherapy informed consent
- ❑ Documented safety/ER plan
- ❑ Teletherapy-specific documentation

Interstate

- ❑ Same as *Intrastate*, plus:
- ❑ Is there a regulation that allows for legal practice (e.g., temporary licensure, COVID waiver, PSYPACT, other, practice in the VA)?
- ❑ Assess additional clinical suitability factors for DISTANT remote care
- ❑ Is there a good justification that treating the patient is clinically equal to or superior to a referral in their own jurisdiction? If so, clearly document the rationale
- ❑ Is effective ER coverage possible?
- ❑ When in doubt, CONSULT

International

- ❑ Same as *Intrastate*, plus:
- ❑ Risk/benefit analysis of regulatory issues
- ❑ Assessment of any additional cultural considerations
- ❑ Assess additional clinical suitability factors for DISTANT remote care
- ❑ Is there a good justification that treating the patient is clinically equal to or superior to a referral in their own jurisdiction? If so, clearly document the rationale
- ❑ Is effective ER coverage possible?
- ❑ When in doubt, CONSULT

Risk Management Checklists

Clinical Suitability

- ❑ Patient/client factors
- ❑ Environmental factors
- ❑ Length and purpose of treatment
- ❑ Ongoing monitoring and assessment
- ❑ Document rationale and decision-making on case-by-case basis

Safety Planning

- ❑ Identify ER resources in patient/client location
- ❑ Address any lack of resources
- ❑ Know relevant laws of both jurisdictions (e.g., mandatory reporting, Tarasoff, involuntary hospitalization)
- ❑ Cultural considerations
- ❑ Document issues/actions
- ❑ Consider signed authorization for emergency contact done in advance

Documentation

Standard documentation, plus:

- ❑ Teletherapy-specific informed consent
- ❑ For <u>each</u> session: Patient's location, phone number, anyone else present, any unusual events
- ❑ HIPAA Security Rule risk assessment
- ❑ Health insurance coverage details
- ❑ Maintain copies of digital communications
- ❑ Procedures for secure deletion of digital communications/records

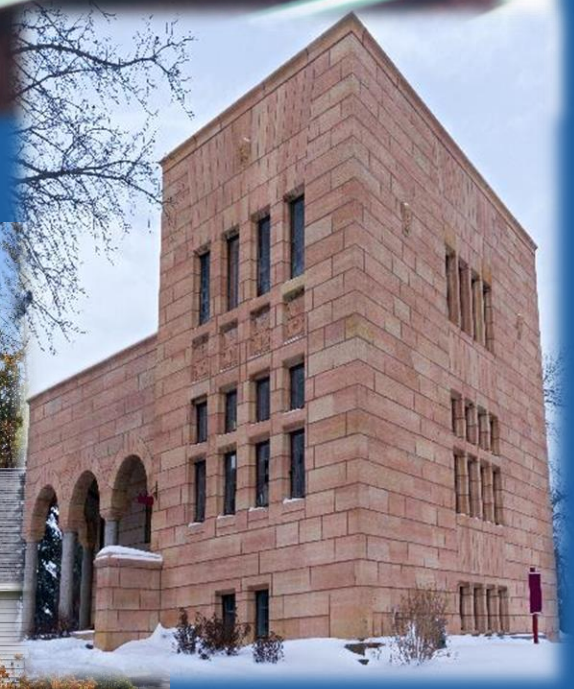
CHALLENGING CONVERSATION 7

OBSESSIVE LOVE

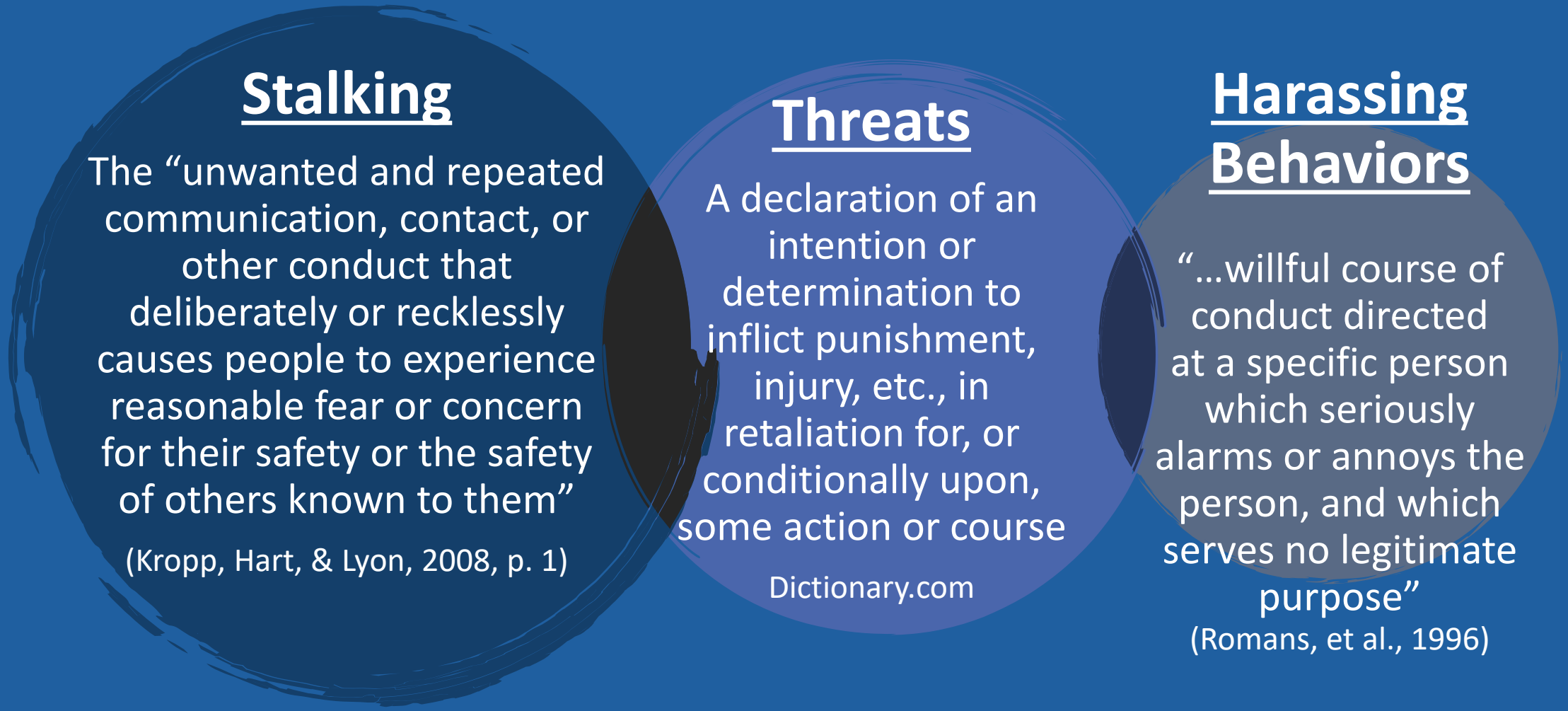
Vignette 7

Mr. Lonely

Dr. Kind



Definitions: Stalking, Threats, Harassing Behaviors (STHBs)

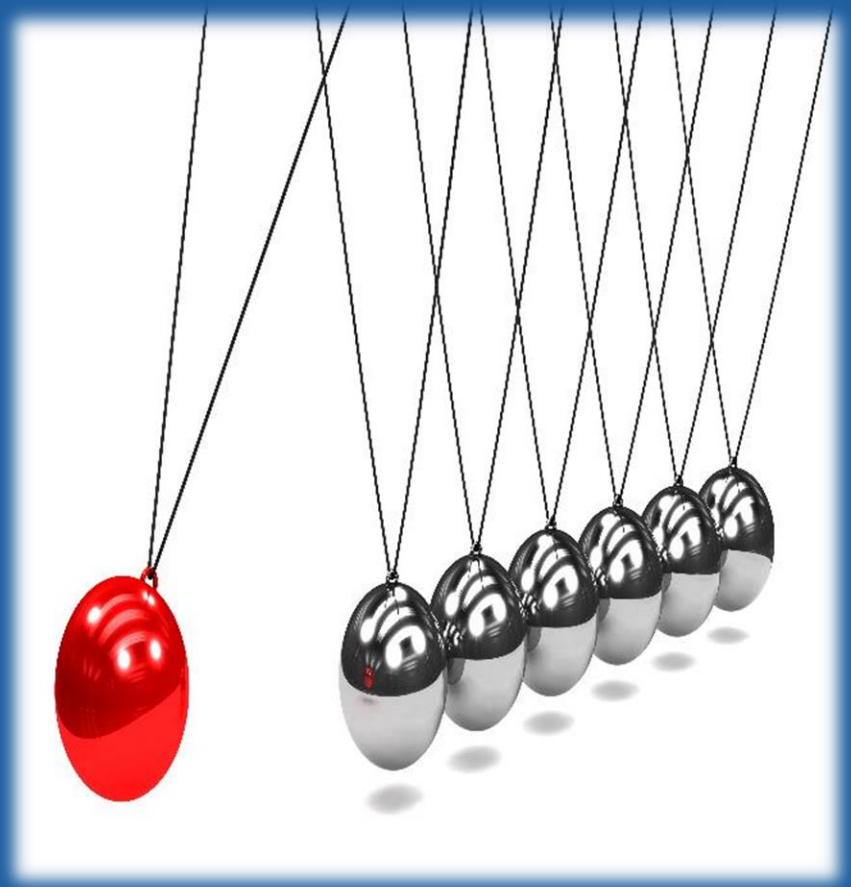


Stalking of Mental Health Professionals (MHPs)

- MHPs and public figures are among the occupations with the highest risk of being stalked (Mullen, et al., 2009)
  - Equally true for male and female providers
  - Research indicates between 3%-20% of MHPs will be stalked during course of their career
- Purcell, et al.'s 2005 survey of Australian psychologists
  - 20% lifetime prevalence (similar to that of other countries)
  - Higher prevalence in forensic (32%), clinical (24%) and counseling (20%) psychologists
- Leavitt, et al.'s 2006 MA survey of forensic psychologists (FPs)
  - 65% had been threatened and 49% had been physically assaulted in their career
  - Stalking rates were 10% (but definition of stalking was not clear)
  - Other studies have found stalking among FPs as high as 42% (Jones and Sheridan, 2009)

Impact of STHB on Mental Health Providers

- Research shows a wide range of impact
  - 8% of MHP's thought of changing their profession
  - 5% actually did so
  - 71% made changes to their professional and personal lives
  - 1 in 4 lost time from work to deal with their stalker and or legal involvement
  - Mental distress due in part to:
    - Safety fears
    - Lack of proper support
    - Uncertainty about when the next confrontation would occur
  - Isolation from others



Clinicians Largely Unprepared (Kivisto, et al., 2015)

Survey of ABPP Diplomates (a highly trained sample)

- 60% of clinicians did not feel prepared by training to handle the STHB
- A sizeable minority engaged in risk management responses that worsened the STHB
  - E.g., referring the patient elsewhere made it worse at least as often as it helped
  - Directly confronting the patient or having the patient hospitalized could also worsen the situation
- There is some complexity as to what works and doesn't work

Nuanced Findings Related to Physical Attacks in STHB Contexts

- Only 1 in 5 psychologists were physically attacked
- None occurred without warning
- Only a very small proportion of threats led to violence
- Threats are at best weakly predictive of overt physical violence

Characteristics of Those that Stalk MHPs

Typical Factors

Patients likely to be:

- Single
- Have diagnosis of mood or personality disorder
- History of childhood relational disturbances
- Experiencing significant stress
- Most studies show majority are at least 30 years old

Stalking in General

(not specific to MHP stalkers)

- Stalkers more likely than other offenders to have personality disorder
- But, not antisocial or psychopathic
- Stalking is a "product of an attachment disorder that is preoccupied rather than dismissive" (Meloy, 2002,p 130)

Diagnoses

Galeazzi, et al., 2005:

- 95% of patients who stalked their clinician had diagnosis of psychosis, mood disorder, or personality disorder (PD)
- 35% had a PD
  - Of those with a PD, over 90% were diagnosed with Borderline PD
- Mullen, et al.,: 51% of sample stalkers were diagnosed with a PD, the majority of which were Cluster B

5-Part Typology of Stalking (Mullen, et al., 1999)

Motivational and Relational Characteristics

Rejected

Complex mixture of desire for reconciliation and revenge

Intimacy Seeking

Central purpose is to establish a relationship

Resentful

Stalk to frighten and distress the victim

Predatory

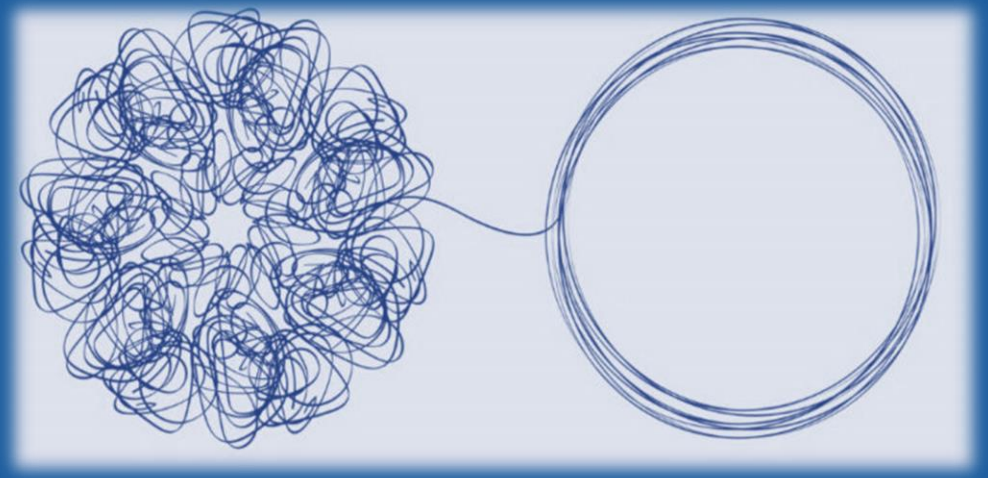
Preparing a sexual attack; taking pleasure in power of stalking

Incompetent

Acknowledge that object of attention does not reciprocate affection; but still hope their behavior will lead to intimacy

STHB Specifically Towards MHPs

- Research has consistently identified two predominant motives:
  - Anger/resentment
  - Infatuation
  - E.g., (Purcell, et al., 2005): 42% of patients engaging in STHB toward clinicians were motivated by resentment and 19% were motivated by infatuation



Additional distinction (Kivisto and Kivisto, 2018):

- Higher-level personality organization vs. lower-level personality organization
- Becomes important when considering appropriate response

Potential Effectiveness of Response Strategies (Kivisto & Kavisto, 2018)

3 Broad Categories of Responses

- Seeking advice or assistance within professional and personal relationships
- Making ch
  or profes
- Using clin
  strategies
  hospitaliz

- With patients/clients who evidenced more severe personality pathology and were motivated by resentment, MHPs benefitted most from interventions that integrated external supports into the clinical dyad
- For higher functioning patients/clients motivated by infatuation, MHPs saw some benefit from various clinical interventions within the therapist-patient relationship

- Obtaining support was per
  STHB by a patient
  - Rated as effective regardless of patient characteristics
  - Supports Meloy's recommendation to utilize a team approach
- Also effective: changes to workplace and home security
- Most common response was to confront patients directly; third most common response was to refer patients elsewhere
  - But these were only modestly effective

Potential Effectiveness of Response Strategies (Kivisto & Kavisto, 2018)

- Some responses were more useful with patients/clients who were motivated by **infatuation vs. resentment:**
  - Examples:
    - Confronting the infatuated patient was effective only 50% of the time
    - Seeking legal assistance (police and attorney) had highest rate of effectiveness for resentful patients/clients
    - Confronting and referring resentful patients/clients, as well as hospitalizing them, was generally ineffective
    - Strategies that involved setting higher intensity limits were most effective with resentful patients/clients
- **THE CRITICAL CONCLUSION:**
  - Clinician responses to patients/clients who engage in STHB must be devised within the context of patient/client characteristics
  - There is no 'one size fits all'
  - Consultation is critical

Primary Prevention Strategies

(Adapted from: Carr, et al., 2014; Meloy, 1997; and Kivisto & Kivisto, 2018)

- Anticipate eventual STHB encounter(s) and plan ahead
  - Know agency guidelines/policies on handling of STHB's, or create your own in private practice
- Identify potential warning signs before they occur and/or escalate
- Consider your work environment
  - Physical safety considerations
  - If working alone, you may need to have a higher threshold for which patients/clients you accept
- Assess patient's/client's prior interactions with providers and identify any weak spots that might impact safety
  - Any history of stalking should likely be referred to a team setting

Primary Prevention Strategies

(Adapted from: Carr, et al, 2014; Meloy, 1997; and Kivisto & Kivisto, 2018)

- Use an expanded informed consent process

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For Psychologists, By Psychologists

SAMPLE ELECTRONIC COMMUNICATION POLICY

https://parma.trustinsurance.com/Resource-Center/Document-Library-Quick-Guides

Produced by:
The Trust's Risk Management Advocates

ABOUT THIS DOCUMENT

While this is a trust product, it is written as a very general and generic policy. Therefore, you should feel free to modify it in a fashion that is consistent with your own clinical practice and any available state regulations. If you have any questions about this policy, please call and speak with one of our risk management advocates at (800) 477-1200.

INTRODUCTION

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of

- **And stick to it**

Boundary Considerations

Boundary Crossings

- Deviation from typical therapy activity
- Harmless, non-exploitative
- Possibly supportive of therapy
- Possibly a helpful break in the frame

VS.

Boundary Violations

- Transgressions that are harmful and exploitative
- Reflective of the provider's desire or motive not focused on therapy
- Misuse of power

Boundary Considerations (continued)

Gutheil (2005):

- Boundaries should be firmly set at the outset of treatment, and re-established when needed (e.g., what to do with a person in the office who begins to act out sexually)
- We must stick to boundaries:
  - *"…even theoretically benign boundary crossings can be misconstrued or portrayed in a worse light in later litigation. Boundary crossings thus require circumspection, weighing of pros and cons, and obtaining consultation with a low threshold."* (p. 480)

Higher-Risk Situations For Boundary Issues

- Clients who ask clinicians to step outside the usual role
- Highly-demanding clients
- Clinician vulnerability
- An unbridled desire to help without consideration of:
  - Competence
  - Training
  - Impact on current role

Primary Prevention Strategies

(Adapted from: Carr, et al., 2014; Meloy, 1997; and Kivisto & Kivisto, 2018)

- Boundary violations from either party increase safety risks
- When boundaries are crossed:
  - Discuss the occurrence(s) explicitly with patients/clients
  - Document these discussions
  - Re-assess risk and protective factors
  - Consider consulting
- Be sensitive to cultural norms and possibly sending "wrong messages"
- Female clinicians and younger clinicians are advised to be especially cautious about crossing boundaries as it relates to STHB

Secondary Prevention Strategies

(Adapted from: Carr, et al., 2014; Meloy, 1997; and Kivisto & Kivisto, 2018)

- Consult – early and frequently
  - E.g., colleagues, professional organizations, supervisors, risk management experts
  - Ideally, consult before you directly confront the patient/client
  - Seek support not just regarding how to respond, but also for your own self-care
- Consulting additionally helps protect from allegations of breaching confidentiality without cause
- Actively tend to and increase self-care
  - Consider one's own therapy and talking with others who have experienced STHB
- Document all incidents in the patient/client record
  - E.g., any gifts, boundary crossing/violations, any behavior that makes the therapist uncomfortable

Secondary Prevention Strategies

- APA Ethics Code, Section 10.01:
  "Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship."

- In such cases, the usual requirements for ethical conclusion of therapy can be altered
  - E.g., the typical requirement for pre-ending sessions does not apply when the actions of clients/patients preclude it (i.e., when safety is an issue)

(Adapted from: Carr, et
2014; Meloy, 1997; an
Kivisto & Kivisto, 2018)

making

Tertiary Preventio Strategie

- In some instances, you will need to discontinue

Release of Confidential Information

- **Ethics Code: Standard 4.05 – allows for disclosure of confidential information without patient consent in situations "where permitted by law for a valid purpose such as to…protect the client/patient, psychologist, or others from harm."**
- **State-specific laws and regulations that allow disclosure of confidential information in the context of preventing harm**
- **If you need to breach confidentiality:**
  - **Consult first, if at all possible**
  - **Release only the minimum necessary information**
  - **Document your rationale thoroughly in the medical record**

(Adapted from: Carr, 2014; Meloy, 1997; Kivisto & Kivisto, 201

noted to worsen the situation in roughly 25% of cases (Sandberg, et al., 2002)

Tertiary Prevention Strategies

(Adapted from: Carr, et al., 2014; Meloy, 1997; and Kivisto & Kivisto, 2018)

- Assess need for criminal justice involvement
  - Attorney (e.g., cease and desist letters)
  - Law enforcement (e.g., police or security)
- Carefully think through the release of any confidential information
- How the patient/client responds to ending of treatment should be carefully documented
- If a stalker feels humiliated or rejected, they may well transfer anger to a new provider and/or engage in escalated STHBs
- Meloy's "*dramatic moments*":
  - Events which humiliate or shame the perpetrator, stoke their fury, and increase risk of violence
  - E.g., rejection, unacknowledged letters/calls; contact by a third party to stop the behavior
  - Risks for actual violence may be higher during these times

NAVIGATING CHALLENGING CONVERSATIONS

SUMMARY

Summary

We reviewed ethical and risk management approaches to difficult conversations in a variety of situations

Risk Management Model

B = Breathe and slow down

E = Exercise cultural humility

S = Solid informed consent process

A = Access routine consultation

F = Follow a structured decision-making process

E = Ensure effective self-care

R = Record rationale and have good record keeping strategies

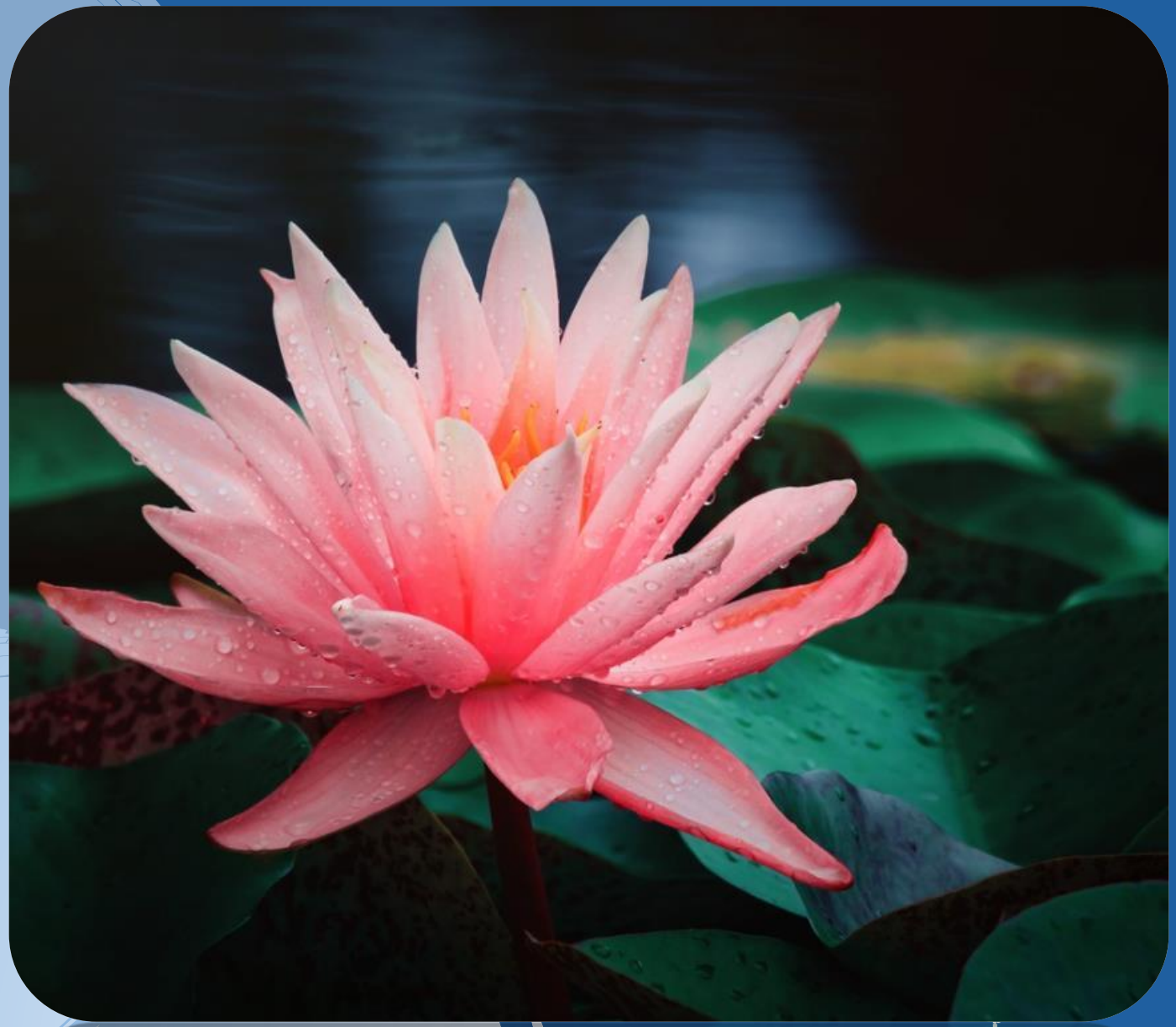
BE SAFER

Additional Risk Management Reminders

- Conduct a conservative evaluation of your intellectual, technical, and emotional competence and actively engage in cultural humility
- Know the legal and ethical standards governing practice
  - Be aware of the need-to-know laws/regulations for multiple states if you practice teletherapy across state lines
- Be very thoughtful about if/when you step into multiple relationships
  - If you choose to do so, make use of additional risk management strategies to help mitigate the risk
- Pay attention to client/patient characteristics and situations – their vulnerabilities and risks
- Take all complaints and dissatisfactions seriously and invite open discussions of these issues with your patients/clients
- Notify your insurance carrier and consult a knowledgeable attorney at the first notice of a suit or disciplinary complaint to ensure coverage is triggered

Concluding Thoughts

- Strive to be aware of your own identities, biases, and emotional vulnerabilities
- All of us will make mistakes
- We cannot help everyone
- We will not know everything
- We cannot go it alone
- Societal, practice, and technological changes will be ongoing; find a rhythm between embracing opportunities and managing risk
- Humility and a sense of humor are essential to a well-lived life and to good risk management



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CONTINUING EDUCATION

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Thank you for your interest, participation, and attendance!

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