43rd Annual Northwest Institute of Addictions Studies Conference

Ethics, Law, & Risk Management in Modern Clinical Practice ©

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Who we are?

Pulling Back the Curtain

Looking at Professional Ethics

A Disclaimer

Today's Focus…

- *Managing the Clinical Setting from Ethical, Legal, & Risk Management Perspectives*

Will NOT be giving …

- **Legal advice,**
- **Clinical advice, or**
- **Licensing board advice**

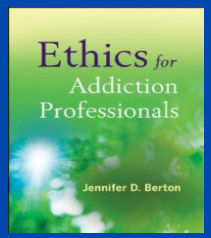
A Couple of Comments about Ethics Trainings

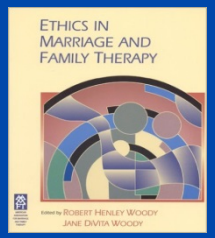
Mental Health Professions & Codes

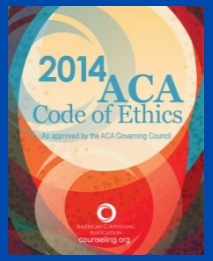
Largely "Fungible"

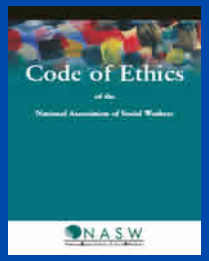
Similarities vs Differences

- Fundamental Ethical Principles -









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"Ethics" …. in a word

Ways of Seeing Professional Ethics
Purposes & Functions

1. Clinical – Serving clients' interests

2. Regulatory – Managing and guiding the profession

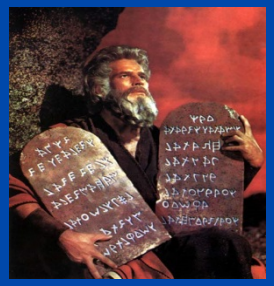
3. Risk Manag'mt – Avoiding problems

If "Ethics" was a Color …

What Color would it be?

Professional Ethics
What are they Based on?

Basic Foundational & Moral Principles



- Promote Welfare
- Do No Harm
- Autonomy - Self-Determination
- Fidelity - Faithfulness; Keeping Promises
- Justice - Equality; Fairness
- Veracity - Truthfulness

And … Codes are Informed by Other Factors

- Laws, Technology, Insurance, and Cultural & Social Factors … Influence Our Prof'l Ethics

Professional Ethics Codes
WHY ?

- **Do Codes of Professional Ethics …**
  - **… make unethical people ethical?**
  - **… make bad people good?**
  - **… make unwise people wise?**

If not …….

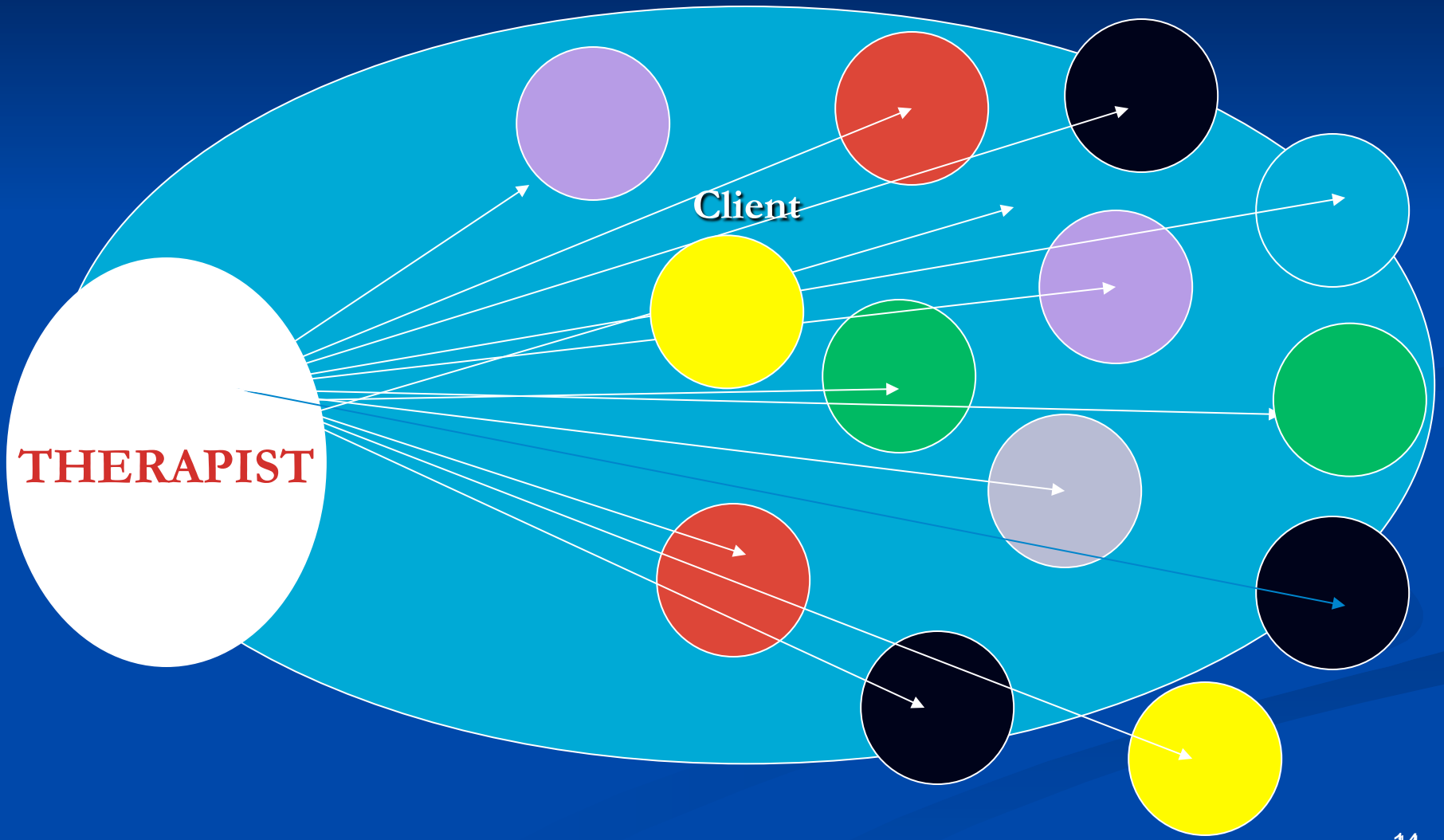
WHY do we have them?

What causes Ethical Dilemmas?

Competing Issues – Ethical Tug-of-war

- Autonomy vs Beneficence
- Confidentiality vs Self-Harm
- Confidentiality vs. 3rd Party Harm
- Boundaries vs. Personal Disclosures
- Informed Consent vs Expediency
- Professionalism vs Client Care
- Self-Care vs Client Care
- Cultural & Diversity Issues
- Etc., Etc., Etc.

What causes Ethical Dilemmas?
Stakeholders – Competing Priorities



Making Ethical Decisions… Best Practices

How are Ethical Decisions Made? By us? By our Employers? Do we have an Identified Process?

Let's Assume ……

- **A Significant Ethical Issue has arisen in your workplace**
- **Very Serious potential consequences**
- **You take Action**
- **Unfortunately, the outcome is *Very Poor!!!***
- *And Afterwards ……*

… *You are asked :*

What *Factors* did you consider? What *Resources* did you use? What *Decision-Making Plan* did you have in place supporting your Actions taken?

How would you like to be able to respond?

Decision-Making Template
Some Considerations

- **1) Intuition:** Common Sense / Experience
- **2) Reflection & Deliberation:**
  - Law & Licensing Board Regs
  - Clinical & Cultural Factors
  - Employment/Agency Policies
  - Prof'l Association Codes of Ethics
  - Moral & Ethical Values
  - Impact on client, others…and counselor
  - Collaboration with Client
  - *Accepted Practices in Professional Community* (!)
- **Consultation & Documentation → Imperative**

Form #1

Decision-Making Template

- Do *I* have a Decision-Making Template?
- Does *my Employer* have a Decision-Making Template?
- Does *my Supervisee* have a Decision-Making Template? Have I asked?

If not, why not???

Deliberation, Consultation, & Collaboration

The Process is as Important as the Outcome!

Why?

The Law in 60 Seconds

A Brief Primer

Types of Legal Actions

(1) **Criminal Actions**: Action by gov't; sanctions include fines or imprisonment

(2) **Civil Actions**: Non-criminal actions by one Party *gen'ly* claiming $ damages against another

(3) **Administrative Actions:** Actions involving Gov't Regulatory Agencies

State Licensing Boards
Administrative Regulations (OARs)

1. **PURPOSE** → Protect Public; Regulate Professionals; Educate

2. **AUTHORITY** → (1) Rule Making, (2) Determine Rule Violations, & (3) Impose Sanctions

3. **SANCTIONS** → Licensing Privileges
   (Ltr/Concern (not public); Reprimand, Suspend, Revoke)

Professional Associations

AAMFT/OAMFT, ACA/ORCA, APA/OPA, NAADAC/ACCBO

Professional Associations

1. **PURPOSE** → Serve Prof'l Membership
   - Political Lobbying; Education
   - *And, serve the Public*
2. **AUTHORITY** → Create Professional Ethics Codes; Educate the Professions/Public
3. **SANCTIONS** → Membership Rts; do not have licensing sanctions; Affects Prof'l Status

Malpractice: A Civil Law Action

Four Elements of a Malpractice Case

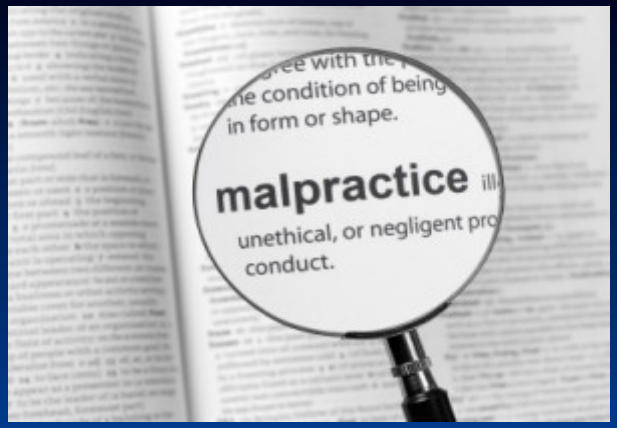
(1) Duty: Responsibility *to "Clients" (and others !)* to conform to Standards of the Profession

(2) Deviation: From those Standards (aka Negligence, Breach of Duty, Fault)

(3) Damages: Physical, Emotional, &/or Economic Injury or Loss, and

(4) Direct Link: Causal Connection

Malpractice Claims - The Realities



- Need attorney
- Fees & Costs
- Prove *each* Element of Case
- Time & Expense
- Likely outcome must Justify Time & Expense

The "*Major Case*" rule

Such as ……

Malpractice Claims vs. Board Complaints

Civil Action/Malpractice

- 4 Issues: Duty, Deviation, Direct Cause, Damages
- Lawyer necessary
- Attorney fees/costs
- 2-3 yrs

License/Certif. Board

- *Single* issue: Were Regs (OARs) violated?
- Lawyer not necessary
- No fees or costs
- Quickest "recourse"

WHY do they happen?

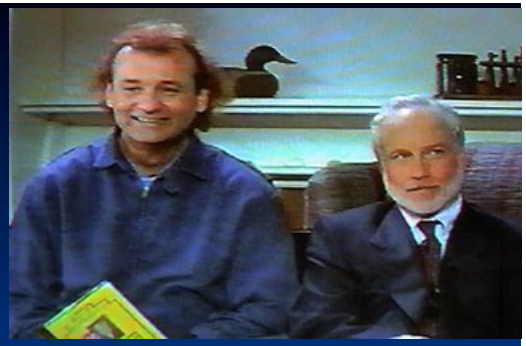
1. Counselor/therapist issues?
2. Client issues?
3. Case issues?
4. Other issues?

Sometimes … it's Not just Ethics that Precipitate Problems & Conflicts

Client …. or 3rd Party Issues:

- 3rd Parties grievances
- < Client Relationship w/Counselor, feeling…
  - Mad, irritated, disgruntled
  - Distrusting
  - Hurt, harmed, disrespected
- Retaliatory

Some Red Flags…



- Signif. Dissatisfaction/anger
- Unrealistic expectations
- Multiple prior tx providers
- Disparaging of providers
- Hx of litigation or board complaints against prof'ls
- Inappropriate efforts to communicate/contact
- Unusual/unexplained out-of-office contact
- Negative Social Media Comments (E.g. Yelp review)
- Exaggerated concern about fees; Non-payments or late payment; Refund demands
- Clients in litigation; Custody
- Requests for file materials
- Threats (physical, legal, reputational, etc.)
- Requests for *special* relationship
- A&D issues
- Intrusive Internet searches
- Tape-recording sessions

Responding to Red Flags ……

(These may or may not apply in any particular case.)

- Don't ignore!
- Consult-Clinical (including counter-transf. issues)
- Consult - Legal and Risk Mngt (Not part of Ct File)
- Address w/ Client
- Thorough documentation
- Assess prof'l objectivity
- Can therapy continue?
- Maintain boundaries
- Include client in any termination decisions
- If terminate, do so only after consultation, w/alternative providers list, & thorough termination session
- Attend to self-care
- Provide file promptly, if requested & appropriate
- Be careful w/confidential records if multiple clients involved

Most Ethical Problems ……

The Majority of Ethical Challenges Involve one or more of these Issues:

- Informed Consent,
- Boundaries,
- Multiple Relationships,
- Cultural Competency,
- Privacy, Confidentiality, Privilege,
- Recordkeeping, and
- Basic Ethical Competence
- ….. Along with Electronic Technology Issues

Electronic Technologies

Terms & Definitions

- **Terminology**: Distance Counseling, Online Psychotherapy, Teletherapy, Technology-Based Therapy, Electronic Therapy, eTherapy, Etc.
- **Definition:** The provision of counseling, therapy, and supervision services using telecommunication technologies as stand-alone services or to augment traditional in-person services; individuals, groups, etc.
- **Methods**: Telephone, mobile device, video-conferencing, email, chat, text, and other Internet services (self-help websites blogs, and social media)

Counseling & Therapy Services
Electronic Technologies - Timing

- **Timing of Communications**
  - **Synchronous** – Real Time
    - In-Person; same phys'l space; w/o Technologies
    - *Non*-In-Person: E.g., Telephone, Video Calls, Chat Rooms, Videoconferencing, Instant Messaging, Online Social Networks (some); Etc.
  - **Asynchronous** – *Not* in Real Time
    - Email, Texting, Online Social Networks (some)

Electronic Technologies

Email & Social Media - Use

Web-based Email

- Nearly 90% of U.S. adults use Internet
- Email: Least used by youngest generation (it's "old school"; prefer informality and quicker response time of texting, instant messaging, chatting, and social networks); > 15-17% for people over 55
- Email: Preferred in business and for commercial & consumer uses (compared to Social Media)
- 75% of users send/receive emails via smartphones

SOURCE: https://bits.blogs.nytimes.com/2010/12/21/e-mails-big-demographic-split/

Electronic Technologies

Email & Social Media - Use

Social Media - U.S. adults

- Facebook - 70% (approx.)
- Instagram - 28% (highest among younger users)
- Pinterest - 26% (highest among women; 3:1)
- LinkedIn - 25% (highest among college-educ'd)
- Twitter - 21% (men/women same; younger users)
- ### social media sites: tumblr, Google+, flickr……

- U.S Facebook users – 76% check the site daily
- *Majority* of U.S. users report getting news from S/ media

SOURCE: http://www.pewinternet.org/2016/11/11/social-media-update-2016/

Facebook – Demographics

Pew Research Center - 2016

79% of online adults (68% of all Americans) use Facebook

% of online adults who use Facebook

All online adults	79%
Men	75
Women	83
18-29	88
30-49	84
50-64	72
65+	62
High school degree or less	77
Some college	82
College+	79
Less than $30K/year	84
$30K-$49,999	80
$50K-$74,999	75
$75,000+	77
Urban	81
Suburban	77
Rural	81

Note: Race/ethnicity breaks not shown due to sample size.
Source: Survey conducted March 7-April4, 2016.
"Social Media Update 2016"

PEW RESEARCH CENTER

Electronic Technology

The Connection

- **Most clients use electronic technology**
  - Social networking; connecting with others
  - Common communication, family & friends
  - Often, personal information Online
  - May expect social media connection w/counselor
- **Most counselors *also* use electronic technology**
  - Personal & professional uses
  - Often, Counselor have personal info Online
  - May communicate w/clients via electronic tech
  - May provide prof'l services via electronic tech

Ethics & Technology
Smartphones

- Large % of emails/social networking – via smartphones
- Most users doubt that their Online activity will remain private and secure – but that does not seem to have had much of a chilling effect on use
- Most smartphone owners do not take adequate steps to secure their devices

- **See Appendix I**
- **http://www.pewresearch.org/fact-tank/2017/03/15/many-smartphone-owners-dont-take-steps-to-secure-their-devices/**
- **http://www.pewresearch.org/fact-tank/2017/01/26/many-password-challenged-internet-users-dont-take-steps-that-could-protect-their-data/**

The Brave New World of Smartphone Apps

Mental Health Apps

- Growing marketplace for mental health apps
- Thousands of apps - Monitor, track, record, remind, manage, soothe, treat mental health conditions
- 1500 for anxiety relief; 1000 for depression management; 2100 for relationship help
- Apps: phobia, addiction, borderline disorder, bipolar disorder, PTSD, anger management, stress management, schizophrenia, crisis help, connection w/ others w/similar problems, real-time w/ therapist

***Image from Scientific American article:** *Should You Take an App for That?* **Nov 2015 - https://www.scientificamerican.com/article/should-you-take-an-app-for-that/**

Mental Health Apps
Some Examples

- **Anxiety Coach; iCBT**
- **PTSD Coach; MoodTools**
- **PE Coach; WorryWatch**
- **MoodTools; Mindshift**
- **Pacifica; Headspace**

- **VA Administration**
- **Anx/Depression Assoc.**
- **Amer Psychiatric Assoc**
- **Nat'l Institute Health**
- **The Gottman Institute**

Solace-by-App
Benefits & Challenges

Potential Benefits	Potential Challenges
• Smartphone use is commonplace often in use many times/day • Apps are easily obtained • Most people favor use of apps • Can be used in private • May be helpful when client is in need (e.g., for guided meditation during times of stress) • May be valuable resource for creating accountability • May supplement professional services • May create helpful record – a "Fitbit" for the mind • May be the only resource available • Inexpensive • Many apps for many different conditions • Apps are likely here to stay! • May be resource to unmet populations	• Thousands on Internet – how can prof'l be knowledgeable? Help/hurt? • No regulatory environment • "Moving target" – constant updates made to apps make oversight difficult • Often not researched-based; few empirical studies re effectiveness • Confidentiality/privacy • Data security & storage issues • Unclear if particular app may be harmful in particular case • Maybe used by consumers w/o professional oversight • Are apps "therapy" or "treatment"? • Does data create a "mental health record" that may be harmful? • Might insurance co.'s get access? • Laws, regulations, & ethics codes lag behind technology

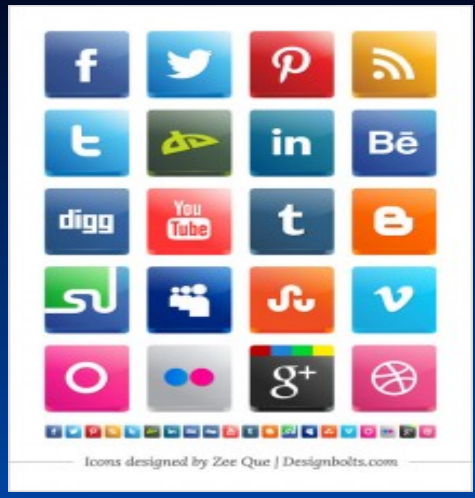
Ethics and Smartphone Apps

Best Practices

- This is *emerging* area; ethics not fully established
- Be aware of what Apps client is using & how they are being used; are they useful, harmful
- Have *general* familiarity with relevant Apps on market
  - Be aware: *most* Apps have little empirical support
- See: Journal of Medical Internet Research
  - https://mental.jmir.org/
  - https://mhealth.jmir.org/
  - Resource list in Appendix (Slide #150)
- Explore the App world; get some Apps, use them
- Discuss with colleagues

Ethics & Technology

The Connection



- **<u>Ethical issues, include:</u>**
  - Informed consent
  - Dual Relationships
  - Self-Disclosures
  - Boundaries
  - Privacy & Confidentiality
  - Professionalism & Clinical care

Problem: Technology services development is outpacing Ethics Codes, Laws, & Regs.

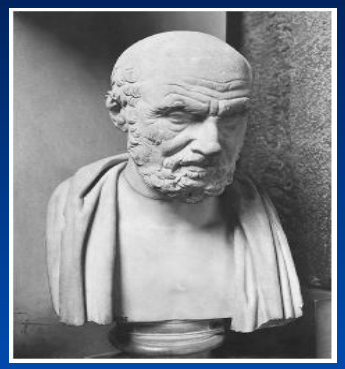
INFORMED CONSENT

Informed Consent --- Where's it From?

In the Beginning...

… there were *Doctors*

The Evolution of Informed Consent



- **Hippocrates (c.460-c.370) - Father of Western Medicine**

- **Tuskegee Research Project, 1932 – Informed Consent gone awry**

- **Canterbury v. Spence (1972) – Patient rights**

- **Chestnut Lodge (1980) – Medicine → Psychotherapy**

Informed Consent - Today

1. **Req'd in *All* Health Care Professions**
2. **Client's *Fundamental* Right**
   - **To *Knowingly* Accept or Refuse Tx**
3. ***Affirmative* Duty; not Passive**

Informed Consent … *Grants Permission!*

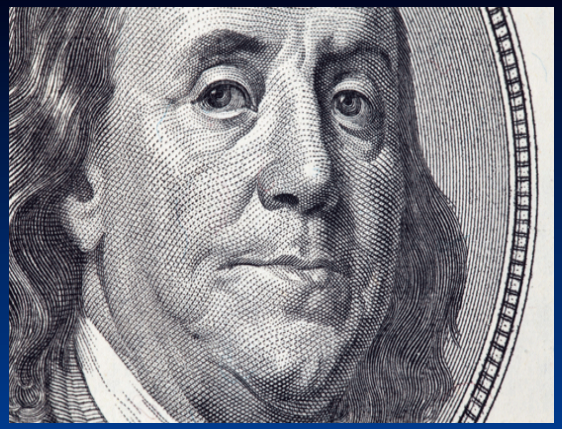
The Essence of Informed Consent

Informed Consent addresses…..

"… the fundamental human right of all individuals to self-determination …"

NAADAC Code of Ethics, Sec. I, Standard 2

Informed Consent
An Ounce of Prevention….



- *Probably most ……*
  - Ethical dilemmas,
  - Client disputes,
  - Lawsuits, and
  - Licensing board problems ….
- *…. could be Avoided or Mitigated by closer attention to Informed Consent process.*

Informed Consent

Clarifying Status: Client vs Non-Client

- **<u>The Complimentary Consultation</u>**
  - Does "Therapy" occur?
  - Counselor – Client relationship?
  - Confidentiality Responsibilities?
  - Recordkeeping Responsibilities?
  - Can you have a post-consultion relationship?
  - What can make this look like "counseling/therapy"?

<u>Form #2</u>

If you are not doing Counseling/Therapy, Say So!

But….there may still be Ethical Responsibilities

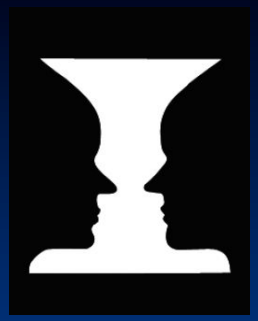
Informed Consent
Clarifying Status

- **Collateral Resource Participant**
  - Is there a client/counseling relationship?
  - Is "counseling/therapy" occurring?
  - Is there Confidentiality?
  - Who is entitled to Records?
  - What can make this look like "counseling/therapy"?
    - Solo sessions vs joint sessions?
    - How many sessions attend?

Form #3

  - *Client's Consent* for 3rd Party participation?

Form #4



Counseling vs Non-Counseling Activities Perspectives

- Non-Counseling Activities: forensic evaluation and/or assessment, mediation, parenting time coordination, court-appointed activity, coaching, etc.

Best Practices

- Informed Consent should Clarify:
  - If this is not counseling/therapy, Say so!
  - If there is no counselor-client relationship, Say so!
- Avoid language/activities that look like counseling
- Use *Activity-Specific* Informed Consent

Thoroughness of Informed Consent Depends on … What, How, When

(1) **CONTENT** – *What* Information is Delivered

(2) **PROCESS** – *How* it is Delivered

(3) **TIMING** – *When* it is Delivered

(1) CONTENT

Is Determined By…

- State & Federal Laws
- Licensing & Certif. Board Regs & Codes
- Prof'l Assoc. Ethics Codes
- Institutional/Agency Policies
- Clinical & Cultural Considerations
- Risk Management Considerations
- Status Considerations *(Is this counseling/ therapy?)*

CONTENT

Some Basic Information to Include

- Extent/nature of services
- Limits of confidentiality
- Risks & alternatives
- Uncertain outcome
- Right to accept/refuse Tx
- Right to participate in Tx planning
- Fees, Cancellations, & Collection policies
- Taping, Recording, Observation of Sessions

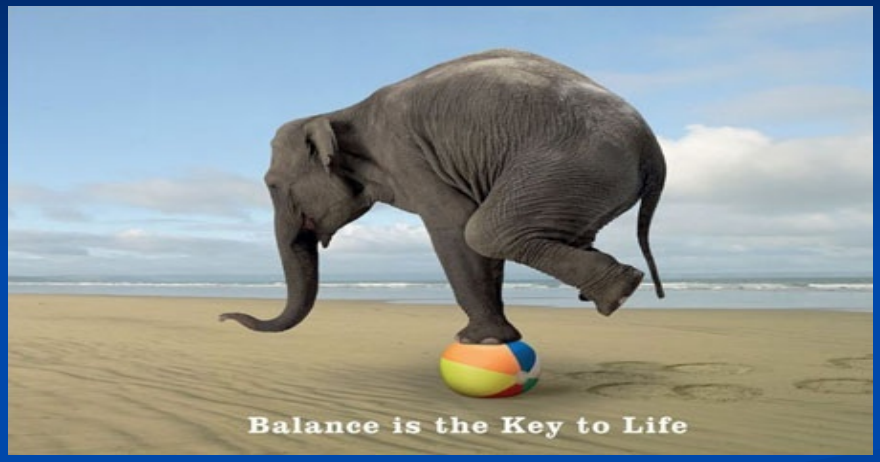
CONTENT

Information to Include

- Termination/Interruption of Service
  - Both Planned & Unplanned
- Supervision/Consultation
- Parental Consent Issues; Group Therapy Issues
- Coordination of Tx with other Tx Providers
- Tech-assisted/Distance Counseling Factors

→I/C Rules Apply to *Each Person in Client Unit* (i.e., individual, couples, families, groups)

The Ultimate Challenge of Informed Consent



Finding the Right Balance

- **Too Much Detail: Legalistic & Confusing**
- **Too Little Detail: Unhelpful & Misleading**

(2) PROCESS
Delivery Options

1. In Writing

2. Verbally

BOTH …are Necessary

Informed Consent Hmmmm

1. What % of our clients have ≤ high school education?

2. For what % our clients is English a Second Language?

3. What % of our clients have *any* circumstances that *might* affect their ability to comprehend the Informed Consent document?

Informed Consent

Today's Problem

Informed Consent – Often seen only as a Risk Management Tool

… a Legal Document

… for Protection

… to get it signed ASAP

… Plain language Not a Priority

→ See, Flesch Readability Calculator ←

http://www.readability-score.com/

Informed Consent

Does *Not* end with client's signature on a written document

It Must be Supplemented Verbally **!**

(3) TIMING

When to Provide Informed Consent

What Ethics Codes say

- **"… as early as feasible" and as "circumstances may necessitate" (AAMFT)**
- **"reassessed throughout" (AMHCA)**
- **"ongoing part" of counseling (ACA)**

Informed Consent:

A Continuing Responsibility !

Electronic, Distance, On-line, Technology-Assisted Therapy/Counseling

Informed Consent – Vital

Distance Professional Services

Informed Consent

The Basic Rule (again!)

The Ethical Principles in *all* counseling and therapy settings are *Identical*, regardless of whether service provided is in-person or via electronic technology.

But, ….. there are additional issues and topics that must be addressed that are a consequence of the fact that services are not in-person.

Informed Consent
Distance Services

Common Informed Consent Issues

- I/C – *before* services are provided
- Confidentiality; encryption; agreed procedures
- Risk, benefits, limitations, & alternatives
- Authorized & unauthorized access potentials
- Record-keeping & file retention issues
- Insurance coverage issues
- Gov'tal & inter-jurisdictional limitations **(Location?)**
- Alternative contact info in event of tech failure
- Emergency procedures & contact information
  - Including, contact for local prof'l assistance

Form #5

Related Informed Consent Issues

Therapist-Client Communication Policy

Even w/ In-Person Counseling-What are the Rules ?

- How to contact, *or not contact*, Therapist
- Phone, Email, Texts, etc.
  - Secure/encrypted vs Non-Secure Communication
  - 3rd Party access – (e.g., therapist's maintenance techs; client's family, employer, etc.)
- Signed Client Consent to Communications Policy, specifically *including* Non-secure Communications
- HIPAA Resources - **http://www.hipaajournal.com/hipaa-omnibus-final-rule-applies-e-mail-communication-patients**

Also Google for Sample Forms:

"*Consent for Non-Secure Communications*"

A Written Communications Policy

- **Social Media**
  - Boundary & Security/Confid Issues - Problematic!
- Other aspects of Communication Policy
  - Non-Secure Communications – Admin & scheduling vs. Counseling/therapy content
  - Response time; weekends & evenings contact
  - Emergency procedures/local resources

See: Social Media Policy – Keely Kolmes, Psy. D.
http://www.drkkolmes.com/docs/socmed.pdf

Thorough Informed Consent Process
The Benefits

Research suggests:

- >Client Autonomy
- >Respect
- >Trust
- >Buy-in
- >Adherence to Tx Plan
- >Speed of Recovery
- < Anxiety

An Easy Pill

BOUNDARIES & MULTIPLE RELATIONSHIPS

Drawing Lines

Wearing Different Hats

Healthy Boundaries in Counseling & Therapy

Are they Important?

Why?

Boundary Basics – 3 Types

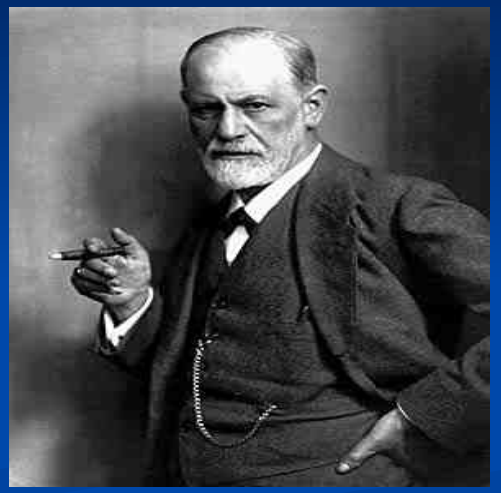
1. Classic/Traditional Boundaries

2. Boundary "Crossings"

3. Boundary "Violations"

1

Boundary Types
Traditional / Classic



Psychoanalytical Rationale

- Therapist: "Blank Slate"
- Protect: Transference Process

The Rules

- Keep Physical & Emotional Distance
- **NO:** Out-of-office contact, Self-disclosure, Touch, Expressions of Familiarity/Warmth; Gifts

2 *Modern Trend*

Boundary "Crossings"/ "Extensions"

- Beyond "Traditional" Boundaries
- Not Unethical *per se*
- Low Risk of Harm
- Beneficial to Client/Supervisee
- Context critical
- Multicultural influences
- Acceptable w/in Prof'l Community !!!

See E.g., ACA Code, Section A.6.b, p. 5 (2014)

Boundary Crossings
Modern Trends

Common Examples

- Appropriate Self-Disclosure
- Accepting Modest Gift
- Gentle Touch or Hug
- Attending Formal Ceremony
- Rural Communities (Risky!)
- Specialty Practice (Risky!)
- Generally, occur by *Choice/Chance*
  - *Can you think of any Examples of Boundary Crossings that occur in your current tx environment???*

Boundaries
What do you think?

Ethically Permissible?

- *Giving* gift to client? Receiving gift from client?
- Face Book friending? LinkedIn Invitation?
- Lending money to client?
- Self-disclosing personal information?
  - Recovery, Marital, Religious Status?
- Attending a client's AA anniversary meeting?
- Writing a reference for current/former client?
- Advocating for client with employment or licensing board issues?

Counselors & Self-Disclosure

Types of Counselor Disclosures

1. **Non-Deliberate** – E.g., common; within & without counselor's control – e.g., age, gender, marital status
2. **Deliberate** – E.g., prof'l credentials, clinically-motivated disclosure, or inappropriate disclosure
3. **Accidental** – E.g., spontaneous verbal/non-verbal reaction or unexpected contact in public
4. **Initiated by client** – E.g., Internet search, etc.

Therapists & Social Media
Self-Disclosure & Disclosure of Self

Do Clients check us out on the Internet ?

Be careful:

1. All your Social Media sites, postings, blogs, etc. & – unless secure privacy settings
2. All photos and other info posted by your "friends" that may identify you; your "likes"
3. Search Yourself Regularly on Internet, using: Name; email, office & home address; phone #'s

→ Encourage Supervisees to do the same

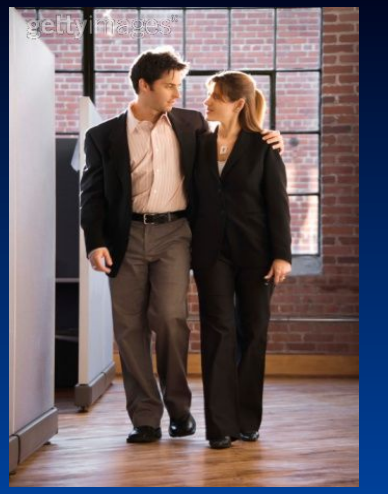
http://www.zurinstitute.com/onlinedisclosure.html

Checking out Clients …
on the Internet

Is it *OK?*

(See ACA Code of Ethics H.6.c.)

3 *Boundary "Violations" Characteristics*



- *Significant Departure* from accepted Professional Standards

- **Potential Harm:**
  - Affects Prof'l Judgment/Objectivity
  - Power Diff.; Exploitation
  - Threat to Relationship & Process
- "Violations" – Occur *Intentionally … Not Accidentally*

Boundary "Crossing" vs. "Violation"? Factors to Consider

- Client issues (presenting issue, assessment, mental status, age, gender, culture, etc.)
- Stage of therapy
- Therapist issues – Age, gender, experience, etc.
- Standards of Prof'l Community (Consult)
- Purpose/Intent of therapist/client, etc.
- Potential harm/benefit

MULTIPLE RELATIONSHIPS

Basic Features

1. Client is *something more*

2. *Not inherently* unethical

3. All Multiple Relationships have *potential* Risks – Some Questions: *Appropriate vs Inappropriate Relationship? What Risks? Informed Consent? Accepted w/in Professional Community?*

Multiple Relationships
Variations

- Concurrent or Consecutive
- Promising a Future Relationship
- Includes Family Members & Significant Others
- *Generally Irrelevant:*
  - Which relationship began first
  - Who initiated; Client consent
  - Whether occurred by chance/choice
  - Professional or Non-Professional
  - Length of Time; When began (start, middle, or end of therapy)

Problematic Dual / Multiple Client Relationships?

Why do they happen?

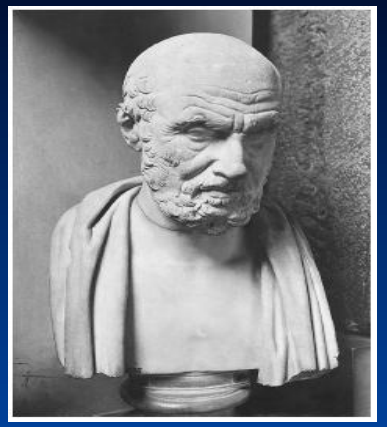
3 Basic Categories Multiple Relationships

(1) Sexual/Romantic Relationships

(2) Non-Sexual/Non-Romantic

(3) Professional Role Changes

(1) Sexual/Romantic



What did Hippocrates say?

" ….. In every house where I come I will enter only for the good of my patients, keeping myself far from … all seduction and especially from the pleasures of love …."

Sexual/Romantic Relationships
What Ethics Codes Say…

- **Clients/Supervisees:** All Codes Prohibit
- **Client's Family & S/Os**: Most Codes Prohibit
- **"Former" Clients (& Family, etc) :** *Most* Codes Prohibit; w/differing time limits; some totally prohibit
- **Former Romantic Partners:** Prohibited
- **Former Supervisees:** Most Codes Silent

No "True Love" Exceptions!!!

Sexual/Romantic Relationships
Sobering Facts

- Inappropriate sexual involvement with clients continues to account for licensing board complaints and malpractice lawsuits;
  Demographics:
  - Primarily middle-aged male counselor/therapist
  - Primarily younger female clients
  - Predictive Factors
  - Recidivism – High

Multiple Relationships
Sexual/Romantic

Risk Management

- **"Vicarious Liability"** – Liability/Responsibility for the conduct of those over whom you have a right/ duty to exercise control

- At Risk: Supervisors, agencies, treatment centers and other mental health facilities

Sexual Misconduct

Would you Report a Colleague?

1. A Client tells you she had a romantic relationship with her prior counselor last year. What should you do?
2. A prof'l colleague tells you he had a romantic relationship w/client last year. What do you do?
3. A Colleague reports to you that a counselor you know is having a romantic relationship with a client. *You believe the colleague's report.* What should you do?

Multiple Relationships
Non-Sexual/Romantic

Considerations

- Therapeutic Benefit? What's the Purpose?
- Potential Impairment of Prof'l Judgment?
- Harm to Client/Others? Repairable?
- Discussed w/Client? Informed Consent?
- Consultation? Documentation?
- Unavoidable? (e.g., Rural/Specific Client Pop.)
- *What are Accepted Standards w/in Prof'l Community?*

Engaging in Relationships with Former Clients

Some Issues to Consider

- Amount of time passed since therapy?
- Nature & duration of therapy?
- Client's personal history & diagnosis?
- Potential harm/exploitation?
- Existed/planned *before* end of therapy?
- Informed Consent – How thorough?
- Consultation & Documentation in file?

Another Type of Multiple Relationship

Changing from one Professional Role to Another Professional Role

Examples:

- Couples/Family counselor ←→ Individual counselor
- Individual counselor ←→ Forensic evaluator
- Supervisor Role ← → Non-Supervisor Role

The Issue:

What's the Impact of one Prof'l Relationship on the other Prof'l Relationship?

Multiple Relationships
The Ultimate Test

What Ethics Codes Say about Multiple Relationship:

- **Potential Harm Test:** Avoid M/R ….that *could*:
  - Create risk of harm
  - Impair judgment
  - Impair objectivity
  - Risk exploitation
  - Result in undue influence
- **Note: "Virtual Relationships"**

Multiple Relationships
Risk Management

<u>Prior to & *During* M/R</u>

1) Informed Consent (& revisit)
2) Discuss issues, risks, benefits
3) Suggest 2nd opinion
4) Clarify Rights to Withdraw
5) Consultation – a good idea
6) Document Critical Thinking!

Risk Management Caveat

If the Propriety of our Boundary practices is Questioned by our client or others…

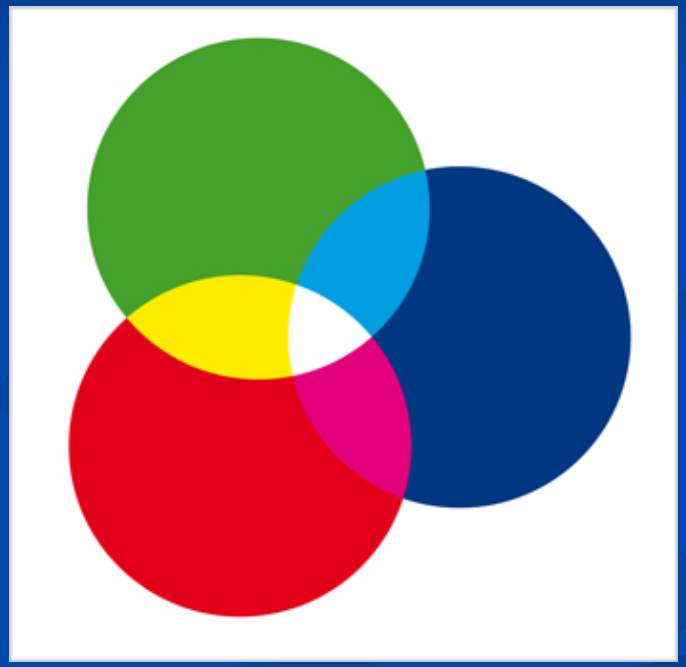
…WE will generally bear
the Laboring Oar

Race, Ethnicity, and Diversity Ethical Implications

Race, Ethnicity, and Diversity

What's in a word?

- "Race"
- "Ethnicity"
- "Diversity"



"Race": A Slippery Concept

Defining "Race"

The Slippery Concept of "Race" Where we are Today

- **Today:** Race gen'ly understood as a **Social/Political Construct**
- **Science:** Gen'ly *rejects* idea of a Genetic basis for "race"
  - There is no "Race" gene or set of genes that scientifically distinguish one group/population from another group/ population
  - Race categories/definitions in U.S.: Socially, politically, & legally changed throughout history
- Human Genome Project: Humans are *99.9% genetically identical*
  - *More* genetic variation is found *within* different population groups, *than between them*
- Nevertheless ….. Race remains a powerful social idea
- *See: Appendix III : "Race" as a Social Construct*

The Slippery Concept of "Race"
Changing Race Categories

At various times in U.S. History…..

- Irish, Italians, Jews, Greeks, Slavs, Mexicans, Chinese, Japanese … were all once socially and/or legally considered as separate, non-White races – for purposes of census, citizenship, voting, land ownership, etc.
- U.S. racial categorizations have often correlated with periods of *high immigration*

"Race"

The U.S. Census

U.S. Census – "Race" – Changing Definitions

- 1790 – Free whites, other free persons, and slaves
- 1870 – White, Black, Mixed, American Indian, Chinese
- 1900 – White, Black, Chinese, Japanese, American Indian
- 1930 – White, Black, Amer. Indian, Mexican, Other
- 1970* – Respondents allowed to *self-identify* racial classification
- 2000* – Respondents allowed to report more than one race
- 2010* – Race Categories: 1. White, 2. Black/African Amer., 3. Amer. Indian/Alaskan Native, 4. Asian, 5. Native Hawaiian or Pacific Islander, 6. "Some other race"
- More changes to come in 2020 Census (especially re the Hispanic population)

Race

Thoughts & Considerations

Categorizing/Classifying People?

- Good idea or bad idea?
- What are some Reasons to Not Categorize groups of people? What are/have been some consequences?
- Are there any circumstances where we should be identifying/paying attention to Categories of People (Races)? Socially, Politically, Legally?

- Dr. Seuss: The Sneetches
  https://www.youtube.com/watch?v=PdLPe7XjdKc

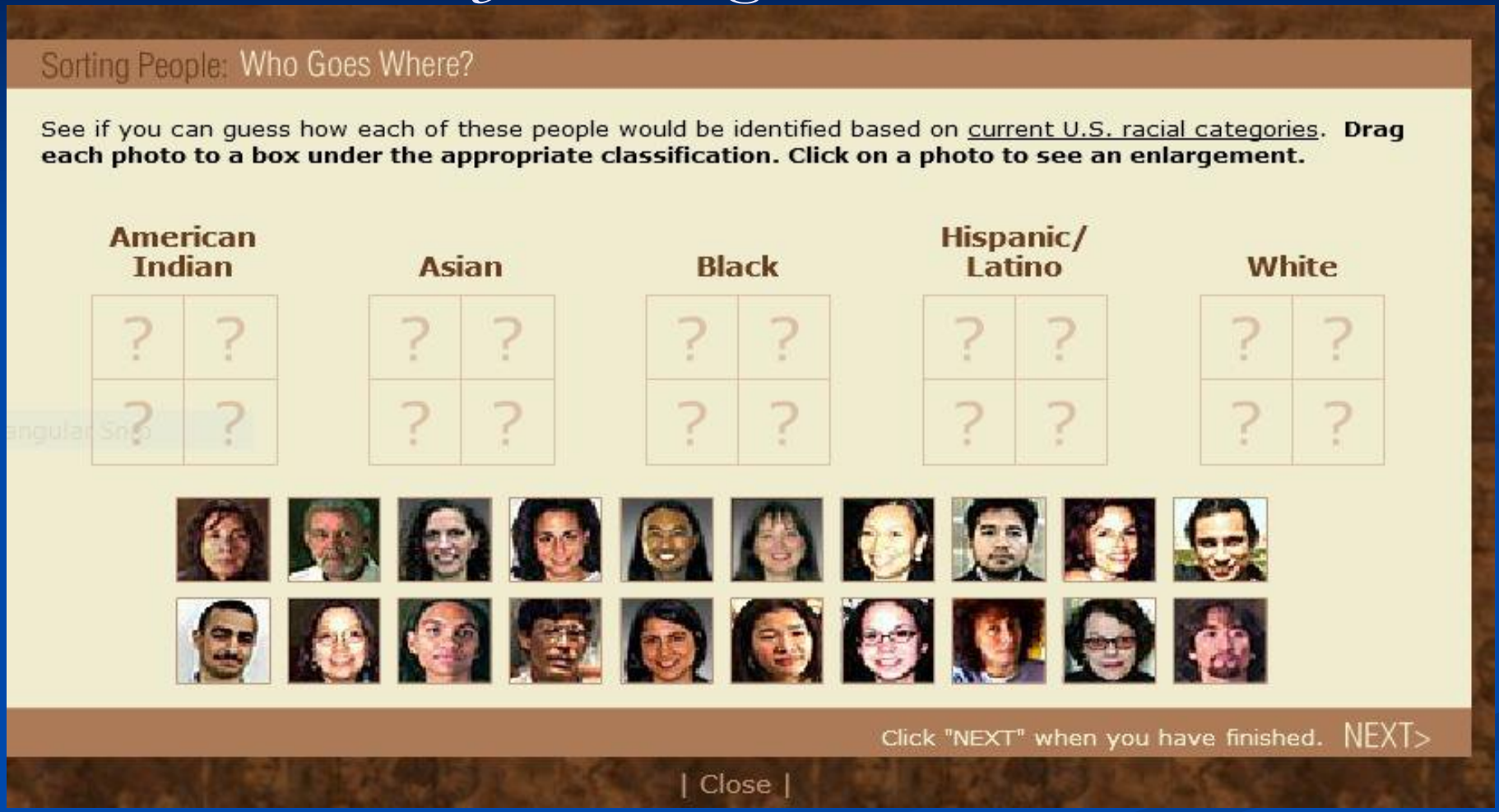
The Slippery Concept of "Ethnicity"

Ethnicity

How do we define Ethnicity?

- *Generally*, thought of as a group's **Shared Social Traits** – historical, ancestral, cultural bkgnd, and traditions
- *Tends* to be self-identified, as opposed to "race", which is often assigned by others based on appearance
- Ethnicity is Not "Race" dependent; Sometimes used in conjunction with "Race"; e.g., "Race/Ethnicity"
- A *Social, Political, and Legal Construct* – Dynamic, evolving, changing

Can You Tell Someone's Race/Ethnicity by Looking at Them?



SEE: http://www.pbs.org/race/001_WhatIsRace/001_00-home.htm

U.S. Population Distribution Race/Ethnicity (2015)

	White	African American /Black	Hispanic /Latino	Asian	Other*
U.S.	**61%**	**12%**	**18%**	**6%**	**3%**
Oregon	**74%**	**2%**	**15%**	**4%**	**5%**
Wash.	**69%**	**3%**	**13%**	**8%**	**7%**
Calif.	**39%**	**6%**	**38%**	**15%**	**2%**

*Amer. Indian/Alaskan Native; Native Hawaiian/Other Pacific Islanders; 2 or more

SOURCE: Henry J. Kaiser Family Foundation
http://kff.org/other/state-indicator/distribution-by-raceethnicity/?currentTimeframe=0

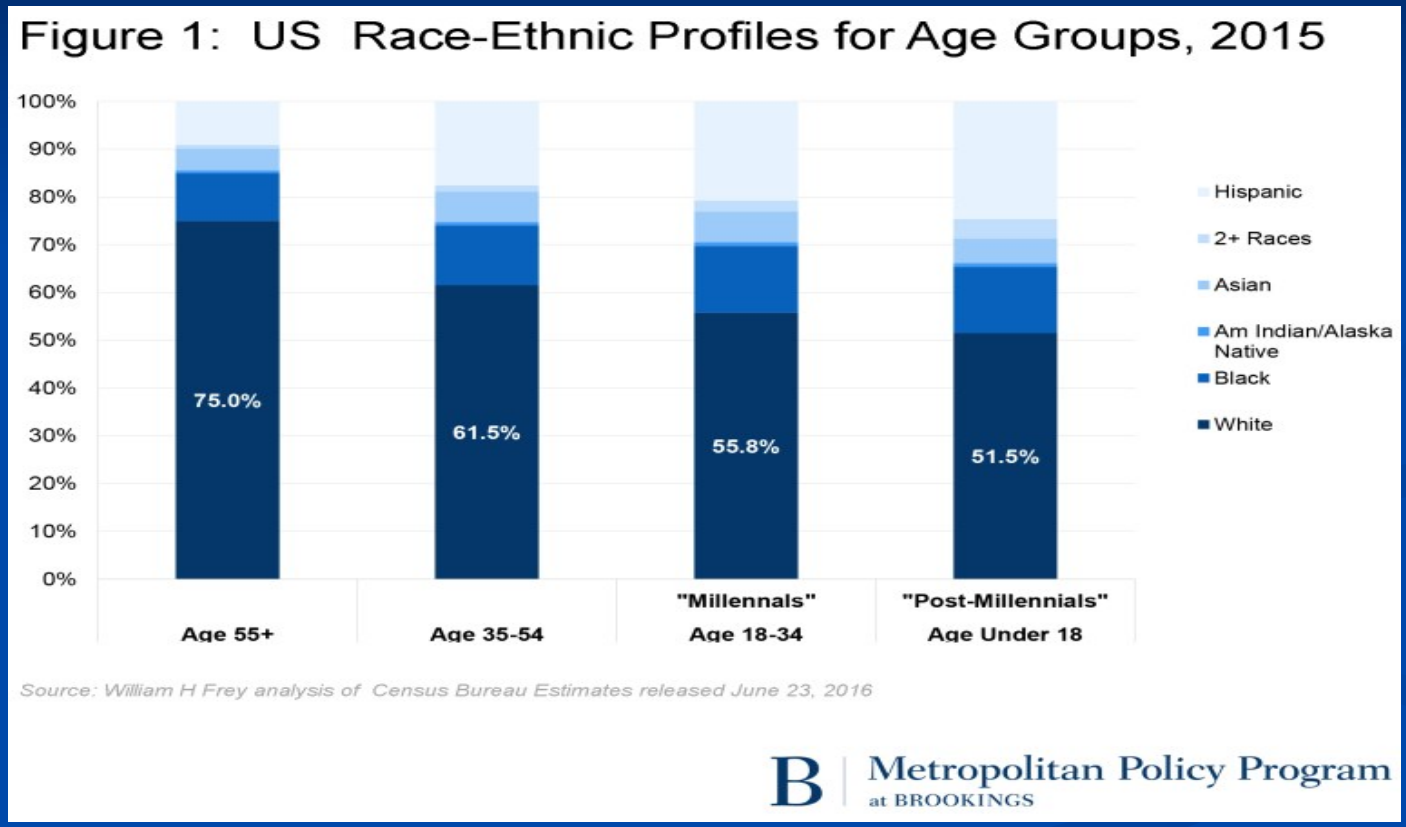
See also, The problematic history of race in Oregon:
https://www.theatlantic.com/business/archive/2016/07/racist-history-portland/492035/

Our Different Generations

- Baby Boomers – Born: 1946-1964 (ages 53-71)
- Gen X'ers – Born: 1965-1981 (ages 36-52)
- Millennials – Born: 1982-1995 (ages 22-35)
- Post-Millennials – Born: 1996 → (ages <22)

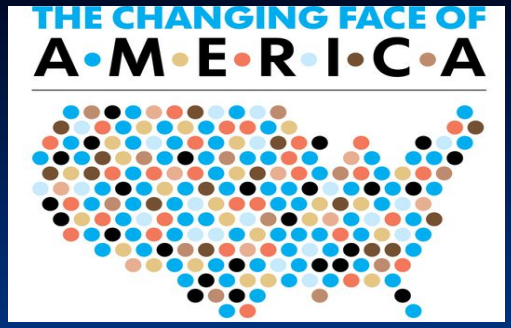
- **http://www.pewresearch.org/fact-tank/2016/04/25/millennials-overtake-baby-boomers/**

Racial & Ethnic Trends by Generation



- https://www.brookings.edu/blog/the-avenue/2016/06/28/diversity-defines-the-millennial-generation/

Racial & Ethnic Trends Tomorrow



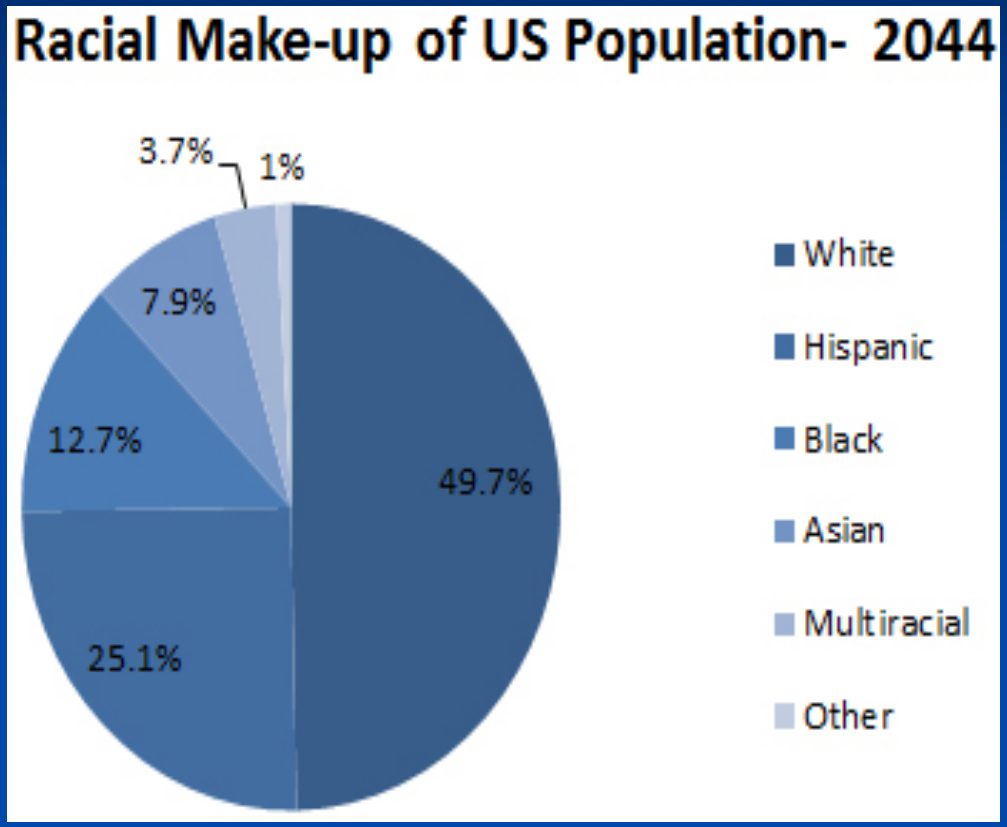
2045

- U.S. population will be approx'ly 390,000,000
- Majority of people will be Non-white
- There will be no single racial/ethnic majority

SOURCE: http://www.voanews.com/a/coming-demographic-shift-will-strengthen-us-culture/2701759.html

Our "Majority Minority" Nation

We Must be able to Serve Our Population



- White – 49.7%
- Hispanic – 25.0%
- Black – 12.7%
- Asian – 7.9%
- Multiracial – 3.7%
- Other – 1.0%

https://www.brookings.edu/blog/the-avenue/2014/12/12/new-projections-point-to-a-majority-minority-nation-in-2044/

The Slippery Concept of "Diversity"

Much Diversity in our Population

Many Different Groups

- **Race**
- **Color**
- **Ethnicity**
- **Nationality**
- **Region**
- **Gender**
- **Sexual Orientation**
- **Socioeconomic Status**
- **Disability**
- **Health Status**
- **Age/Generation**
- **Immigration Status**
- **Language**
- **Political Views**
- **World Views**
- **Religion**
- **Education**
- **Employment**
- **Appearance**

Millennials
b. 1982-1995

- Today…
  - Largest generation; has surpassed Baby Boomers
  - Most culturally diverse generation (44%- Non-White)
    - Baby Boomers: Approx.'ly 25% Non-White
  - Higher levels: Education; tech savvy; tech use
  - *More* 18-34 yr-olds are living at home than are married/cohabitating in separate household
  - Fewer married between ages 18-30
  - Highest support for: gay marriage & marijuana legalization; less religious
  - Politically: Lean Independent/Democrat

SOURCE: Pew Research Center

Race, Ethnicity, Diversity and Ethics

Race & Ethnicity, Diversity

Why are these *Ethical Issues* for the Professional Mental Health Community?

Race & Ethnicity in Oregon

Some Facts

- Oregon racial & ethnic minority populations
  - Growing at faster rate than nation
- 1 in 5 (21%) Oregonians identify as people of color
- Ore. – 137+ languages spoken in Oregon
- Ore. – 1 of the 15 most language-diverse states in U.S.
- 40% of Ore. Health Plan enrollees – "people of color"

SOURCE: Oregon Health Authority:
https://www.oregon.gov/oha/oei/Documents/Cultural%20Competence%20CE%20Brief_FINAL.pdf

Health and Health Care Disparities Statistics

Racial, ethnic, & cultural minorities, *including* low income, less educated, LBGQT, less English proficient, disabled, & other groups, *disproportionately* experience:

- **Barriers to accessing health care**
- **Poorer quality health care**
- **Worse health care outcomes**
- **Poorer health & lower quality of life**
- **Higher mortality**

Source: Kaiser Family Foundation - http://kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/

Cultural Competence Training

- "Studies show that Cultural Competence Training can help *improve health outcomes* for diverse populations who are disproportionately affected by *health disparities and inequities* and *reduce costs for health systems.*"

Helps reduce disparities, improve health care equities, & reduce Costs of Health Care

SOURCE :Oregon Health Authority:
https://www.oregon.gov/oha/oei/Documents/Cultural%20Competence%20CE%20Brief_FINAL.pdf

Cultural Competence
Does it Affect the Counseling Process?

What aspects of the Counseling Process, including substance use Tx, are affected by being, or not being, Culturally Competent?

What are some of the Primary Characteristics of a Culturally Competent Counselor/Therapist?

Cultural Competence
Some of the Basic Characteristics

- Aware: Clients' diverse racial, ethnic, and cultural characteristics - play *significant role* in counseling process
- Teachable: Consultation; CEs; Trainings, etc.
- Curious: Clients are often the best Resources
- Respectful: Differences can be challenging
- Empathic: Appropriately sensitive, and …..

Must be Self-Aware: Alert To our own Cultural Assumptions, Preferences, Values, Biases

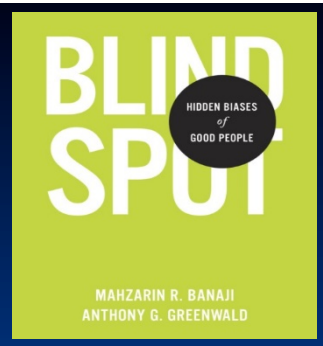
---

Multicultural Competence will likely become a CE Requirement

Google: "Oregon Health Authority – Cultural Competence"

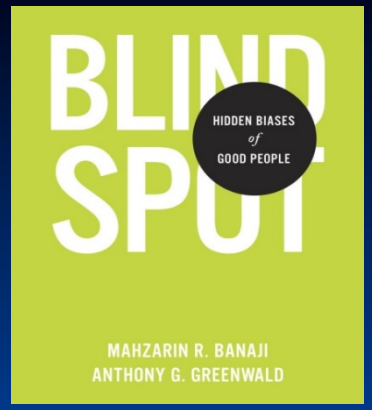
OAR 943-090-000 et seq.

Can we know ourselves?
Explicit vs. Implicit Bias



- Recent research using *Implicit Association Test (IAT)* suggests many of us may carry *unconscious / hidden* biases → about which (1) we are wholly unaware and (2) are contrary to what we consciously believe to be true about ourselves
- These unconscious biases are our "Blind Spots"
- Multiple IATs: Race, Skin Color, Ethnicity, Sexual Orientation, Age, Body Weight, Disability, Etc. → *Hidden Biases*
- When researchers compared Race IAT scores with real life behaviors of groups of test takers
  - *IAT* → *"moderate predictor of racially discriminatory behavior."* (p.52)
    - Racial minorities *were* disadvantaged - E.g., interviews, medical tx, job applicants, mortgage apps

Can we truly know ourselves?
Do we have Blind Spots???



- *Project Implicit* - Harvard University - https://implicit.harvard.edu/implicit/
  - Approx'ly 18+ million IATs completed
  - A tool to gain greater awareness about our unconscious preferences and beliefs

Ethical Implications

  - How can I improve my cultural competence?
  - Do I have implicit biases? How does this impact my Tx of my clients/patients? Outcomes?
  - Can I overcome my implicit biases? How?
- See, Journal Article: Intervention training to develop Long-term reduction in implicit race bias https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3603687/

Professional Ethics

We Cannot be Ethically Competent unless we are Culturally Competent!!!

PRIVACY, CONFIDENTIALITY, & PRIVILEGE

At the Heart of the Relationship

Let's Start With …

Privacy – The Right

An "Inherent" Right …

- Our Right to determine *for ourselves* When, How, and Whether Information about ourselves is Obtained and/or Communicated to Others; our Right to:
  1. Prevent Intrusion
  2. Control Access
  3. Control Disclosure
- The Right does *NOT depend on any Special Relationship* between us and the person intruding on our Privacy
- Today: Technology < Expectations of Privacy!!!

Privacy Rights In the 21st Century

- Privacy – 2 Important features:
  - Expectation that info will *not* be made public
  - Privacy Rights can be Waived

Do Clients Waive Privacy by Using Social Media?

(See, ACA H.6.c.)

And what about…..

Confidentiality

CONFIDENTIALITY
What is it?

- **It <u>is</u> "Relationship-dependent"**
  - **Arises out of the Professional Relationship**
- **Duty to Not Disclose…**

  1. Information from or about "Client"….
  2. Received *in the course* of Prof'l Relationship

  - What about *other* info?
- Req'd by: Statutes, Lic. Board Regs, Case Law, Prof'l Ethics Codes, Standards of Profession

Confidentiality
What's Not Protected?

Presume Everything is Protected from Disclosure!

- Client Identity
- Communications by or about Client
- Info from 3rd Parties
- Entire Case File; Documentation, Tests, Reports, Assessments; etc.
- Electronic Communications (E.g., Email, Texting, Social Media, etc.) – Risky!

- *A Breach is a Breach* – Intentional, Negligent, & Accid'l

Common Confidentiality Exceptions

The Common Exceptions

- Client Consent
- Court Orders-(Subpoena alone may be insufficient)
- Mandatory Reporting (e.g., Child Abuse)
- Threats of Harm to Self/Others
- Client Lawsuits
- Licensing Board Investigations/Client Complaints
- Needed for further prof'l assist./coordinate care
  - *Should cover this in Informed Consent*
- Collection of Fees, *but Risky*

Client Consent to Disclose
Verbal v. Written

Ethics Codes & Regulations

- Some Codes: Require *Written* Consent to Breach
  - **OBLPCT – OAR 833-100-0051; AAMFT – Pr. II 2.2; ACCBO Pr 8**
- *Most* other Codes are *Silent* about Written Consent - they do require at least Verbal Consent

Best Practice

Verbal *and* Written … & Documented

Confidentiality

Electronic Communications w/ Clients

Email, Video Conference, Skype, Texting, Chat Rooms, Tweeting, Telephone, Social Media etc.

Confidentiality
Electronic Communications

- Most Regs./Ethics Codes: Use Encryption, if possible
  - If *not* encrypted, advise client; limit un-encrypted transmissions to *general* communications (e.g., scheduling; no clinical content)
- Consult: Licensing Boards; Laws & Regs
  - E.g., OAR 833-090-0010; ACA Sec. H; AAMFT Standard VI
  - Different states – Different laws/regulations; whose laws/regs apply?
    - **Best Practice: If practicing Distance Professional Counseling w/ client in another state, be aware of that state's laws/regs – as well as your own state's**

Confidentiality & Electronic Communications Emergencies, Crises…and Informed Consent

The Client you are Communicating w/ Electronically… may be in Crisis;

Best Practice

All Confidentiality policies/practices regarding **Electronic Communications** w/clients should be:

(1) Spelled out in *Written* Informed Consent,

(2) *Verbally Discussed, and*

(3) **Documented**

Confidentiality – Electronic Records

Lost/Stolen Files & Confid. Breaches

- Most breaches are Behavior driven,
  - *Not* Technology driven
- Precautions & Protections
  - Passwords; Encryption
  - Erase remotely/disable function
- Backup files & have Secure Storage (back seats & car trunks don't qualify)

Who ya gonna call?

What's your Lic. Board Require???

Confidentiality

Couples, Families, & Groups

Form #6

- Confid – Couples, Families, Groups
  - *Each client* has an individual right of confidentiality – same as w/Individual Counseling
  - Cannot Disclose O*utside* OR *Inside the Client Unit* w/o Individual Consent

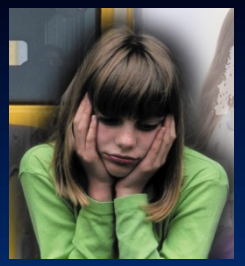
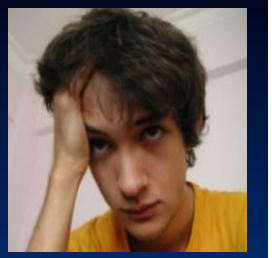
- **Caution:** "No Secrets" Policy –
  - Get it in Writing!
- Non-Disclosure Agreements by Group Members

  Good Idea, but *probably not enforceable*

See, generally, OAR 833-100-0051; AAMFT Standard II 2.2

Minors – 14+

Tx w/o Parent Consent

- **Outpatient Treatment:** Age 14> OK to Dx & Tx w/ o Parental Consent for mental or emotional disorder or chemical dependency **ORS 109.675 et seq**
  - Must have Parental involvement *before* end of tx, unless contra indicated
  - *Civil immunity* for Dx & Tx w/o parents' consent
  - *Civil immunity* for disclosure to parents w/o minor's consent

But See → 42 CFR Part 2
https://www.law.cornell.edu/cfr/text/42/2.14

- **Caution:** *Written Consent from Minor is Required for all disclosures (including to parents) when A&D Tx is w/o parental consent (42 CFR 2.14)*

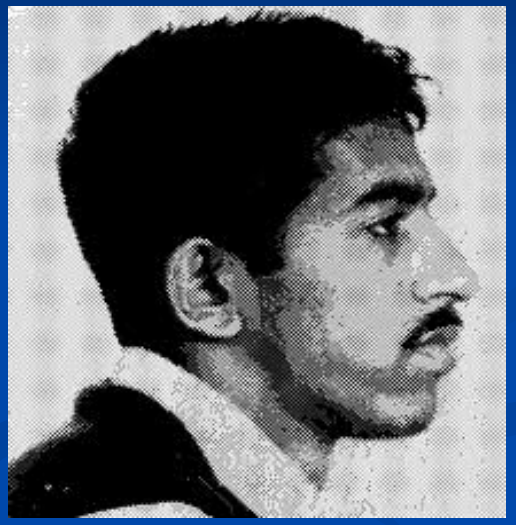
Access to Minor Child's Treatment Records

- *General Rule*: Person "legally responsible for the client's affairs" can Consent to disclosure of minor's records – **See, ORS 675.580 & 675.765…** *But, see 42 CFR Part 2 regarding A&D Treatment of Minor; written consent of Minor req'd*
- **Caution: When Non-Custodial Parent wants records/info** – Be Careful! Lic. Boards may differ – See, **ORS 107.154**

Best Practice

- 1. Clarify *"at the outset"* – Confidentiality limitations & parental access to records
- 2. In Writing, Signed, & Document
- 3. Get copy of Parenting plan; Divorce decree, etc.

Confidentiality – Duty to Warn Tarasoff Case



Tarasoff **Case & Duty to Warn Oregon**

Tarasoff Duties – Expanding!!!

- *Tarasoff Case:* Duty to warn/report when *Client* reports intent to harm a 3rd Party
- *Ewing v. Goldstein* (2004) Therapist's duty to act when dangerous client's intent was reported by a *Non-Client* (client's father told therapist)
- *Jablonski Case*: **(VA Hosp)** Client killed 3rd party. Information about client's dangerousness was in another VA dept's *medical records,* but not reviewed by therapist; no threats were reported by client
- *Garamella Case:* Supervisee posed risk of harm to public; Supervisor responsible to take some action

Confidentiality

Preventing 3rd Party Harm

What Ethics Codes say…

Permit breach confidentiality when….

- **OBLPCT:** *clear & imminent* danger to the client/others
- **OBLSW:** *clear intent* to commit a crime expected to result in physical injury to a person **(ORS 675.580)**
- **AAMFT:** … when mandated or permitted by law
- **ACA:** … *serious and foreseeable* harm to clients or *identified* others; (removed "imminent"); or as required by law

Confidentiality
A Cautionary Note

Risk Management Tips

Caution:

(1) "Imminent" vs. "Foreseeable" danger

(2) "Identified others" vs. "Identifiable others"

Major Case Rule May Apply!

Breaching Confidentiality

The Ultimate Risk Management Test

Which Case do I want to Defend?

(1) Claim for Breach of Confidentiality *or*

(2) Claim for Harm due to Failure to Warn/Protect?

"Privilege"

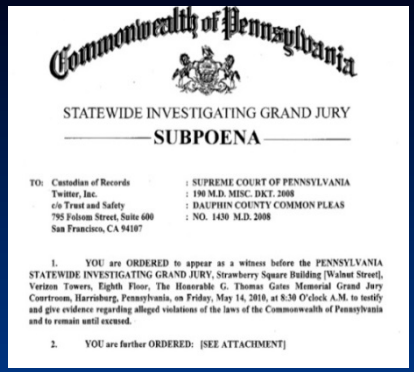
The Right to Refuse to Disclose Confidential Information *in Legal Proceedings*

- The Right *belongs only to the Client*
- *Multiple Exceptions; defined by statute; generally similar to Confidentiality Exceptions*

Best Practice:

Always assume: Client wants to assert Privilege (to prevent disclosure) … unless client waives the Privilege *in writing*

Privilege
Subpoenas: Practice Tips



Commonwealth of Pennsylvania

STATEWIDE INVESTIGATING GRAND JURY

SUBPOENA

TO: Custodian of Records
Twitter, Inc.
c/o Trust and Safety
795 Folsom Street, Suite 600
San Francisco, CA 94107

: SUPREME COURT OF PENNSYLVANIA
: 190 M.D. MISC. DKT. 2008
: DAUPHIN COUNTY COMMON PLEAS
: NO. 1430 M.D. 2008

1. YOU are ORDERED to appear as a witness before the PENNSYLVANIA STATEWIDE INVESTIGATING GRAND JURY, Strawberry Square Building [Walnut Street], Verizon Towers, Eighth Floor, The Honorable G. Thomas Gates Memorial Grand Jury Courtroom, Harrisburg, Pennsylvania, on Friday, May 14, 2010, at 8:30 O'clock A.M. to testify and give evidence regarding alleged violations of the laws of the Commonwealth of Pennsylvania and to remain until excused.

2. YOU are further ORDERED: [SEE ATTACHMENT]

Subpoenas & Subpoenas *duces tecum*

1. Discovery – Production of documents
2. Testimony – Trial/Hearing or Deposition
3. Issued under authority of court
4. But…..*Not* the same as a Judge's Court Order

See, C.F.R. 164.512(e) et. seq. - HIPAA

Practice Tips: Subpoenas
Best Practices

Before Responding to Subpoena:

- Follow Agency/Employer protocol
- Advise client of the subpoena !!!
- Client Consent – get it in *Writing & Signed*
- A Resource: Your Professional Insurance Co.
- Consult w/ Lawyer/Colleagues, *when appropriate*

- Never ignore Subpoena; Some Response always needed
- Do Not disclose therapist-client relationship w/o client's *written* permission

Privilege
Practice Tips: Subpoenas

If Client *Refuses* Consent (or cannot be reached)…

Best Practices:

- Do *not* produce information; follow Agency protocol
- Seek Legal Advice, Consult, Request Court Order

Tips & Reminders

- Do not confirm client relationship w/o Consent
- *Courts* decide Privilege Issues, *not Therapists*
- Be careful about 3rd party references in records
- An attorney *threatening* a subpoena is *not* a subpoena !
- Document your process

Mandatory Reporting

1. ***Suspected*** **Child Abuse/Neglect (ORS 419B.005** ***et seq.*****) – 24/7**

2. ***Suspected*** **Abuse of Elderly Person (ORS 124.005** ***et seq.*****) – 24/7**

3. ***Suspected*** **Abuse of Developmentally Disabled/ Mentally Ill Adult (ORS 430.765** ***et seq.*****) – during official capacity**

AND

4. ***Suspected*** **Professional Misconduct (ORS 676.150** ***et seq.*****)**

Mandatory Abuse Reporting

- If a *Public or Private Official* (i.e., Mandatory Rptr) …..
- ….. has *Reasonable cause to believe* …..
- ….. that Victim or Abuser with whom the Mandatory Reporter *Comes in Contact* .....
- ….. has suffered *Abuse* …..
- … *there is a Duty to Report …. unless Exception applies*
- *24/7 duty* - vs. - *while acting in an official capacity*
- Exceptions are *based on Privilege*: Psychiatrist, psychologist, clergy, attorney, guardian ad litem – are Mandatory Rptrs, but are exempt from reporting if the communication is *Privileged*

Mandatory Abuse Reporting

Considerations and Caveats

- *Reasonable cause to believe* – reasonable belief/suspicion; *not* "probable" cause; it's DHS's duty to investigate
- *Comes in contact with victim/abuser*– does not mean that the information upon which the belief is based can only come from the victim/abuser; it can come from 3rd party (but Rptr must have/have had some contact)
- Duty is *Personal;* can't rely on others to report for you)
- *Immunity* - for good faith reports, based on reasonable grounds; liability for *knowingly* making false report

Mandatory Abuse Reporting

Considerations and Caveats

- Challenging issue: whether to rpt long-ago abuse
- Reporting must be verbal, not written
- Must report *Immediately* when have reasonable cause….
- Consequences for *Not* making a required report:
  - Class A violation & Licensing board issues
  - Potential civil liability

Best Practices:

1. Always Consult & Document
(*especially if not reporting*)
2. Can ask DHS hypothetical?

Reporting Professional Misconduct – ORS 676.150

Licensed* Health Professionals *must* Report *Other Licensees, including Licensees of Other Health Licensing Boards*, who engage in:

(a) "Prohibited Conduct" Or

- Criminal acts

(b) "Unprofessional Conduct" = Conduct ….

- unbecoming a licensee
- detrimental to best interests of public
- contrary to recognized standards of prof'l ethics
- endangers health, safety or welfare of client

Reporting Professional Misconduct – ORS 676.150

- Reporting licensee must have "**reasonable cause to believe**"
- **Shall** report to appropriate licensing board
- **Exception:** When state/federal law prohibits disclosure (e.g., Therapist – Client Confid'ty)
  - *Confidential Communications are Protected; Exempt from reporting*
- Report w/in 10 days
- Civil Immunity – reports made in "good faith"

Reporting Professional Misconduct – ORS 676.150

Considerations and Caveats

- Likely includes *credible hearsay* – information that creates *reasonable cause to believe*
- Must report info obtained that is *not* privileged
- Confidential communications are *not* reportable
- What about Professional Consultations?
- What about Supervision?

Recordkeeping

What's a "Client Record"?

***Any* information maintained in *Written, Printed, or Electronic* form … from, by, or about a client**

(Client file, Notes, Reports, Texts, Emails, Letters, etc.)

(See: OAR 833-010-0001; 877-030-0100; 858-010-0060)

Excluding…..

- **Psychotherapy Notes – a HIPAA Exception**
- **Legal & Lic. Board Communications**

Client Records
The Regulations (OARs)

At a Minimum…

- Legible and Concurrently kept for *Each Client*
- Secure, safe, & retrievable

Content → Requirements vary; see OARs:

- OBLPCT- Formal or informal assessment; goals or objectives; & progress notes
- OBLSW-Assessment; tx or intervention plan, & progress notes
- OBPE-Presenting prob, purpose, or dx

- Records Destroyed/Lost: Report to Board & Client

Ethics & Record Keeping
Ownership & Access

- Agency/Professional "owns" the Records
- *Assume* … Client is entitled to *full access*
- *Assume* … Client will complain to Licensing Board if you refuse him/her access
  - You have Laboring Oar if deny client access
  - *Never* withhold records for Non-payment
- Others w/ *potential access*: Licensing Board, Courts, Law Enforcement, Parents, etc.
- Supervision Records: Supervisee likely gets access

Counselor/Therapist Unavailability
- Incapacity or Death -

Client Records

What's Client to do if Counselor/Therapist is Unavailable???

Contingency Planning

Licensing Boards – Requirements

- In event of Incapacity/Death
  - Designate Custodian/"Qualified Person" (QP)
  - Applies to Licensee & those seeking licensure
- Purpose: Conf'l Maintenance/Records Access
- Custodian/QP Req'mts; See Regs
- Register w/ Lic. Board: Person/Co. Name & Contact Information
  - OBLPCT has Designated Custodian Form On Line

Custodian of Record/Qualified Person Some Considerations

- Informed consent re therapist's unavailability
- Written Agreement w/ Custodian/QP
- Be sure Custodian/QP has info to access your records
- Custodian/QP should be a person who **would** be available if you became incapacitated
- Review Annually – Keep Info Current
- Limit your # of agreements to be a Custodian/QP
- Supervisors: Confirm Supervisee compliance
- Note: Custodian/QP *may* have Potential Liabilities

Records & Record Keeping
Additional Considerations

Best Practices

Record Unusual or Non-Traditional Matters

a. Gifts (offered; accepted; rejected; client response)
b. Significant Personal Disclosures (and why)
c. Multiple Relationships & Boundary Issues, Social or Business Involvement, etc.
d. Unusual Client Contacts (e.g., out of office)
e. Unusual Client Remarks/Threats

Records
Should also include….

Best Practices

- Clinical Consultations
- Client's clinical status; is client responding to tx?
- Critical Thinking regarding clinical, ethical decisions
- Referrals recommended & client response
- Attendance of everyone in client sessions
- Medical and other provider records
- The angry/threatening client
- Termination status of client

Ask: Who might see my client records?

Records Should NOT Include

- Gratuitous comments about client *(…..client comes in w/ same old complaints)*
- Conclusory/Non-Descriptive statements (… *client is angry, sad, happy…)*
- Irrelevant/embarrassing comments about client (*bad hair day…)*
- Legal consultations
- Correspondence w/ Licensing Board

Records & Record Keeping
Retention of Client Records

- Agencies/Institutions – follow protocol
- 7 yrs – record retention; counselors, therapists, social workers, psychologists (Oregon)
- Disposal of Records – Protect Confidentiality
  - May need IT person for disposal of electronic records

Ethical Competence

What makes an

"Ethically Competent" Therapist?

(The Ethical Characteristics, not just the Skills)

Ethical Competence
Some Primary Characteristics

#1 – Honesty, Integrity, Self-care

#2 – Know the Rules

#3 – Continue to Improve Professional Skills

#4 – Know our Prof'l Limits

#5 – Be Alert to Diversity/Multicultural Issues

Ethical Competence
1. Taking Care of Self

- Taking Care of Self
  - Harvard Study of Adult Development
    - https://www.ted.com/talks/robert_waldinger_what_makes_a_good_life_lessons_from_the_longest_study_on_happiness
- Common Challenges in *All Professions*
  - Personal Life Stresses & Burnout
  - Substance Abuse & Mental Health Issues
  - Professional and/or Personal Isolation
  - Reluctance to Seek Help
  - Complacency

Self-Care is an Ethical Obligation










What's *Your* Preference?

Ethical Competence
2. Know the Rules

- Current Ethical/Legal Rules & Regs
- Current Agency Rules, Policies, Practices
- Be Familiar w/Standards of Prof'l Community
- Participate in Professional Associations
- Be familiar w/Board Websites:
  - www.oregon.gov/OBLPCT/
  - www.oregon.gov/BCSW/
  - www.oregon.gov/OBPE/index.shtml
  - http://www.accbo.com/

Ethical Competence

3. Continue to Improve Prof'l Skills

- Education, Practica, Internship, Supervision, Consultation, and Professional Experience
- Trainings & CEs
- Familiarity w/ Ethics Codes & Lic. Board Regs.
- Purposefully seeking to Improve
- Lack of Experience: No excuse for ethical violations
- *Many Years of Experience – May also* **creates risks.**

Why?

What's Most Helpful to You in Developing & Maintaining Your Professional Skills?

1. **Continuing Education & Workshops**
2. **Supervision/Consultation**
3. **Newsletters/Journals**
4. **Interaction with Colleagues**

Ethical Competence

4. Know Our Prof'l Limits

- *Accurately* Assess our Prof'l Skill Level
- Don't assume expertise in *all areas/cases*
- New Practice Areas require:
  - Education, Training, Supervision/Consult.
- Many legal & ethical problems are the result of exceeding skill level
  - Do Economics …. influence our decisions to take cases??? … Do they influence Agency case load decisions???

Ethical Competence
Impairment & Self-Reporting

Duty to Self-Report – ORS 676.150*

- All Codes: Prohibit - Practicing while "Impaired"
- *Must* Self-Report (10 days):
  - Misdemeanor/Felony – Conviction
  - Felony – Arrest
- Most Code require Self-Reporting (*often w/in 30 days):*
  - Civil Lawsuits (practice related)
  - Prof'l & Regulatory Sanctions
- Failure to Report – may result in Disciplinary Action

**Applies only to Or. Lic. Board regulated prof'ls*

Ethical Competence

5. Diversity/Multicultural Awareness

- What are some Examples of Diversity?
- How do Diversity and Multicultural issues affect Clinical Treatment?
- All Codes Require Diversity/Multicultural Awareness
  - **OBLPCT; BLSW; OBPE; OSBN**
  - **AAMFT, ACA, NASW, APA, AMHCA, ACCBO**

Ethics, Law, and Risk Management in Modern Clinical Practice©

July 19, 2017

Thank you!

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Professional Ethics, Law, & Risk Management Consultation

dsquerin@comcast.net

43rd Annual Northwest Institute of Addiction Studies

Ethics, Law, & Risk Management in Modern Clinical Practice

July 19, 2017

Appendix - I

Sample Forms

Douglas S. Querin, JD, LPC, CADC-I

Professional Ethics, Law, & Risk Management Consultation

dsquerin@comcast.net

Appendix - II
Resource Links - Apps

- https://www.psychotherapynetworker.org/blog/details/1064/sorting-through-the-bewildering-world-of-therapeutic - PsychNetworker article 11/16
- http://militarymedicine.amsus.org/doi/full/10.7205/MILMED-D-15-00293 - Research study abstract re anger management for vets
- http://www.psychiatryadvisor.com/top-10-mental-health-apps/slideshow/2608/ - Apps recommendations
- https://www.adaa.org/finding-help/mobile-apps - Anx & Depression Assoc.
- http://www.huffingtonpost.com/2015/02/09/mental-health-apps_n_6622358.html - Huffington Post article
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4795320/ - Mental health smartphone apps: Review and evidence-based recommendations for future development 3/16
- https://www.scientificamerican.com/article/should-you-take-an-app-for-that/ - MH Apps – Do they work 2015
- http://www.psychiatrictimes.com/telepsychiatry/evolving-potential-mobile-psychiatry-current-barriers-and-future-solutions - APA Task force

Appendix - III

Race: A Social Construct or Genetic Reality?

- **The Surprising Science of Race and Racism -** http://www.huffingtonpost.com/2015/06/30/racism-race-explained-science-anthropologist_n_7687842.html

- **What Scientists Mean When They Say "Race" is Not Genetic -** http://www.huffingtonpost.com/entry/race-is-not-biological_us_56b8db83e4b04f9b57da89ed

- **Race Is a Social Construct, Scientists Argue -** https://www.scientificamerican.com/article/race-is-a-social-construct-scientists-argue/

Appendix - III

Race: A Social Construct or Genetic Reality?

- **The Science of Race, Revisited -** http://www.huffingtonpost.com/2015/07/06/human-race-biology-scientific-racism_n_7699490.html
- **Race: The Power of an Illusion -** http://www.pbs.org/race/001_WhatIsRace/001_00-home.htm
- **What We Mean When We Say 'Race Is a Social Construct' -** https://www.theatlantic.com/national/archive/2013/05/what-we-mean-when-we-say-race-is-a-social-construct/275872/

Appendix - III

Race: A Social Construct or Genetic Reality?

- **A Psychologist's Explanation Of Why Racism Persists In America -**
- http://www.huffingtonpost.com/2015/07/10/social-psychology-racism_n_7688910.html?utm_hp_ref=science
- **Race and the Human Genome Project -**

  http://theracecardproject.com/wp-content/uploads/gravity_forms/1-45689d01ca5f907d5c16739859e5c15b/2013/10/McCann-race-human-genome.pdf