The Activity Planner and Deborah Henson have indicated that the content being presented at today's educational activity is without bias of any commercial product or drug.
Deborah M. Henson, MSW, LCSW, J.D., LL.M. is a Licensed Clinical Social Worker and Lawyer with more than 25 years professional experience and more than 15 years experience training mental health practitioners on the interface of clinical practice and litigation. Deb maintains a psychotherapy practice in New Orleans, trains social service agencies, and consults regularly with clinicians around the country who find themselves involved in legal proceedings of all types, including disciplinary matters. Ms. Henson also practices law with a special focus on mental health law, including ethics consultation/risk prevention. She has represented numerous lawyers and mental health practitioners in malpractice lawsuits and disciplinary matters. Deb has lectured frequently in the areas of mental health ethics and risk prevention, and effective collaboration with attorneys to help clients who have ongoing litigation issues.

Deb earned a Master of Social Work degree from Tulane University, a J.D. degree from Loyola University School of Law, and an LL.M. (advanced law degree) from the University of California, Berkeley—Boalt Hall School of Law. She has conducted continuing education presentations and general lectures for PESI, Inc., National Association of Social Workers, NASW Louisiana Chapter (Annual Conferences), Louisiana Association of Clinical Social Workers, Tulane School of Social Work, University of Texas School of Social Work, St. Edward’s University Professional Education Center, New Orleans City Attorney’s Office, Prime Time CLE Institute, Tulane School of Law, and other organizations. Deb is licensed to practice clinical social work in Louisiana and Texas, a Board Approved Supervisor in Texas, and admitted to practice law in Louisiana, Texas, and the federal courts, including the United States Supreme Court.
Deborah M. Henson, LCSW, JD, LL.M.
Licensed Clinical Social Worker & Attorney at Law
AVOID ETHICS COMPLAINTS & MALPRACTICE LAWSUITS

I. High Anxiety Clinical Practice
A. Understanding Factors that Precipitate Disciplinary Complaints and Malpractice Lawsuits Against Therapists
B. Advance Planning to Manage Risk Factors Before They Erupt
C. “Best Practice” Procedures for Clinicians to Avoid Legal Problems

II. Handling Legal Involvement Ethically and Self–Protectively
A. Dealing with Difficult Attorneys and Subpoenas
B. Strategies to Deal with Clients Who Refuse to Allow Therapist to Release Information Compelled by Subpoena
C. Preparing for Depositions or Court Testifying
D. Preparing Clients for Clinical Affects of Therapist Testimony to Avoid Clinical and Legal Consequences Adverse to Client and Therapist
E. What to Do and NOT Do if You Receive an Ethics Complaint or Malpractice Lawsuit

Deb is a professional hybrid: psychotherapist (Tulane MSW, 1977) and lawyer (Loyola JD 1991, University of California, Berkeley LL.M. 1993). She is a Licensed Clinical Social Worker in Louisiana (1980) and Texas (2006) and admitted to Louisiana State Bar (1991), Texas State Bar (2006 – inactive at present), United States Supreme Court, and United States Fifth Circuit Court of Appeals. She has represented mental health professionals and attorneys in disciplinary matters since 2000. Deb has recently returned to New Orleans after a 3-year sojourn in Austin following Hurricane Katrina. She currently practices in New Orleans: clinical social work (i.e., therapy, consultation, and training) and law (mental health, professional licensing defense, and appellate). For more info: deb@deborahmhenson.com.
AVOID ETHICS COMPLAINTS & MALPRACTICE LAWSUITS

About the Speaker ~

- Deborah Henson's hybrid professional background — clinician and lawyer — gives her the unique perspective of being able to offer practical, ethical solutions to high-risk clients and situations that increase the therapist's chances of licensing complaints and/or malpractice lawsuits.
- Ms. Henson has maintained a practice of psychotherapy, supervision, and consultation since the early 1980s. She has taught mental health practitioners at Tulane School of Social Work (New Orleans), University of Texas School of Social Work (Austin), St. Edward's University Professional Education (Austin), and Louisiana NASW Annual Conferences. She has lectured nationally for PESI and Cross Country Education, Inc. in the area of Legal & Ethical Issues of Clinical Practice.
- Ms. Henson currently maintains active therapy and law practices in New Orleans. For more information, visit her web site at www.deborahmhenson.com.

AGENDA

I. HIGH ANXIETY CLINICAL PRACTICE

II. HANDLING LEGAL INVOLVEMENT ETHICALLY & SELF-PROTECTIVELY

II. Handling Legal Involvement Ethically and Self-Protectively

A. Dealing with Difficult Attorneys and Subpoenas

B. Strategies to Deal with Clients Who Refuse to Allow Therapist to Release Information Compelled by Subpoena

I. HIGH ANXIETY CLINICAL PRACTICE

A. Factors That May Precipitate Ethics Complaints and/or Malpractice Suits

B. Advance Planning to Manage Risk Factors

C. "Best Practice" Procedures for Clinicians to Avoid Legal Problems

C. Preparing for Depositions or Court Testifying

D. Preparing Clients for Clinical Affects of Therapist Testimony to Avoid Clinical and Legal Consequences Adverse to Client and Therapist

E. What to Do and NOT Do if You Receive an Ethics Complaint or Malpractice Lawsuit

Presenter:
Deborah M. Henson, LCSW, JD, LL.M.
Attorney and Licensed Clinical Social Worker
www.deborahmhenson.com
A. FACTORS THAT MAY PRECIPITATE ETHICS COMPLAINTS AND/OR MALPRACTICE SUITS

1. Failure to Communicate Specifically Enough with Client

2. Failure to Explain Office Procedures in Advance in Detail with Supporting Reasons For Client Understanding

3. Release of Confidential Information Pursuant to Subpoena Without Client’s Permission or Over Client’s Objection

(see NASW and APA guidelines for confidentiality as examples, and Limitations to Confidentiality)

Professional Codes of Ethics and Standards of Practice

- NASW = Protect clients’ confidentiality except for “compelling professional reasons” (e.g., exception for harm to client or others); but, even if therapist must disclose, release the least amount of information necessary.

- APA = Disclose confidential information without consent only as mandated by law or where permitted by law to:
  1. provide needed professional services;
  2. obtain appropriate professional consultations;
  3. protect the client/patient, psychologist, or others from harm; or
Professional Codes of Ethics and Standards of Practice

- APA (cont’d)
  4. obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum necessary to achieve the purpose (must also inform client that collection agency may be used and give client a chance to make prompt payment prior to taking that step).

State Law

- Statutes -
  Rules of Evidence in each state protect the confidentiality of mental health information obtained during clinical treatment and consultation.
  General rule: Communications between a patient/client and a professional are confidential and shall not be disclosed in civil cases. The rule pertains to both records and verbal information from the clinician.

State Law

- Statutes -
  General rule also specifies who may claim the privilege: the privilege may be claimed by the client/patient or by a representative of the client/patient or by the professional, but only on behalf of the client/patient.
  The privilege belongs to the client!!!

Federal Law

- HIPAA - “Privacy Rule”
  [statute = Health Insurance Portability and Accessibility Act of 1996 Medical Privacy Regulations]
  1. “psychotherapy notes” = recorded by mental health professional concerning contents of conversations during private counseling session or group, joint, or family counseling session; and [see next slide]

Federal Law - HIPAA

2. separated from the rest of the individual’s medical or clinical record
  [The record includes: medication info, start/stop times, modalities of treatment used; results of clinical tests, summary of diagnosis - treatment plan-prognosis-progress, intake info, billing info, formal evaluations, notes of collateral contacts, and records obtained from other providers.]

Federal Law

- Under HIPAA Privacy Rule:
  “psychotherapy notes” are not subject to disclosure without separate and distinct authorization from the client.
  [Thus, if clinician receives a subpoena for “all records,” must still have client sign separate consent to release the psychotherapy notes (if maintained separately from the rest of the medical record, which is not required, but best practice to do so).]
Federal Law

- HIPAA Privacy Rule may also provide additional protection for minor clients re: parents seeking confidential information.

Federal Law

PROTECTION FOR MINORS’ RECORDS b/c:
- No federal right for patients to access separately maintained psychotherapy notes, and because parents act as reps under HIPAA for their children in exercising privacy rights, denying access to separately maintained psychotherapy notes would not violate HIPAA.
- But, may be different under state law!

Federal Law

- Jaffee v. Redmond, 518 U.S. 1 (1996) - significant factor in the creation of the HIPAA “Privacy Rule” because the Supreme Court in Jaffee recognized that “all fifty states have adopted some form of the psychotherapist-patient privilege.”

Federal Law

- DHHS stated (re: HIPAA Privacy Rule exception for psychotherapy notes):
  "We have provided additional protections for psychotherapy notes because of Jaffee v. Redmond and the unique role of this type of information . . . .”

Federal Law


FACTS: Police officer (Redmond) shot and killed a man while on patrol, then sought counseling from a social worker. The family of the deceased man sued Redmond and her employer in federal court (unconstitutional excessive force [42 U.S.C.S. § 1983]) in a civil action for money damages and sought release of clinical notes for evidence.

Federal Law

Jaffee v. Redmond:
- Extended the psychotherapist-patient privilege to licensed social workers and reinforced the principles that:
  (1) confidentiality is necessary to encourage people to seek psychotherapy, and
  (2) clinicians have the obligation to protect client confidences using the legal process if necessary.
Limitations on Confidentiality

1. Abuse & Neglect
2. Imminent Harm/Duty to Warn
3. Fee Collection
4. Disciplinary Complaints/Malpractice
5. Other State/Federal Limitations

Abuse and Neglect

- **General Rule**: Must report = Abuse or neglect of children, elderly, and/or disabled.

  May also have specific statute for abuse or neglect of any resident of an institution (e.g., nursing home, residential treatment center, etc.)

  May have specific duty to report suspected sexual abuse/exploitation by mental health provider during course of treatment - can report suspicion only; if client wants to remain anonymous, statutes allow that to protect privacy.

Imminent Harm – Duty to Warn

Notorious case that established duty to warn a potential victim of harm threatened by a client = Tarasoff v. Regents of the University of California, 551 P.2d 334 (Cal. 1976).

Patient had informed his therapist that he intended to kill Tarasoff (student) when she returned from a trip. The therapist contacted the police to take patient into custody and have him committed, but police let him go. No one notified Tarasoff’s parents of the threat and she was killed.

Imminent Harm – Duty to Warn

- **State Case Law – varies by state**: [examples]
  - No duty to warn = Texas, Hawaii, Florida, Alabama, Mississippi
  - Duty to warn if specific victim identified = California, Colorado, Louisiana, Michigan, Missouri, Vermont and New Jersey
  - Duty to warn if general threat or to public = Wisconsin, Delaware, Washington, Nebraska

Imminent Harm – Duty to Warn

- **Federal Law = HIPAA**

  Therapists *may* disclose confidential info to “prevent or lessen a serious or imminent threat to the health or safety of a person or the public.”

  HIPAA does not require disclosure, but permits it without liability on part of therapist - but, *state law usually controls*!!

Other State/Federal Limitations

- **State/federal law may dictate certain situations where therapist MUST release confidential information**, but be sure to keep such disclosure narrowly tailored; i.e., give as little information as possible.

  - Examples: some HMO contracts require QA eval with clients; criminal (state or federal) lawsuits - e.g., IRS (tax fraud), drugs, etc.
A. FACTORS THAT MAY PRECIPITATE ETHICS COMPLAINTS AND/OR MALPRACTICE SUITS

4. Failure to Create Paper Trail for Therapist’s Protection in the Event of Ethics Complaint or Malpractice Suit

5. Client’s Disrupted Object Relations and Psychopathology

6. Therapist’s Poor Judgment and/or Boundaries with Clients

B. ADVANCE PLANNING TO MANAGE RISK FACTORS BEFORE THEY ERUPT

1. Identify High-Risk Patients/ Clients Before Problems Arise

2. Mark files to alert you each time you write in these files – potential for lawsuit or ethics complaint, so WATCH WHAT YOU WRITE!

Common problems that often result in discipline:

1. Sex with Clients
2. Dual Relationships & Boundary Improprieties

[discuss dual relationships and boundary issues]
3. Staff/discuss these cases regularly in agency or private practice groups; consider forming "Litigation Consultation Group" with a few colleagues who agree to support each other to the point of trial testimony, if necessary.

4. Communicate with these clients very clearly and consider writing up agreements for clients to sign for paper trails in file - for treatment goals and steps to achieving same, no-suicide contracts with consequences of attempts detailed (e.g., termination and referral to inpatient), no-harm contracts (for duty to warn purposes), and consequences that would precipitate therapist disclosure to identified person and/or police or mental health authorities, etc.

5. Ensure that communication with client explains in detail the exceptions to client confidentiality; consider writing these down and having client sign his/her understanding.

6. Create form letters in advance to respond to subpoenas - (a) to requesting attorney (outline need for client’s written permission and payment in advance) and (b) to client re: need for release or, if objecting to release, client’s obligation to pay for attorney’s fees to quash subpoena.

7. Know the steps for responding to subpoena if client refuses to allow disclosure, including identifying mental health lawyer to assist you in objecting to disclosure, if necessary.

8. Understand your specific state’s law re: duty to warn, discuss these cases in Litigation Consultation Group, and keep notes of group recommendations in file with dates staffed.
C. “Best Practice” Procedures for Clinicians to Avoid Legal Problems

1. Review Office Policy paperwork frequently as though you are a new client reading it – is it specific, yet written in a warm, egalitarian manner?

2. Always include Consent for Treatment, but talk with client face-to-face in session prior to signing (and specify that such is your procedure in the consent).

3. Discuss “missed session” policies thoroughly and explain why necessary to charge for sessions missed and how client can avoid charges for emergencies that arise – define “emergencies” (e.g., “beyond your control” versus “running late at work”). Include policy for illness cancellations.

4. Regularly consult with Litigation Group re: high-risk clients – be sure to sign attendance sheet at each meeting for verification and reference if needed.

5. Always write up agreements with high-risk clients, have client sign indicating consent with the plan, and keep copy in the client’s file – give copy to client as well.

6. Fee Collection – include Advance Client Consent in Office Policy paperwork, but also protect privacy of client as much as possible in collection efforts – have client pay each session and plan to skip collection!
Fee Collection

- State Law varies =
  
  [Only CT allows disclosure of client info without consent to collect fee.]

2. Billing policies should be clearly worded and explain consequences of nonpayment.

3. Preferable to have client pay each session so bill will not accrue - can discuss any changes in client's financial situation in office.

4. If bill accrues, send friendly letter first with date for payment or telephone call to work out payment plan.

5. If first letter gets no response, send second letter with copy of signed consent to release info for collection and date upon which action will be taken unless full payment is received - or, mutually acceptable payment plan is agreed upon (in writing!!).

- HIPAA Privacy Rule:
  
  Permits disclosures without consent for collecting a therapist's fee, but Codes of Ethics do not allow disclosure without prior consent.

CAUTION:

- Disclosure for fee collection without consent may elicit counterclaims (if lawsuit was filed for collection) and/or client grievance to licensing Board.

II. Handling Legal Involvement

Ethically and Self-Protectively

A. Dealing with Difficult Attorneys and Subpoenas
A. Dealing with Difficult Attorneys and Subpoenas

1. Always write/fax requesting attorney (e.g., form letter stating your desire to obtain client’s written permission to release requested confidential information)

2. Okay to charge per page for copies provided and to charge for writing up summaries or reports for lawyers - get paid in advance of releasing records (e.g., when person comes to pick up records, or tell attorney to mail check and then you will mail records)

3. Remember - contrary to what the attorney may want you to believe, a subpoena is NOT a court order!! You must respond to the subpoena, but if your professional Code of Conduct and applicable state law prevents you from releasing confidential information without client’s permission, and your client has not given you permission to release, then you can resist release with various legal pleadings or by going to court and invoking the privilege of confidential on behalf of the client

4. Therapist may charge for preparing, traveling to/from, and attending depositions and trial for purposes of testifying.

II. Handling Legal Involvement Ethically and Self-Protectively

B. Strategies to Deal with Clients Who Refuse to Allow Therapist to Release Information Compelled by Subpoena

1. Ask clients to instruct their attorney to quash the subpoena or pay for you to retain counsel to resist release of confidential records and testimony
B. Strategies to Deal with Clients Who Refuse to Allow Therapist to Release Information Compelled by Subpoena

2. Explain that client must pay for your legal fees to resist the subpoena if client wants you to hire an attorney yourself - the privilege belongs to the client and therapist may invoke it on behalf of the client, but if client refuses to give you permission to release records, it is client’s responsibility for costs associated with resisting the subpoena.

3. Better to have discussion with client in person, rather than over the telephone, even if client is no longer in treatment.

4. If client refuses to pay or cannot afford to pay for legal fees, yet still objects to your release of information, you should protect yourself by retaining counsel to resist release of records to avoid complaint or lawsuit.

Responding to Subpoenas: Summary
- If client refuses to give consent for release of records or testimony, invoke the (client's) privilege of confidentiality and the state evidence rule of confidentiality for mental health information.
- Write a cordial, but firm letter to attorney who sent subpoena explaining that you cannot comply.

II. Handling Legal Involvement Ethically and Self-Protectively

C. Preparing for Depositions or Court Testifying
C. Preparing for Depositions or Court Testifying

1. Understanding Differences between Lawyers' and Clinicians' Goals and Mindsets

[See Differences Paradigm slides that follow]

- **Clinician** = cooperative; help others feel comfortable
- **Lawyer** = analytical; size up others for gaining advantage to win

**Differences between Clinicians' and Lawyers' Mindsets & Goals**

- **Clinicians** = put others at ease to establish rapport
- **Lawyers** = increase opponent's anxiety to gain advantage

**Differences between Clinicians' and Lawyers' Mindsets & Goals**

- **Clinicians** = trained to think in interactive context; i.e., strive for mutual agreement and overall satisfaction for the group or person
- **Lawyers** = trained in "us-them" modality; i.e., gather info to use to best advantage and to gain upper hand.

**Differences between Clinicians' and Lawyers' Mindsets & Goals**

- **Clinicians** = answer questions fully; strive to be clear
- **Lawyers** = answer questions narrowly; give as little info as possible

**Differences between Clinicians' and Lawyers' Mindsets & Goals**

- **Clinicians** = out of comfort zone in deposition or courtroom, and with manner of probing from attorneys
- **Lawyers** = more familiar in depositions and court, and with style of questioning, probing, searching for facts
C. Preparing for Depositions or Court Testifying

(a) It is NOT your job to help attorney ask questions in the deposition or the trial

(b) It is NOT your job to be clear and overly explanatory in your answers

Get Paid In Advance!!

- Always get paid in advance prior to appearing at depo or court - ask attorney who sent subpoena to estimate time that she will need you and add on ample prep and travel (to/from)

- Explain that you must be paid a week (or at least several days) in advance to clear your client schedule

Be Prepared!!

- Always bring your résumé or vitae to the depo even if you have already provided it

- Review it beforehand (add to prep time) b/c you will be asked many questions about your experience - don't feel defensive if you have weaknesses in your experience - you can always state your opinion with: "In my professional judgment and experience . . . ."

C. Preparing for Depositions or Court Testifying

2. Building Skills as a Deponent or Trial Witness

Remember To Breathe!!

- Practice deep relaxation or self hypnosis regularly during litigation involvement and do breathing right before appearing for deposition/court

- Can always take a "rest room" break and go take some time to breathe and relax by yourself.
Building Skills for Testifying

- Remember how to answer questions in litigation context:
  - "YES", "NO", "I DON'T REMEMBER", "COULD YOU REPEAT THAT QUESTION?"
  - Don’t try to help attorney ask his/her questions, even if s/he acts sweet, friendly, charming

- If the opposing attorney is particularly adversarial, it may help to practice role-playing with colleague or lawyer consultant prior to deposition or court testifying
  - Always rely upon your professional training and experience to bolster, but not in a defensive way - e.g., "In my professional training and experience . . ."

C. Preparing for Depositions or Court Testifying

3. Learn and Practice Methods to Quickly and Efficiently Reduce Anxiety

Building Skills for Testifying

- If attorney says, "Help me out here, . . ." JUST DON'T!!
  - It is attorney’s job to formulate questions - all you have to do is answer: "Yes" or "No" or the favorite, "I don't recall/remember"

- If the opposing attorney is particularly adversarial, it may help to practice role-playing with colleague or lawyer consultant prior to deposition or court testifying
  - Always rely upon your professional training and experience to bolster, but not in a defensive way - e.g., "In my professional training and experience . . ."

Role-play ahead of time with colleagues in Litigation Consultation Group or attorney friends

Methods for Immediate Reduction of Anxiety

- Take meditation, yoga, and/or self-hypnosis classes if involved with litigation
  - Practice regularly during day: e.g., in between clients at office, close eyes and breathe - pay attention to the resulting warmth and relaxed state that you can access immediately.
**Methods for Immediate Reduction of Anxiety**

- Trust yourself! You will be fine and remember it will be over soon!
- Recall the worst, most conflictual couple or family session you ever had and remember that you did fine - you have the skills to deal with conflict!
- Remain calm, confident, and relaxed in the face of stressful examination - you are not trying to win accolades; rather, you are present to tell what you know.

**Methods for Immediate Reduction of Anxiety**

- Remember that taking a “relax” break is always possible, even on the witness stand, by asking attorney to repeat question or telling attorney that you are thinking about the answer.

**Methods for Immediate Reduction of Anxiety**

- Develop internal images for certain situations to ground yourself; e.g., focus on a certain safe place or a specific item from home or therapy office that brings peace, relaxation, and comfort (having practiced beforehand).

**Methods for Immediate Reduction of Anxiety**

- Remember: whatever happens, you must not react defensively, angrily, or attack others - attorney may try to provoke such reactions.
- Expressing some emotion about the client’s struggles or horrid experience is ok, but don't overdo it.

**II. Handling Legal Involvement Ethically and Self-Protectively**

D. Preparing Clients for Clinical Affects of Therapist Testimony to Avoid Clinical and Legal Consequences Adverse to Client and Therapist
D. Preparing Clients for Clinical Affects of Therapist Testimony to Avoid Clinical & Legal Consequences Adverse to Client and Therapist

1. If you are released to testify about client and his/her therapy and mental health issues, remember that client/patient will be sitting right there (in deposition or in courtroom) and such information heard out loud in public is very unsettling – discuss what you will say in advance and client’s reaction to info – no surprises with high-risk clients!

2. Suggest client bring a trusted, supportive friend or family member to session in advance so you can work with them together to help with support at deposition or trial (client may not be able to have person sit with her at deposition or trial, but may be able to meet in rest room in between times, or have supportive eye contact, etc.).

II. Handling Legal Involvement Ethically and Self-Protectively

E. What to Do and NOT Do if You Receive an Ethics Complaint or Malpractice Lawsuit

Therapist can defend her/himself in ethics or malpractice actions without violating confidentiality.

Client has already brought the issue of the therapy to the attention of the Board or Court, so defending by releasing confidential information is ok.

What NOT to Do!!

Don’t panic.

Don’t call the client.

Don’t submit your own Response without another’s review due to emotions possibly clouding your objectivity.

E. What to Do & NOT Do if You Receive an Ethics Complaint/Malpractice Lawsuit

- Discuss complaint with colleague or consult with attorney familiar with mental health and licensing law
- Prepare an unemotional Response to the Complaint or lawsuit; state facts
- Show response to colleague or consulting attorney before submitting to Board – if lawsuit, this Response will help attorney understand the situation to best defend you – be HONEST w/ attorney!
Avoiding Disciplinary Complaints to Board or Malpractice Lawsuits

IMPORTANT:
- Practice within your competency and with the utmost respect for your clients!
- Participate in regular clinical and ethical consultation groups.

Checklist - TO AVOID COMPLAINTS OR MALPRACTICE LAWSUITS:

1. Review ALL office forms to ensure that all policies for billing, canceling, and rescheduling appointments are clearly explained and DISPLAY Professional Disclosure statement if your state requires display (make sure to keep it updated).

2. Incorporate client consent to release records for fee collection.

3. Include paragraph at end of form stating that client has had opportunity to ask all questions before signing – then have signature after sentence that specifies agreement to the terms/conditions contained in Office/Billing Policy Form.

4. Discuss billing, appointment policies, and reason for paying at beginning of each session with client at end of first session – important to include a time for “business” discussion in intake session to let client understand your expectations and have a chance to seek clarification on policies: “Therapy is an important investment of time and money.” [DH]

5. Consult legal counsel for questions to sticky situations or to write response if disciplinary complaint or malpractice lawsuit is received. Better NOT to write response for yourself, but can sign letter that lawyer ghost-writes.

6. Differentiate between functioning as a therapist and any other role; for example, as a custody evaluator – DO NOT MIX ROLES!

Why? Therapist of child cannot ethically make recommendation re: custody or visitation issues unless he/she has conducted an extensive evaluation of both parents and homes. Mixing roles can lead to ethics complaints.
THE END ~ ~ ~    :-)

Henson, Deborah M. “Legal & Ethical Issues in Clinical Practice: Protecting Yourselves and Your Clients” in Louisiana Association for Clinical Social Workers Newsletter, Fall 2008. [article enclosed in this Manual]


Legal & Ethical Issues in Clinical Practice:
Protecting Yourselves and Your Clients

By: Deborah M. Henson, MSW, LCSW, JD, LL.M.

PART ONE:

The clinical office is more likely than ever to be invaded these days by various aspects of litigation: subpoenas for records, for depositions or for the therapist to testify at trial, or due to a disciplinary complaint or malpractice lawsuit. Sometimes our clients want us to comply with demands for their records, but other times they refuse to authorize us to release their confidential information. Worse yet, sometimes clients bring professional malpractice suits against therapists and/or file ethics complaints with licensing boards. Responding ethically and professionally to lawyers’ demands for confidential information is not taught in most graduate programs, nor is defending oneself if a disgruntled client files a suit or complaint.

The Louisiana State Board of Social Work Examiners’ web site - socialwork@labswe.org – is the source for the rules and regulations of our profession. Most of us, however, do not regularly peruse the forms that govern our practice, but for reference, they are: (1) the Louisiana Social Work Practice Act, enacted in 1972 and amended periodically, and (2) the Rules, Standards, and Procedures. These publications instruct social workers, including clinical practitioners, on the standards by which we will be held accountable when and if clients complain to the Board.

When lecturing in the area of legal and ethical issues of concern to clinical social workers and other mental health disciplines, the most common areas of concern are as follows: (1) how to ethically respond to subpoenas if clients do not give permission to release the confidential material compelled; (2) what are some of the high-risk situations
that can precipitate client licensing complaints and/or malpractice suits, and how to practice ethically and self-protectively in this increasingly litigious society; and (3) how to respond (and how not to respond) to licensing board complaints and/or malpractice lawsuits. The next newsletter will explore two “tips” regarding subpoenas and disciplinary complaints or malpractice lawsuits to help clinicians avoid the latter nightmares.

PART TWO:

Last month I introduced the subject of legal and ethical issues that may arise in clinical practice. I mentioned that the following month would discuss some tips for best practice to protect the therapist and the client, while attempting to avoid licensing board complaints or malpractice suits.

The following “tips” do not cover these broad topics, by any means, but are offered as a primer for further thought and discussion among colleagues. Additionally, they are offered in the hopes that one or two busy clinical social workers might have a ready response, or at least know where to turn for some consultation in the event that he or she receives a subpoena, board complaint, or petition for malpractice.

**Some Tips to Avoid Licensing or Malpractice Problems:**

1. **Subpoenas**

   If you receive a subpoena for records or testimony, always attempt to gain the client’s written permission to release the records or to provide the testimony. Lawyers will tell you that you do not have to do so – that the subpoena is a court order. It is not a court order. The “court” refers to a judge and unless a judge orders you to release the records or
your testimony, best practice procedure is that you must always invoke the privilege of confidentiality on the part of your client if the latter does not want to give you permission to release records or testify. This means that you **resist** releasing the subpoenaed records or testimony.

What does “resistance” entail? It can start with a letter to the attorney who sent the subpoena (better than making a telephone call – you want to have a paper trail of your efforts to protect client’s confidences) and continue with a court appearance or even an appeal of a trial court order to release records or testify, if you think that such divulging of client’s material is dangerous or if the client continues to deny permission for you to divulge. The point is this: confidentiality of client-therapist communications is the most highly prized tenet of our profession; it is what helps clients open their hearts and souls to us in an effort to reduce their suffering. My belief, which also happens to be enshrined in Louisiana (and most other states’) laws, is that despite the lawyers’ desire to obtain confidential information in the midst of litigation, our duty is to protect our clients’ confidences above all – if the client wants us to do so.

Keep in mind that most subpoenas are issued in furtherance of our clients’ goals, to some degree, and generally they want us to testify or release the requested records. But, imagine the nasty custody battle wherein one spouse wants to use the therapy information of the other spouse against him/her for the purpose of further disrupting the family. As you know, these cases can become horrible battlegrounds with everyone involved suffering greatly. Therapists can, unfortunately, become embroiled in these battles despite their wishes and it is these high-risk situations (as one example) that can result in licensing board complaints and/or malpractice actions against the well-meaning therapist.
In sum, do not ever ignore a subpoena, but also do not just immediately produce the requested information without thinking through the procedures – unless you have the client’s permission (those are the typical situations and, obviously, the easy ones). Remember: it is always better to have a written release of information form to produce if you find yourself defending an alleged breach of client confidentiality lawsuit or complaint in court or before the licensing board.

2. **Client Complaints or Malpractice Actions**

If you receive a licensing board complaint from a former client, or a malpractice action, do not respond immediately. Most therapists whom I have represented in these matters feel so hurt and anxious that emotions run high and the universal tendency is to become defensive and, perhaps, overreact. Only being able to give general guidance in this brief article, the one constant piece of advice that seems to work across the board is to give the matter some time to settle before responding.

Also, consider consulting some trusted colleagues or a mental health attorney to review the allegations before sending in a response to the board or answering the petition. In general, I recommend to participants in my trainings that clinicians who practice in any high-risk areas (e.g., family, children, custody evaluations, borderline and other acting out personality disorders) should have an ongoing litigation consult group of other clinicians who also have high-risk clients. Staffing these cases can help protect the treating therapist when and if the stuff hits the fan. These colleagues must be willing to assist each other in testifying, if needed, concerning the treatment decisions, the group’s advice and guidance, and the treating therapist’s continued efforts to operate within a “best practice” framework; that is, treating the client within an ethical and clinically competent context.
ADDENDUM

Case Studies of Malpractice Suits Against Clinicians

Assembled by Deborah M. Henson, LCSW, JD, LL.M.

Social Workers:

November 2007 Legal Case Study

Man claims improper treatment of young daughter led to unfounded claims of sexual abuse of daughter by him, resulting in inability to bond with daughter and have good relationship — Defendant claims man’s problems in relationship was his own substance abuse — $350,000 net verdict.

The plaintiff’s daughter began seeing defendant, a licensed clinical social worker, at the age of two years and nine months. The girl’s parents were divorcing at that time. The treatment ended in 4 years later. Shortly after treatment began, the plaintiff was accused by his estranged wife of sexually abusing the child as a result of a statement allegedly made by the child.

The child was taken to a pediatrician and the information was reported to state officials as required. Within two to three months after the initial accusation, the defendant social worker testified at a deposition for the divorce that he believed that the plaintiff had sexually assaulted the daughter. The sexual abuse investigation by the state was closed as "unsubstantiated."

The plaintiff alleged negligence by the social worker in the treatment of his daughter, which resulted in him being unable to have normal visitation rights and opportunities to develop a healthy relationship with his children. The social worker asserted that there was no negligence and that the plaintiff’s abuse of substances prior to separating from the child’s mother was the cause of a failure to bond with his child. The social worker also claimed that the plaintiff continued to abuse substances after he was allowed to reunite with his daughter.

According to a report, a jury returned a $500,000 verdict, finding the plaintiff thirty percent at fault and the social worker seventy percent at fault.

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October 2006 Legal Case Study

The plaintiff’s decedent, age nineteen, dropped out of college in January 1998, returned home and sought counseling for depression. Over the next three months she was seen by five different therapists, including a psychiatrist, two social workers and a psychologist. The decedent received medical management from the psychiatrist and was sent to social workers and psychologists for counseling. After the psychiatrist prescribed Paxil, she was seen by one social worker thirteen
times before switching to a second social worker. After one session with this social worker, she switched to a psychologist.

In late May 1998 the decedent’s father came home to find her dead from hanging. The plaintiff alleged negligence in the failure to recognize warning signs of suicide and take proper actions. The plaintiff pointed to notes by the second social worker mentioning a previous suicide attempt, with no action being taken. The plaintiff also claimed that the psychologist, the last therapist to treat the decedent, failed to read the decedent’s diary, which referenced a desire to die. The defendants claimed that there was no negligence and also that the decedent was contributorily negligent. The therapists claimed that the decedent was not forthcoming with her suicidal thoughts or the severity of her emotional duress and that her father failed to relay important information regarding her suicidal tendencies.

According to a published account, a $1.1 million settlement was reached, which included contribution for the psychologist and both social workers.

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Counselors:

December 2008 Legal Case Study

The plaintiff, age fifty-three, was diagnosed with bipolar disorder and prescribed Risperdal by her treating psychiatrist. In January 2003 the plaintiff was seeking treatment for alcohol abuse with the defendant, an independent counselor. The plaintiff claimed that the defendant told her she needed to be “drug-free” to work with her, which included prescription medication. This caused the plaintiff to cease taking the Risperdal, resulting in a manic episode.

The defendant denied advising the plaintiff to stop taking the medication and argued that the plaintiff had a longstanding history of failing to take medication prescribed by her psychiatrist.

According to a published account a defense verdict as returned.

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April 2006 Legal Case Study

Plaintiff presented to Therapist A for therapy for decreased marital sex life following a rape. The therapist diagnosed plaintiff as having a Borderline Personality Disorder, and this diagnosis was subsequently confirmed by a consulting psychiatrist after plaintiff began exhibiting disassociative symptoms. Plaintiff was then assigned to defendant therapist (Therapist B), who was serving his residency under Therapist A preparatory to qualifying for his license. Therapist B diagnosed plaintiff as having Multiple Personality Disorder and allegedly undertook regressive
memory therapy through hypnosis, allegedly creating false memories of childhood sexual abuse by her father and brother, satanic ritual abuse, and physical abuse by her parents. Plaintiff further alleged that this resulted in iatrogenic or "therapist-induced" Multiple Personality Disorder, with the creation of thirty-six distinct personalities.

After Therapist B left Therapist A's practice, the plaintiff continued treatment with Therapist B, where he started his own practice. Plaintiff, through one of her alter personalities, claimed that sexual contact took place, although plaintiff's core personality had no recollection of any sexual exploitation. Defendants denied implanting false memories through hypnosis and denied that any sexual contact occurred.

Defense contended that plaintiff was hospitalized for mental problems over thirty times since adolescence (for as long as eleven months at a time), that Therapist A was the forty-first therapist that the plaintiff had seen, and that Therapist B was the third treater accused of sexual impropriety without evidence. Defense argued that the plaintiff had Factitious Disorder and had a long and significant record of false histories, inconsistent symptoms, and psychosomatic complaints. Defendants asserted that the plaintiff's disassociation was delusional and that plaintiff's manifestations of alleged alter personalities were episodes of psychosis stemming from her underlying schizophrenia, due in part to her refusal to take any medication.

Defendants claimed that the plaintiff had been disassociating since the age of fourteen, that she presented to Therapist A with seven personalities already, and that the defendants did not engage in regressive therapy but were attempting to make a definitive diagnosis. Defense counsel reports that at the time of plaintiff's testimony, the court swore in plaintiff's core personality as well as her thirty-six alleged alter personalities; over defendant's objection, the court allowed testimony by the alter personalities at trial subject to competency examinations of the individual alter personalities as they emerged and subject to cross examination (however, one of plaintiff's alter personalities emerged during direct examination but failed to appear/testify under cross).

According to the report, the jury awarded a verdict for $540,000 as to both therapists. The jury returned a verdict for the defense as to Therapist B on psychologist sexual exploitation count.

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**April 2005 Legal Case Study**

The plaintiff, a thirty-eight year-old consultant, contended that the defendant registered professional counselor, Dr. Deborah Gillham, provided counseling services to the plaintiff, and these services included both traditional psychotherapy and alternative modalities, including a technique called "HBLU" ("Healing from the Body Level Up") and body "energy" work. During the one-year period of treatment, the defendant and the plaintiff freely socialized outside of therapy, individually and in the company of their husbands, and ultimately the defendant developed a romantic, and then a fully sexual, relationship with the plaintiff's husband. The plaintiff and her husband then separated, followed by divorce.
The plaintiff then reported the defendant counselor's misconduct to the Department of Health licensing agency. Following investigation, the Department suspended the defendant's registration to practice as a counselor in the State of Washington for a period of three years - but the suspension was initially stayed on certain conditions. The plaintiff alleged complex and severe emotional distress as a result of the defendant's destructive actions - including sleep disorder, nightmares, intrusive thoughts, loss of appetite, suicidal ideation, and a profound sense of painful betrayal.

In this action, the plaintiff offered a pre-filing settlement mediation, which was rejected. The defendant was uninsured. The plaintiff then filed suit contending professional counseling malpractice.

The defendant filed a counter-claim, contending defamation, tortuous interference with business expectancy, intentional and negligent infliction of emotional distress, etc. The plaintiff required the defendant to undergo a CR 35 independent psychological evaluation on her counter-claims. The plaintiff also moved for summary judgment on the defendant's counter-claims. Summary judgment was granted in this regard in favor of the plaintiff. Such judgment was granted before the CR 35 evaluation process was complete (but after revealing psychometric testing was performed and released).

The defendant refused to admit liability. Pre-trial mediation failed. One week before trial, both the plaintiff and defendant agreed to waive the jury. After the plaintiff had rested and the defendant's case had begun, the defendant personally made ex-parte contact with the Court without her attorney's knowledge, and also left a voice mail message contending that she felt her attorney was impaired due to health reasons. Two separate hearings were held. The defendant's counsel was determined not to be impaired, but he was permitted to withdraw from her representation pursuant to RPC 1.15(b)(5). The defendant's motion for trial continuance was denied, and the trial was completed with the defendant acting pro se. Result of the bench trial was a plaintiff verdict for $125,000. The defendant's pro se motion for new trial was denied.

Terri Fincham v. Deborah Gillham, Ph.D., King County (WA) Superior Court, Case No. 01-2-07393-1SEA. Christopher E. Young and Matthew G. Knopp, Peterson, Young and Putra, Seattle, WA for the plaintiff. William Mays, Williams, Kastner and Gibbs, Seattle, WA counsel for the defendant for the first five days, after which the defendant proceeded pro se.

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Psychologists:

**June 2009 Legal Case Study**

The defendant psychologist was hired by a law firm to consult regarding the plaintiff’s decedent. The decedent was one of the law firm’s partners whom they believed had a serious alcohol abuse problem. The defendant was present during a meeting with the decedent. Several hours after the meeting, the decedent became intoxicated and committed suicide with a self-inflicted shotgun wound.
The plaintiff alleged that the defendant psychologist and the decedent had formed a tangible doctor-patient relationship, and that the defendant’s conduct during the meeting did not meet the standard of care, resulting in the suicide death only hours after seeing the defendant. The plaintiff’s experts argued that even though there was no contract between the defendant and the decedent, the defendant psychologist owed a duty to the plaintiff.

The defendant contended that he was a consultant to the law firm only, and never had a defined treatment relationship with the decedent. Additionally, the defendant claimed that he met the standard of care and that nothing he did or failed to do contributed to the decedent’s independent decision to commit suicide.

The defendant’s experts testified that the decedent’s suicide death was caused by the decedent’s own independent and willful actions, and that this action was not foreseeable.

The jury returned a defense verdict, according to a report.

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October 2004 Legal Case Study

This claim arose from negligent acts and omissions of the defendant psychologists, family medical doctor, and nurse practitioner, and focused on improper outpatient treatment of depression and recurring suicidal ideations. The decedent had been treating with the defendant psychologist for several problems. The plaintiffs alleged the psychologist failed to properly manage and stabilize his depressed and potentially suicidal patient.

The defendant referred the decedent to the defendant family practice physician, who negligently failed to properly treat or refer his patient, who admitted having recurrent suicidal thoughts. Further, the family practice doctor told his depressed patient with suicidal ideation that there may not be a medical "fix" for her symptoms, causing her to lose hope and become even more entrenched in depression and despair, and more suicidal. The decedent reported experiencing "crazy suicide thoughts." The defendant family doctor took essentially no action.

After a particular long bout with severe headaches, the decedent presented to the family practice clinic and was seen by the defendant nurse practitioner, who failed to review the patient's prior chart notes, and also failed to follow-through on the commitment made to the patient to advise the doctor that the patient had quit taking all of her medications. All defendants failed to perform structured suicide risk assessments.

The decedent died by self-inflicted gunshot wound thirteen days after the last office visit. Claim was brought on behalf of her estate, surviving spouse, and one disabled adult child. A $350,000 settlement was reached.

November 2003 Legal Case Study

Leslie Sartori, a forty year-old married nurse who was a private patient of a treating psychologist, alleged that the defendant psychologist breached her confidentiality by telling others about one of their conversations. The defendant's psychology office was located next to a horse barn on her property.

The plaintiff had an appointment at the defendant's office, and during the appointment the defendant allegedly walked out of the office and into the horse barn, where the plaintiff allegedly observed the psychologist talking with visitors in the barn about what the patient had been discussing. This violated her confidentiality, breached the trust of the privileged relationship, humiliated her, and aggravated her pre-existing psychological condition. She sought non-economic damages for loss of reputation.

The defendant denied the allegation, testifying that the plaintiff was a difficult patient, and she never divulged privileged information regarding the plaintiff's treatment with visitors at her property. The defendant argued that anything that was said during treatment sessions, and in an adjoining interior space, was within the bounds of propriety.

The jury returned a defense verdict, determining that the defendant had not communicated any confidential information. Plaintiff's Experts: Mary C.; Reed, Ph.D., psychology, Grosse Pointe, MI. Michael Abramsky, Ph.D., psychology, Birmingham, MI. Leslie Sartori v. Darlene Stieber, Oakland County (MI) Circuit Court, Case No. OI-O32180-NM. William S. Stern, Southfield, MI for the plaintiff. Lawrence J. Acker, Bloomfield Hills, MI for the defendant.

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Avoid Ethics Complaints & Malpractice Lawsuits

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At the completion of this seminar, I have been able to achieve these seminar objectives:

1. Identify high-risk clients and situations that expose clinicians to disciplinary complaints and/or malpractice lawsuits.
2. Anticipate clinical situations that foreshadow legal involvement for clinicians.
3. Implement office management procedures to reduce the risks of complaints or lawsuits.
4. Respond ethically to subpoenas when clients refuse to authorize release of confidential information without precipitating complaints/lawsuits against the clinician.

**If there are no additional objectives above, please select "not applicable"