SEQUENCE X

PERPLEXING PROBLEMS IN PSYCHOLOGICAL PRACTICE (P^4): DECISION SCIENCE, ETHICS, & RISK MANAGEMENT

6 Hours CE Credit

Agenda	**Slides**
Introduction & Overview	1 – 9
Heuristics, Biases, and Ethical Decision-Making	10 – 52
(Break)	
Interjurisdictional Practice	53 – 83
Technology Challenges	84 - 120
(Lunch)	
Technology Challenges (cont.)	84 - 120
Supervision	121 - 141
(Break)	
Subpoenas and Depositions	142 – 178
Wrap-Up	179 – 183

SEQUENCE X

Perplexing Problems in Psychological Practice:
DECISION SCIENCE, ETHICS, & RISK MANAGEMENT

THE TRUST

Agenda

- Introduction/Overview
- Heuristics, Biases, & Decision-Making

Break

- Problem 1: Interjurisdictional Practice
- Problem 2: Technology Challenges (Begin)

Lunch

- Problem 2: Technology Challenges (Continued)
- Problem 3: Supervision

Break

- Problem 4: Subpoenas & Depositions

Learning Objectives

1. Describe basic principles of risk management, as applied to several specific clinical situations that frequently arise in professional practice;
2. Identify core heuristics and biasing processes that can interfere with appropriate risk management and ethical decision-making;
3. List three strategies to ameliorate decision-making challenges;
4. Describe preliminary considerations prior to engaging in interjurisdictional practice;
5. Identify three methods for reducing privacy risks when using technology in clinical practice, and responding appropriately to breaches if they occur; and
6. Evaluate potential issues and preventive responses to supervisory risks;
7. Name three strategies for handling subpoenas and deposition demands.

Primary Risks to Psychologists

- Licensing Board Complaint
  - High incidence
  - High consequence
- Malpractice Suit
  - Low incidence
  - High consequence
- Ethics Complaints
  - No insurance coverage
  - Public expulsion - only consequence
- Internet Reviews
- Insurance audits
- Contracts and employment issues

The Trust Risk Management Program

- www.trustinsurance.com
  - Sample documents and templates
  - Education Center: Resources and articles
- *Assessing and Managing Risk in Psychological Practice*
- Workshops and webinars
- Advocate 800 Consultation Service
  - (800) 477-1200
- Policy enhancements
  - Deposition representation
  - Regulatory coverage (e.g., HHS, Medicare investigations)

The Trust Risk Management Team

Leisl Bryant, PhD, ABPP

Julie Jacobs, JD, PsyD

Joe Scroppo, PhD, JD

Dan Taube, JD, PhD

Amanda Zelechoski, JD, PhD, ABPP

Emeritus: Eric Harris, EdD, JD; Jeffrey Younggren, PhD, ABPP

What is Risk Management?

"Life can only be understood backwards; but it must be lived forwards."

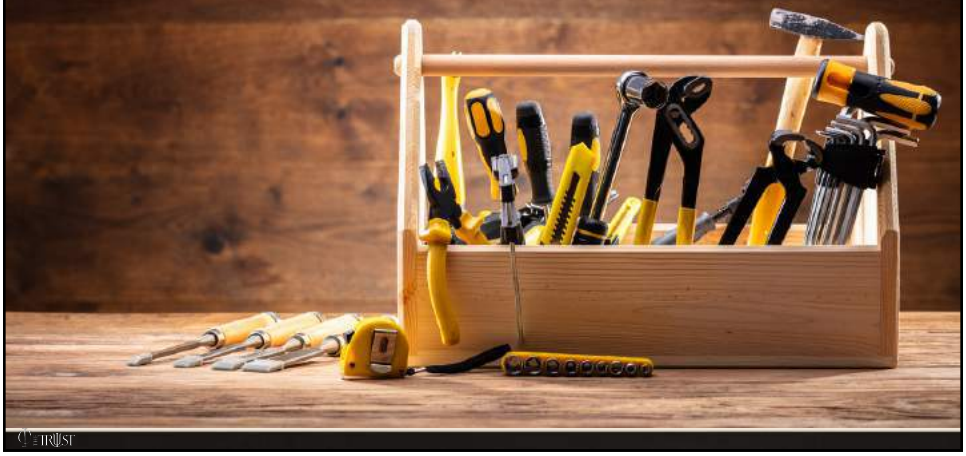
-Soren Kierkegaard

The prospective assessment of retrospective evaluation

What is Risk Management?

- Informed Consent
- Documentation
- Consultation

- Client Risk Factors
- Situational Risk Factors
- Clinician Risk Factors



HEURISTICS, BIASES, AND ETHICAL DECISION-MAKING

Case A

Mr. Finley

Dr. Jones

Reactions

- What kinds of emotional reactions might you feel at this point, if you are Dr. Jones?

Feeling the Decision

- There has been an explosion of research on the emotional elements of decision-making under uncertainty.
- "**affect heuristic**"
  - the assumption that valence (negative v. positive emotion) impacts how we make decisions (Slovic et al., 2002; Slovic & Peters, 2006)
- But…
  - this initial notion gave way some 35 years ago
  - to a more nuanced theory that different emotions (not just whether they were "negative" or "positive") would impact decisions in particular ways

Feeling the Decision

- Different emotions have related, evolutionarily beneficial "**action tendencies**"
  - This was first an intuitive idea, then was empirically supported (Fridja, 1987).
  - States of readiness to execute a given kind of action, [which] is defined by its end result aimed at or achieved. (p. 70)
- Action tendencies (e.g., toward approach, avoidance) would influence decisions
  - Not because the emotion was negative, per se;
  - Rather, because of its particular quality and ability to enhance adaptation to the specific context and social environment

Feeling the Decision

- Need to control external events
- Agonistic
- Actions to remove obstacles

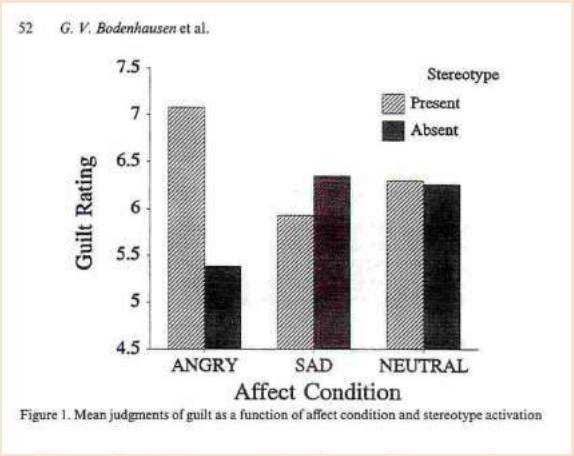
- Caution
- Inhibition of responses

Feeling the Decision

- Studies on the impact of the emotions on decision-making have shown some fascinating effects.
- Bodenhausen, Shephard, and Kramer (1994) did an early series of studies with the purpose of exploring:
  - whether different emotional states had differential effects on using stereotypes and heuristics.
  - the degree to which anger v. sadness v. neutral feelings affected peoples' use of heuristics and stereotypes when judging the behavior of peers

Feeling the Decision

The anger group, was significantly more likely to find the stereotyped defendant guilty as compared to the neutral or sad condition.



Bodenhausen, Shephard, and Kramer (1994)

Feeling the Decision

- Kouchaki and Desai (2015)
  - Series of 6 studies
  - Does anxiety have an impact on ethical decision-making?
- One sub-study was a classic experimental design
  - Participants were randomly assigned to the control (neutral) group or the experimental (anxiety) group…

Feeling the Decision

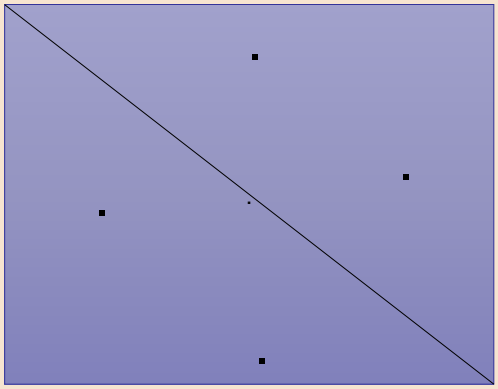
- Kouchaki & Desai (2015): NEUTRAL GROUP

Feeling the Decision

- Kouchaki & Desai (2015): ANXIETY GROUP

Feeling the Decision

- The participants were then asked to engage in a “visual perception task”



Feeling the Decision

- Across this and the other 5 studies, Kouchaki and Desai found (among other things) that:
  - Participants in the anxiety condition *LIED MORE FREQUENTLY*
- They suggested that this is because:

Feeling the Decision

- But…feelings are NOT the enemy!
- Damasio (1994)
  - damage to ventromedial frontal cortices → inability to feel, but fully retained cognitive functioning → still profound effects on rational decision-making ability
  - "**somatic markers**"
    - gut feelings
    - decisions based on quick, emotionally-laden assessments that are often tied to emotions from past (good/bad) experiences and outcomes

Feeling the Decision

- "Affect may serve as a cue for many important judgments." (Slovic et al., 2002)
- AFFECT = INFORMATION

How do you know that something is wrong, or potentially questionable or unethical?

But…Heuristics and Biases

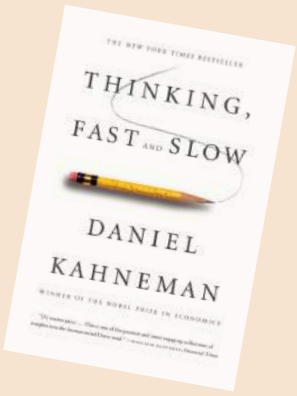
- The effects of our feeling states on decisions can be examples of mental shortcuts (heuristics) in judgment and decision-making.

Heuristics and Biases

- In addition to the *affect heuristic*, Kahneman, Tversky and others have identified many shortcuts in thinking, such as:
  - **Availability heuristic** (we're often biased by information that is easier to recall, and that have in our experience, occurred together)
  - **Anchoring** (basing decisions more heavily on initial estimates, even if far off or irrelevant, without sufficient adjustments for new/other information)
  - **Representativeness** (relying on how similar a new event is to an old group of events—often without considering base rates or sample sizes)
  - **Confirmation bias** (the tendency to seek evidence to confirm preconceptions, and to under emphasize information that contradicts them)

Thinking Fast and Slow

- Daniel Kahneman (2011)



System 1

- Fast, intuitive, emotionally reactive
- Evolutionarily essential
- Subject to many biases
  - Does not handle novel situations or complexity well
  - But, with practice and accurate, timely feedback, expertise and accuracy can develop

System 2

- Effortful, slow, deliberative, logical, self—aware
- Comes into play when situations are more complex
- "Supervises" System 1 intuitions
  - (Kahneman & Frederick, 2002)
- But…System 1 reactions *strongly* influence System 2 processes

What's all this have to do with ethics?

- Ethical conflicts and situations that involve risk are, by definition, uncertain
  - Increases likelihood of System 1's inherent biases influencing judgment
- These decisions also tend to trigger a variety of emotions:
  - e.g., anxiety, annoyance, guilt, shame
- These emotions and intuitive responses can…
  - offer direction, action tendency, embodied knowledge and awareness of ethical issues
  - lead to significant errors in judgment

What's all this have to do with ethics?

- So, how do we reap the benefits of…
  - intuitive judgments
  - feelings
  - action tendencies
- …but not fall prey to their systematic biases?

- A difficult task
  - requires attention and effort
  - being distracted or "cognitively busy" can reduce our ability to use the data we already have

What's all this have to do with ethics?

Our traditional risk management approach has included:

- Conduct a conservative evaluation of your competence
  - Intellectual competence
  - Technical competence
  - Emotional competence
  - Cultural competence
- But…how accurate are we when doing so?

What's all this have to do with ethics?

- Superiority bias (Hoorens, 1993)
- McCormick et al. (1986)
  - 189 drivers surveyed and asked to rate their comparative driving skills
  - 80% said they were above average

- But this does not apply to highly trained clinicians, does it?

What's all this have to do with ethics?

- Walfish et al. (2012)
  - Surveyed 129 mental health professionals
  - No participants rated their skills as below average
  - 75th percentile was modal rating
  - 25% rated their skills at the 90th percentile or above
- We likely tend to overestimate our skills and competencies, like everyone else.

What's all this have to do with ethics?

- "De-biasing" in our decision-making processes, and engaging in accurate self assessment processes, are easier said than done
- **But,** efforts in that direction are essential in addressing ethical problems and choosing appropriate courses of action in risky situations, like the one in which Dr. Jones found himself
- There are a number of strategies that have been proposed…

Slow Down

- Even when we feel the press to act quickly…

"Festina Lente"

(Make Haste Slowly)

- Slowing down allows for System 2 engagement

Slow Down

- When we encounter challenging **situations** or **patients** that pose a greater risk, a critical initial step is to take time, and actively slow things down, so as not to give in to the press of immediacy
- Exceptions?

High-Risk Patients Triggering "*Festina Lente*"

- Cluster B Personality Disorders (Borderline/Narcissistic/Antisocial)
- Dissociative Identity Disorder (DID/MPD)
- PTSD (complex)
- Patients who were abused as children or are in abusive relationships
- Potentially suicidal patients
- Potentially violent patients
- Patients involved in unrelated lawsuits
- Patients with recovered memories of abuse

High-Risk Situations Triggering "*Festina Lente*"

- Child custody-related cases
- Third party evaluations
- Supervision
- Isolated, vulnerable, or narcissistic therapists
- Excessive positive or negative counter-transference
- Attractive or wealthy patients

Slow Down

- Keeping these patients and situations on our radar can help initiate a deliberative process
- So can staying abreast of current ethical principles, standards, and evolving issues
- Techniques for slowing down:
  - Consultation
  - Documentation/record-keeping
  - Using a structured decision-making model

Slow Down → Consultation

Benefits:

- Requires us to describe the situation which, in itself, makes us slow down enough to articulate our concerns
  - Helps "cool" hotter emotions
  - Provides opportunity to reflect on our feelings and action tendencies – and their possible (good/bad) consequences
  - Allows for an increase in the deliberate integration of ethical principles and standards of care
  - AND, we get to borrow other people's pre-frontal cortex for a bit
- Challenges and barriers?

Slow Down → Consultation

- Consultation as forum for ongoing skill development
- It's difficult for clinicians to get accurate, timely feedback on effectiveness
- Even if we do get feedback,
  - it does not necessarily translate into improvements (Tracey et al., 2014)
  - there's some evidence that we may LOSE some effectiveness over time (Goldberg et al., 2016)
- ***But…all is not lost.***

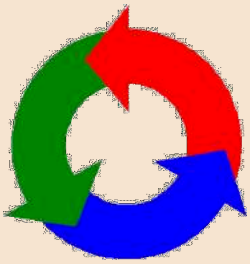
Slow Down → Consultation

- Goldberg et al (2016)
  - 7-year case study at a clinic evaluating whether clinicians can improve their skills and get better outcomes over time
  - They found that clinicians COULD get better over time if:
    - we get regular **feedback**
    - AND **routine consultation** about challenging cases, with a focus on fostering the ***alliance***, client engagement, and client goals,
    - AND engage in **rehearsal/practice** of relevant approaches

Slow Down → Consultation

- Focus on the ***alliance***
  - Protective factor against complaints/lawsuits
- Education, communication, and engagement with patients around negative outcomes reduce the risk of malpractice claims
  - e.g., Hickson et al., 1992; Kachalia et al., 2018; Levinson et al., 1997; Kohn, Corrigan, & Donaldson, 2000
- So, communication, a focus on relationship quality, and taking patient complaints seriously are critical

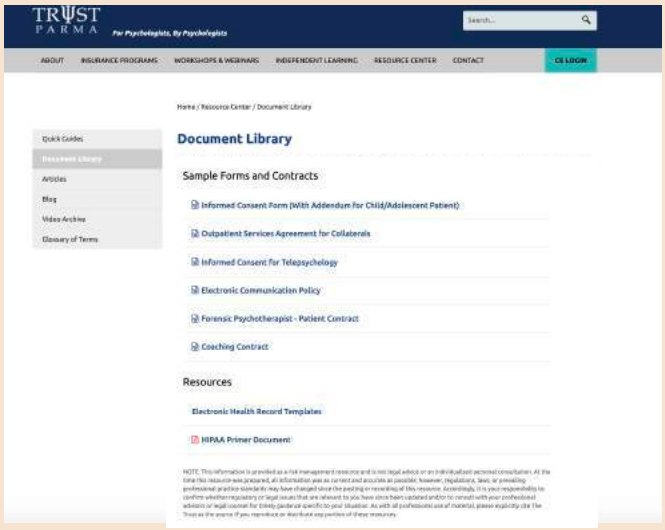
Slow Down → Informed Consent



What is it?

- Informed consent process is a platform for setting the frame for the relationship
- It can also help to reduce surprises and uncertainty

Slow Down → Informed Consent



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

Slow Down → Documentation

- Documentation/record-keeping is another way to slow down and engage System 2
- It is a critically important risk management strategy
- Requires at least some reflection on:
  - Evaluations and assessments we have completed
  - Actions we have/have not taken
  - Actions we are considering

Slow Down → Documentation

- Example: high-risk patient becomes increasingly suicidal after the disruption of an important relationship

- Eric Harris RM Note:
  - Use a structured assessment method
  - Document questions and responses about risk and protective factors
  - Provide a rationale for how the assessment/data support the chosen course of action

Slow Down → Decision-Making Model

- Structuring the decision-making process can also help us slow down
- There are numerous models, such as:
  - Hill et al. (1995)
  - Kitchener (1984)
  - Knapp & VandeCreek (2012)
  - Koocher and Keith-Spiegel (2016)
  - Pope & Vasquez (2016)

Slow Down → Decision-Making Model

- Knapp, Gottlieb, & Handelsman (2015) - **Five Step Model**:
  1. "Identify or scrutinize the problem"
     - e.g., is it a conflict between values?
  2. Develop alternatives or hypothesize solutions
     - including getting input, involving patients, reflection, consideration of non-rational factors, as detailed earlier
  3. Analyze and evaluate alternatives
     - consider which principles may take precedence, and try to reduce harm caused by possibly violating other principles
  4. Implement the decision
     - "act or perform;" engaging in an effective course of action
  5. Evaluate the outcome
     - "look back"

Case A

Mr. Finley

Dr. Jones

Decision Science and Risk Management

To summarize:

- Make haste slowly
  - Especially when it comes to patient dissatisfaction
- Consult
- Use a collaborative informed consent process
- Document well
- Routinely obtain and reflect on feedback (assessing our own competencies and limitations)
- Use a structured decision-making process

INTERJURISDICTIONAL PRACTICE
"I'M LEAVING FOR COLLEGE"

Case B

Dr. Link

Bobby

Case B

Dr. Link

Case B

Dr. Link

Bobby

Case B

Dr. Link

THE TRUST

Potential Areas of Concern

- Clinical Issues
- Ethical Issues
- Legal Issues
- Risk Management Issues

Clinical/Ethical Issues

- Who is Dr. Link's client?
  - College coach?
  - Bobby?
  - Bobby's parents?
- What is Dr. Link's role?
  - Psychotherapy?
  - Coaching?
  - Consultation?
  - Combination of the above?

Clinical/Ethical Issues

- Is it coaching or psychotherapy?
  - ICF certification
- Regulatory problems for board
  - The Duck Test
  - Harris-Younggren Risk Continuum
    - Client's reasonable perception
    - Subject matter
    - Techniques
    - Client vulnerability
    - Marketing
- Billing insurance

Risk Management for Coaching

- Informed consent disclaimer
- Good case selection
- Competence
- Carefully documented rationale

- The Trust resources:
  - www.trustinsurance.com/Resources/Education-Center
  - Article: *"**The New Frontier of Coaching**"*
  - *"**Sample Coaching Contract**"*

Legal Issues

- Was Dr. Link practicing without a license?

- Where is Dr. Link advertising? Who does she reach?

- Scope of advertising on the internet

Legal Issues

- Regulation of professions is assigned to states, including:
  - Education and training
  - Privacy and confidentiality
  - Disciplinary procedures and perspectives
  - State may have specific requirements for intra-state Telepsych (e.g., CA)
- Where does a transaction take place?
  - e.g., the client is in Florida, the provider is in Montana, and they are using an Internet-based video chat program?
    - Where client resides?
    - Where clinician resides?
    - In cyberspace?

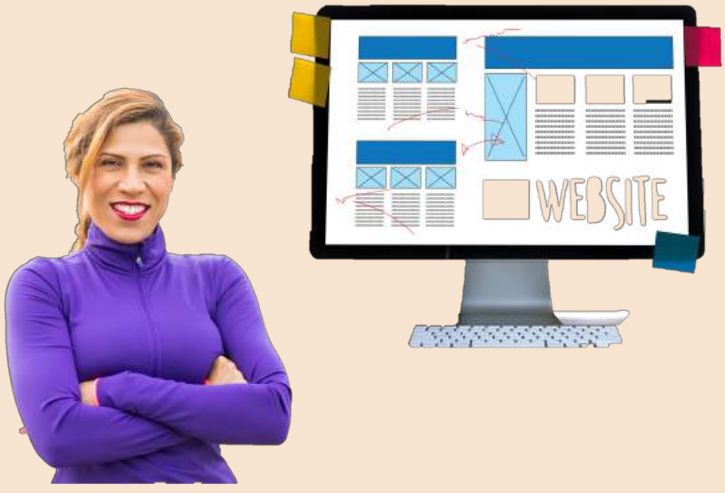
Legal Issues

- Many states have taken the position that the transaction takes place in the forum state (where the client is located):
  - But, state licensing boards will have difficulty with direct enforcement against clinicians not licensed by that board.
  - 48 states have temporary practice provisions.
- Still, much of the literature on this subject accepts that assertion about the forum state sufficiently to urge great caution in practicing across state lines.

Legal Issues

- **Minimum Contacts Test**
  - The courts have ruled on when the state can claim jurisdiction, and it can only do so when there is some commercial or legal connection, otherwise known as the *minimum contacts test,* and where the patient's rights to good treatment do not outweigh the potential and severity of any reasonably anticipated harm.

- ***Prince* v. *Urban*** (1996)
  - Is there a "systemic and continuing effort on the part of the doctor to provide services in the client's state?"



Dr. Link

Legal Issues

Psychology

- Efforts underway to promote and regulate interstate practice
  - ASPPB
    - Interjurisdictional Practice Certificate
    - E-Passport
    - PSYPACT
    - Model Licensing Law
  - APA
    - Telepsychology Guidelines

Legal Issues

Psychology Interjurisdictional Compact (**PSYPACT**)

- Interstate compact → enforceable contracts between states
- Goal is to develop agreements between states that allow the remote practice of psychology
  - Also permits temporary face-to-face practice in states that join the compact (30 days in a calendar year)
- Current status
- Barriers to overcome

ASPPB MOBILITY PROGRAM E.PASSPORT OVERVIEW

E.Passport Info

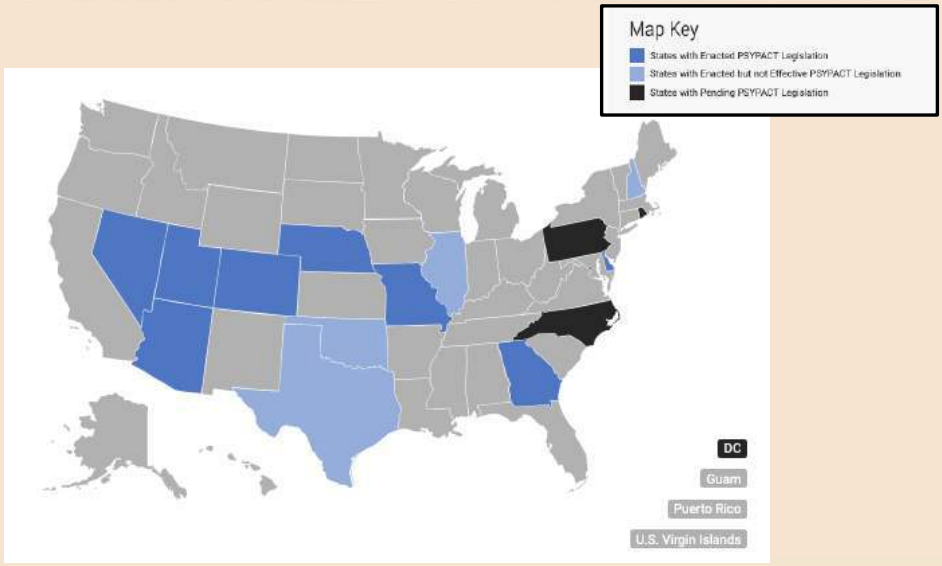
The E. Passport promotes standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across jurisdictional lines in jurisdictions that accept the E.Passport. The E. Passport also provides more consistent regulation of interjurisdictional telepsychology practice and allows consumers of psychological services to benefit from regulated practice.

Applying for the E.Passport

Application for the E. Passport can be made through the ASPPB Mobility Program. Eligibility requirements can be found on Page 2. Please make sure to read the ASPPB Mobility Program Policies and Procedures for a comprehensive look at the Mobility Program and certificate requirements.

Renewing the E.Passport

PSYPACT Status (as of September 2019)



Legal Issues

- Practitioners should be ***familiar with the laws in the forum state and abide by them to the extent possible***.
- And consider clinical, ethical, legal, and risk dimensions of this work

Legal Issues

Tentative conclusions:

- Even if a psychologist actively promotes services in an interstate manner, forum state licensing boards may be unable to gain jurisdiction unless a PSYPACT member state (though arguably, a court in that state could).
- Psychologists who actively market non-therapeutic services such as coaching, with appropriate disclaimers, appropriate case selection, and appropriate referrals when issues require therapy will also be safer, provided that their language describes what they actually do.
- Psychologists who provide services across state lines will be subject to review by ***their own*** state licensing boards.

Risk Management for Interjurisdictional Practice

1. The relationship between the psychologist and the client comes from **the client's initiative** and not as the result of the psychologist's attempt to advertise services interjurisdictionally or the psychologist's participation in a commercial enterprise that provides interjurisdictional services.

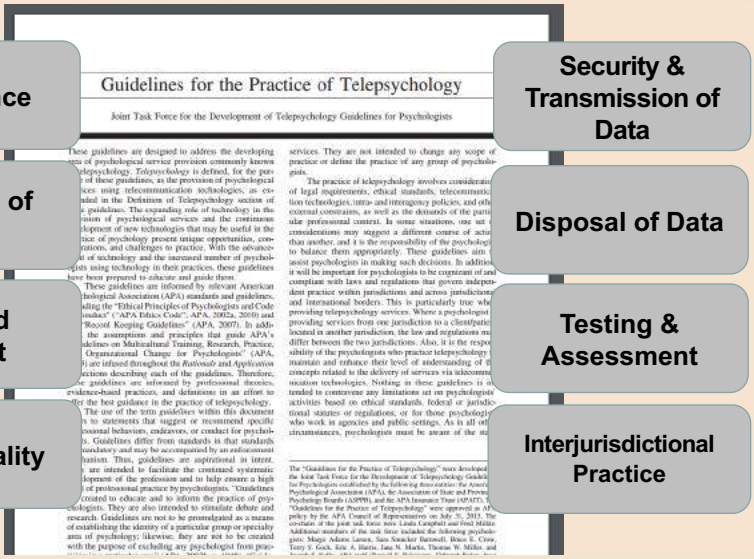
2. There is a clear **rationale** that providing services using telepsychology would be at least equal, if not superior, to those services which the client could receive through an in-person referral to a provider in the clients jurisdiction

Risk Management for Interjurisdictional Practice

3. The psychologist takes reasonable steps to ensure the **competence** of his or her work and to **protect clients and others from harm**. This means psychologists, at a minimum, are conversant and compliant with all of the [APA] telepsychology guidelines.

4. The psychologist has conducted a conservative **assessment** of the clients diagnosis, history, and risk level and determined that these factors do not contraindicate providing services via telepsychology.

APA Telepsychology Guidelines



- Competence
- Standards of Care
- Informed Consent
- Confidentiality
- Security & Transmission of Data
- Disposal of Data
- Testing & Assessment
- Interjurisdictional Practice

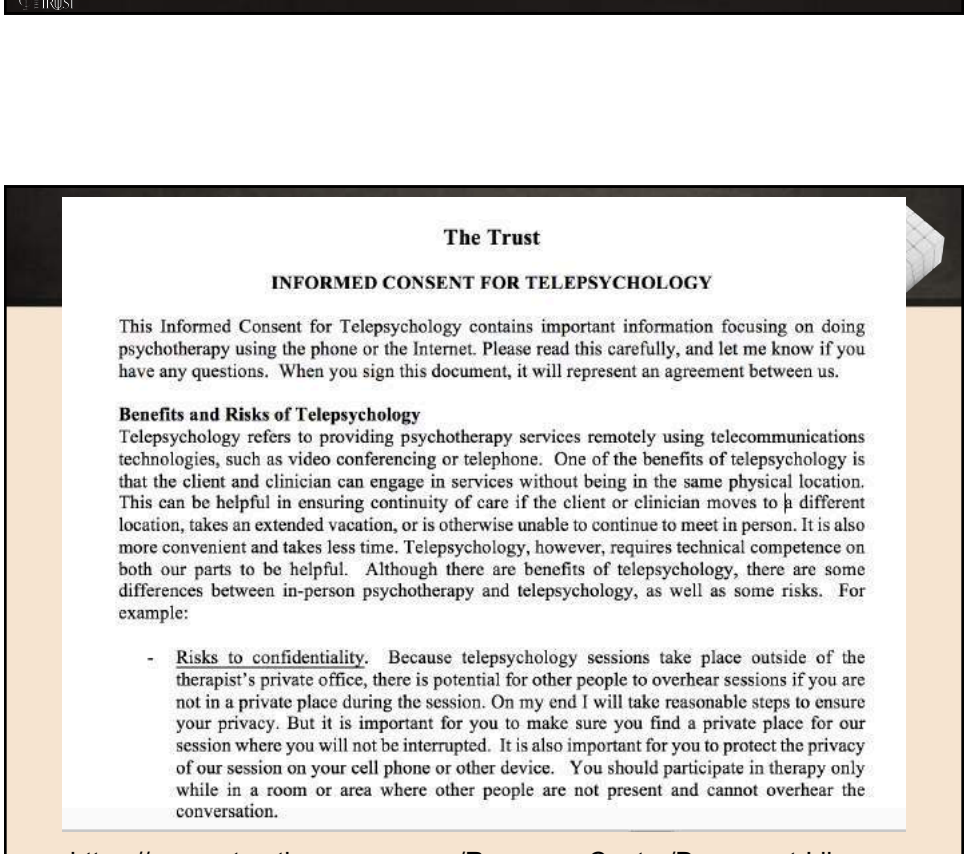
Risk Management for Interjurisdictional Practice

- Would the interjurisdictional practice be:
  - International
  - Domestic
  - Permanent
  - Temporary
  - Transitional period
- Are there temporary practice provisions in the client's jurisdiction?
  - Are there specific telepractice policies or requirements in this jurisdiction?

Risk Management for Interjurisdictional Practice

Additional considerations:

- Client suitability/clinical appropriateness
  - Clinical benefits v. risk
  - Efficacy
- Training/competence in the area
  - Technological competence
  - Clinical competence
- Informed Consent
- Confidentiality
- Preparation for emergencies
  - Safety concerns
  - Local resources available
- Service reimbursement



The Trust

INFORMED CONSENT FOR TELEPSYCHOLOGY

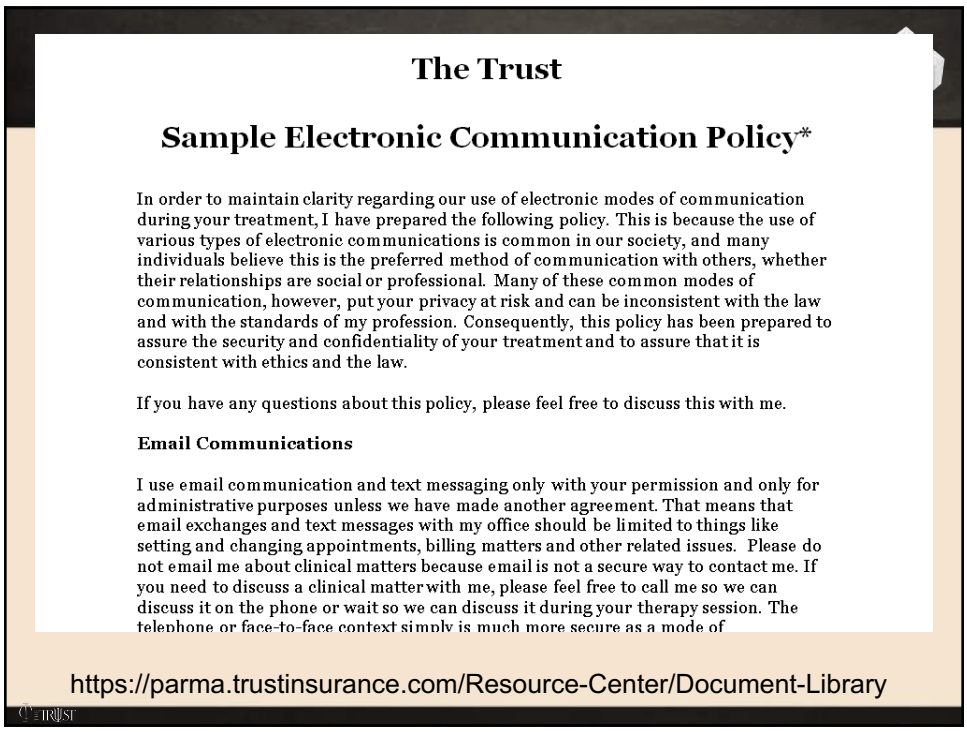
This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

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



The Trust

Sample Electronic Communication Policy*

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email Communications

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of

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

Risk Management for Interjurisdictional Practice

The Trust Coverage Policy

- Coverage for interstate psychological services for malpractice (if properly licensed) and licensing board complaints
- Coverage for coaching
- NO coverage for criminal prosecutions for unlicensed practice

Case B

Dr. Link

Bobby

Case B

- Would it make a difference if Bobby will be in:
  - A different part of Dr. Link's state
  - Another state
  - A different country
- What about if he will be there for:
  - 3 months
  - 1 year
  - Forever

Case B

- Would it make a difference if Bobby's diagnosis is:
  - Adjustment Disorder
  - Generalized Anxiety Disorder
  - Bipolar 2 with Borderline features
- What if your treatment approach is:
  - Existential
  - Psychoanalytic
  - Behavioral

TECHNOLOGY CHALLENGES

Case C

Dr. Connect

Ms. Mad

Potential Areas of Concern

- Clinical Issues
- Ethical Issues
- Legal Issues
- Risk Management Issues

Relevant Ethics Code Standards

- **EC 4.01:** A primary obligation to take reasonable precautions to protect confidentiality in any medium
- **EC 6.01:** Create and handle records to facilitate care, allow replication of research, ensure fiscal accuracy, and meet institutional/legal mandates
- **EC 6.02 (a):** Maintain confidentiality in all aspects of We maintain confidentiality in all aspects of record development, access, transfer, storage and in any medium.

HIPAA Regulations

Three general rules were imposed by HIPAA on covered entities:

- **"Final" Privacy Rule** (2013)
  - related to whom and in what circumstances providers can disclose protected health information about an identifiable patient
- **Security Rule** (2005; updated 2013)
  - related to steps a psychologist must take to protect ELECTRONIC confidential information (PHI) from unintended disclosure, destruction
- **Breach Notification Rule** (2009)
  - what CEs are required to do if PHI is accessed, used, or disclosed in violation of HIPAA

HIPAA Vocabulary

- Who has to comply?
  - Health care organizations and providers who send health care information in a "***covered transaction***"
- Covered Transactions
  - "...the transmission of information between two parties to carry out financial or administrative activities related to health care."
  - Includes e.g., information related to health claims, payment requests, online inquiries about benefit/plan eligibility, referral authorizations
- Covered Entity

HIPAA Vocabulary

- Protected Health Information (PHI)
  - "any individually identifiable info that is created or received by a health care entity that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual; or the past, present, or future payment for the provision for health care to an individual."
- Breach Notification Rule (BNR)
  - Breach: impermissible use, access to, or disclosure of *unsecured* PHI
  - Requires notification to patient(s) and possibly DHHS and the media

HIPAA Breach

- Can involve digital, hard copy, or oral information breaches for covered entities
- Does not need to disclose much
  - Identifying information (e.g., client name) that is related to health care (e.g., email re: therapy appointment time) would trigger the requirement
- "Secured" vs "Unsecured" PHI
  - **Secured**: encrypted or adequately destroyed
  - **Unsecured**: impermissible use/access/disclosure triggers BNR

Encryption

- "the use of an algorithmic process [a method of solving a problem with a limited number of steps or instructions] to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key"
- HHS wants us to "scramble" the records using programs that allow us to unscramble them with (usually) alpha-numeric keys.
  - (assuming, of course, that the key hasn't been stolen or discovered)

https://www.trustinsurance.com/Resources/Articles/ID/10/Choosing-Encryption-Software

HIPAA Security Rule

- Focuses only on electronically transmitted or stored PHI
  - Distinguished from **Privacy Rule,** which applies to **all PHI**
- Electronic transmission includes:
  - Internet, extranets, dial-up lines (not phone calls), computer-generated faxes (not traditional paper-to-paper faxes), private networks, and ePHI that is physically moved from one location to another

HIPAA Security Rule

Per DHHS, this rule was intended to:

1.Ensure the confidentiality, integrity, and availability of all e-PHI providers create, receive, maintain, or transmit

2.Identify and protect against reasonably anticipated threats to the security or integrity of the information

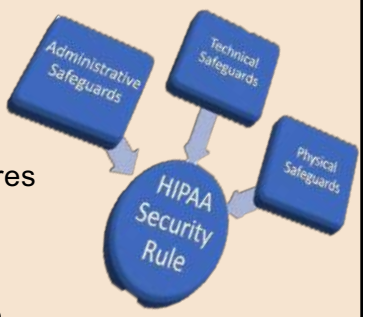
3.Protect against reasonably anticipated, impermissible uses or disclosures

4.Ensure compliance by their workforce

HIPAA Security Rule

Consists of 3 types of security safeguards:

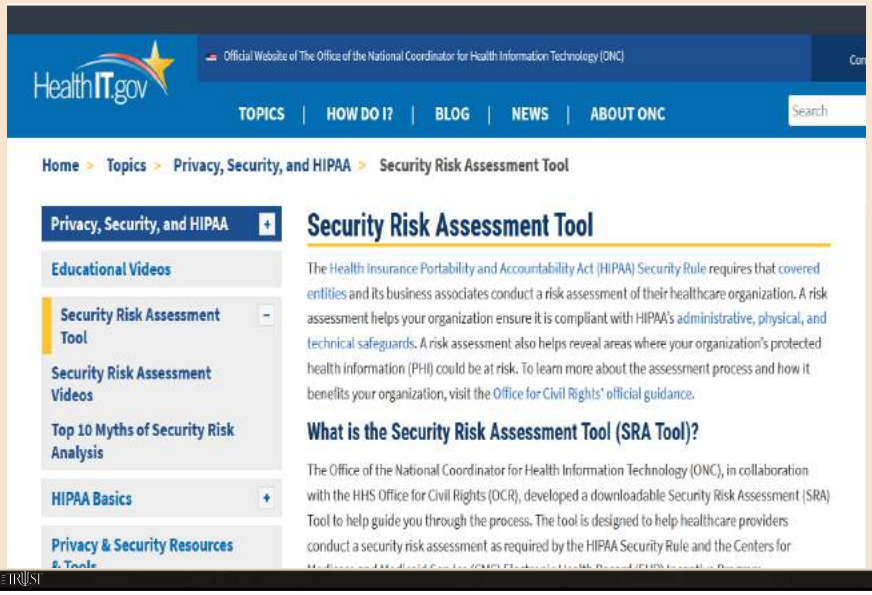
- **Administrative Standards**
  - Includes office policies and procedures for compliance, including training
- **Physical Standards**
  - Procedures for limiting access to the places where the information is stored
- **Technological Standards**
  - Technological requirements for protection of data (including backup systems)



Implementation Considerations

- Conduct a **documented risk analysis**
  - Confidentiality of ePHI
  - Integrity of ePHI
  - Information is not changed or altered or lost in storage or transmission
  - Availability of ePHI
    - Information is accessible to the appropriate people when needed
- Appoint someone who is responsible for security and compliance (for solo practitioners—it's you)
- Periodically review risk analysis policies and procedures, and modify as necessary.

Implementation Considerations



Example: Mobile Device

- **Assess what PHI could be developed, stored, sent or received on the device**
  - e.g., email, text, healthcare apps, contact lists, etc.
- **What are the risks of compromise of those data?**
  - Loss, theft, viewing by unauthorized people, interceptions, etc.

Example: Mobile Device

- **How likely are those risks, and what impact?**
  - Study by Consumer Reports found that 5.2 million smartphones were lost or stolen in the U.S. in 2014, the numbers may be decreasing, and what would be the impact?
- **What security controls can be used?**
  - e.g., secure email systems with device-based app; DO ENCRYPT YOUR DEVICES; secure remote erasure

Digital Communication

- Communication Methods
  - Voicemail
  - Websites
  - Text Messaging
    - Note that one model of texts is to use them for brief administrative contacts, updates, and so on (e.g., the client notifies the clinician that she'll be late)
    - Another model is to engage in ongoing clinical interactions via text (e.g., in an online private chat, clinician, and client interact with each other in real time)
    - Beware the perils of autocorrect…

Digital Communication

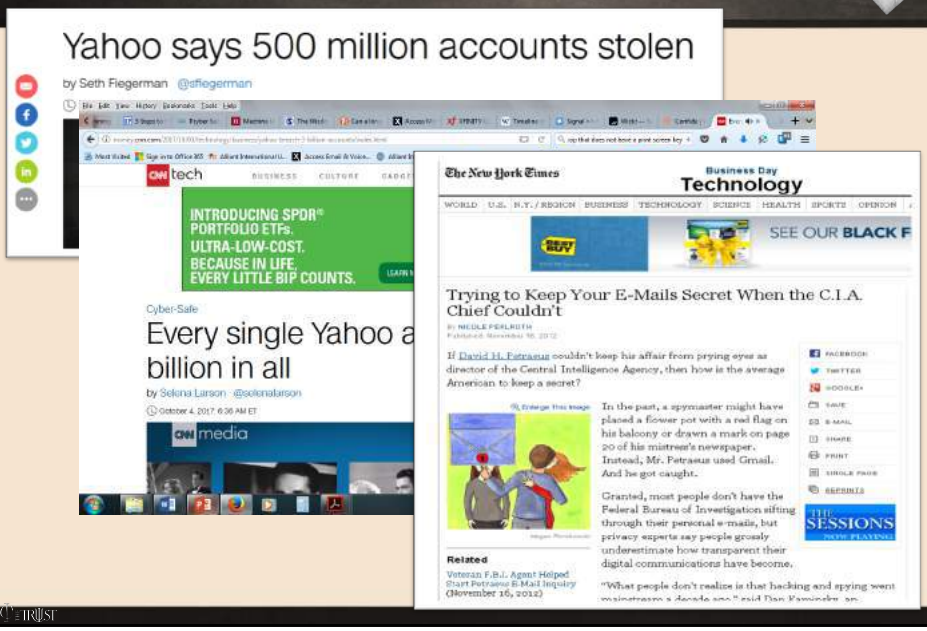
- Communication Methods (cont.)
  - Social Networking
    - Facebook
    - Twitter
    - Youtube
    - Instagram
    - Blogging

Social Media

Digital Communication

- Communication Methods (cont.)
  - Virtual worlds
  - Email

Email



Email

Must emails be secure?

- HIPAA allows the use of non-secure emails (and texts, presumably—though DHHS is not as clear in that regard), **so long as the client has agreed, and has been advised in general about the risks**.
- If the provider believes the client does not understand the risks of unsecured email, or is concerned about liability, she/he should alert the client to those risks, and let the client decide.
- **BUT providers are still responsible for privacy, at least on their end of the conversation.**

Secure Email Examples

Hushmail (www.hushmail.com)
Enigmail (www.enigmail.net)
ProtonMail (www.protonmail.com)

Text Communication

End-to-end encryption has become available for some very common text messaging apps, including (but do your research!):

- WhatsApp https://www.whatsapp.com/ though note recent questions have arisen as to its security)
- Signal (https://whispersystems.org/)
- Silent phone (https://www.silentcircle.com/)
- Wickr (https://www.wickr.com/)
- Threema (https://threema.ch/en/)
- Chatsecure (https://chatsecure.org/)

Text Communication

Ongoing Challenges:

- It's wise to keep texts as part of the clinical record, but sometimes it can be challenging to copy them with all the time and date data preserved
- Some apps (e.g., Wickr) have texts that self-destruct, and no copies of texts are maintained on the servers
- Others do not allow screen shots (e.g., Confide: https://getconfide.com/)
- Thus, imagine a client who texts a threat to kill her employer, the clinician does a *Tarasoff*—but the text disappears and the client makes a board complaint…

Case C (cont.)

- Dr. Connect realized what happened, and contacted his patient and the gym director

Breach Notification Rule

- If PHI is **secured**, no breach and no notification required
- If **unsecured** PHI is impermissibly disclosed, (like with Dr. Connect) it is **presumed to be a breach *unless*** the covered entity or business associate "demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment."

Breach Notification Rule

- A risk assessment requires addressing four factors:
  1. the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
  2. the unauthorized person who used the PHI or to whom the disclosure was made;
  3. whether the PHI was actually acquired or viewed; and
  4. the extent to which the risk to the PHI has been mitigated.

Breach Notification Rule

- What if PHI was unsecured and we can not demonstrate low risk?
  1. **Must notify affected patients**
     - "without unreasonable delay"
     - ASAP, but no later than 60 days after discovering breach
  2. **Must notify DHHS**
     - >500 patients affected: within 60 days
     - <500 patients affected: keep a log and notify within 60 days of the end of the calendar year
  3. If >500 patients affected: **notify local media**
     - ASAP, but no later than 60 days after discovering breach

What Must the Patient Breach Notification say?

A.A **brief description** of what happened (plus breach date and discovery date, if known;

B.A description of the **types of unsecured PHI** that were **involved** in the breach (e.g., whether full name, social security number, diagnosis, CPT code, etc, were involved);

C. Any **steps patients** should **take to protect themselves** from potential harm resulting from the breach;

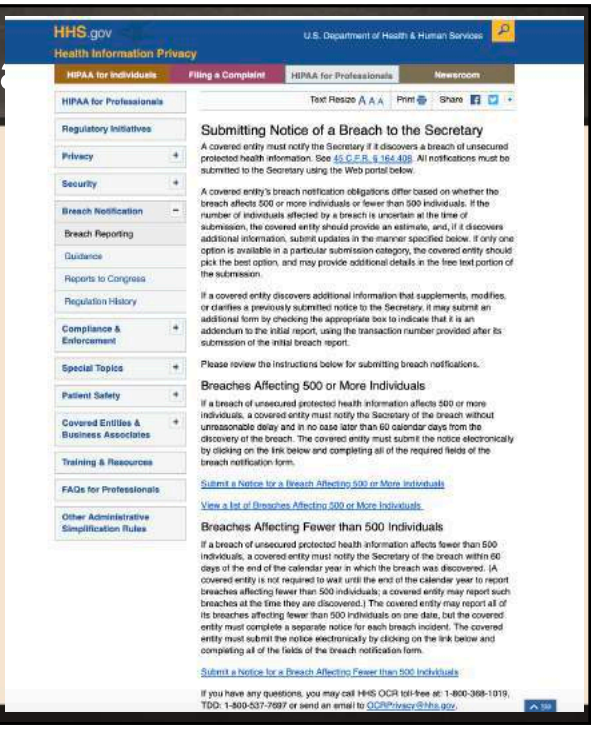
D.A brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and

E. **How** the person **can contact you** to ask questions or learn additional information (e.g., a toll-free telephone number, an e-mail address, etc.).

Breach Notifica

How do I notify DHHS?

https://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html

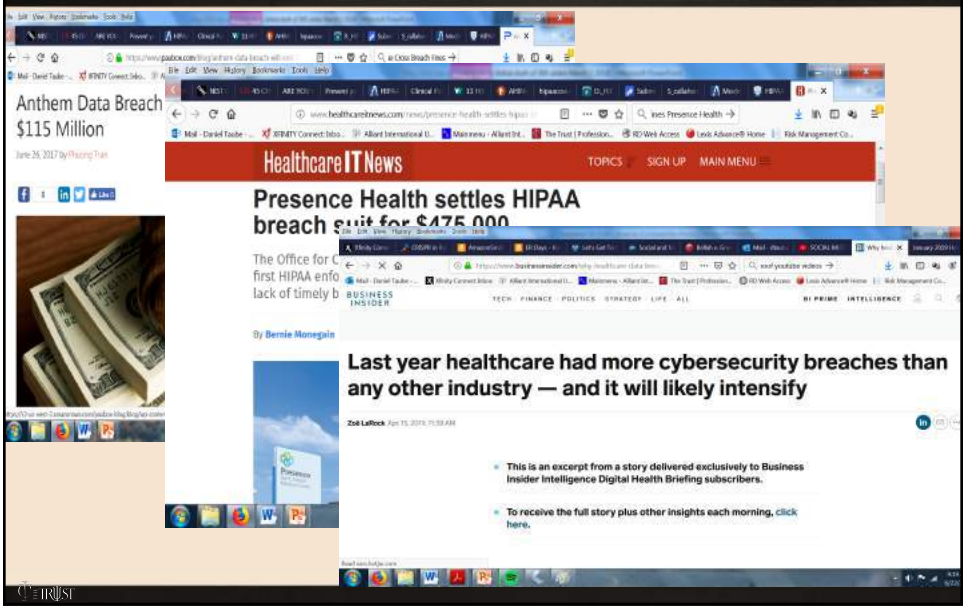


Breach Notification Rule

- Note that many states have similar notification rules, for example:
  - Recall the Bellflower breach in CA government in the "OctoMom" case (involving CA H & S section 1280.15 that applies to licensed organizations)
  - Georgia Code§10-1-910 et seq. "Any Entity that maintains computerized data that includes PI of individuals shall give notice of any breach of the security of the system following discovery or notification of the breach to any resident of GA whose unencrypted PI was, or is reasonably believed to have been, acquired by an unauthorized person."

Breach Notification Rule

- What if we don't comply?
- There are fines—ranging from modest amounts when did not know of a breach ($100 per patient), all the way up to $50,000 per patient with a maximum of $1.5 million in a year) if we willfully disregard the BNR
- There are also fines for violating HIPAA



Technology and Breaches

Technology & Risk Recap

- Using a wide range of technologically based-methods to communicate and provide services is allowed.
- This ranges from phone to video-chat to emails to texts…
- BUT providers must attend to the privacy and security of the communication methods
  - e.g., assuring that VTC is secure; using secure email for sending PHI; informing clients of the risks of open emails and obtaining consent from clients to use such non-secure methods (but note limits).
- AND address PHI breaches according to BNR

SUPERVISION

Case D

Dr. Super

Ms. Intern

Potential Areas of Concern

- Clinical Issues
- Ethical Issues
- Legal Issues
- Risk Management Issues

- Can I be held responsible for my supervisee's failure to do the things I asked?
- What are supervisors legally and ethically expected to do?

Relevant Ethics Code Section

7.06 Assessing Student and Supervisee Performance

a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

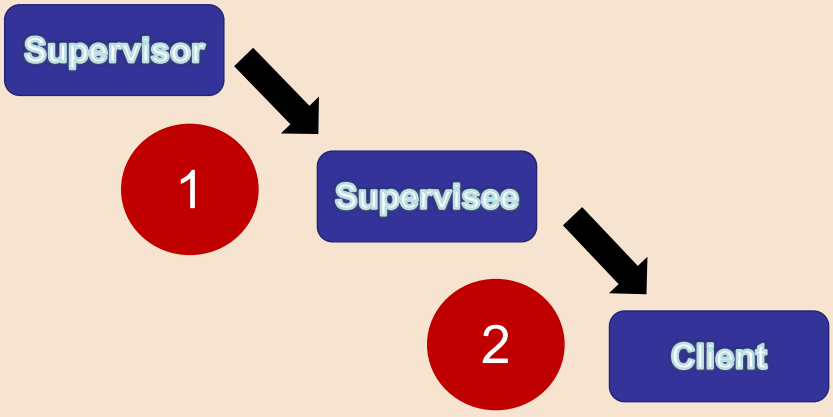
Supervisory Responsibility

- Vicarious liability
  - Supervisors are responsible for all of their supervisees' activities
  - *respondeat superior* = "let the master answer"
- Direct liability
  - Supervisors can be held responsible under the legal theory of *negligent supervision*
- Supervisees do not have "patients" or "clients" because they are not licensed.

Adapted from Dudder (1994); Recupero et al. (2007)

Risk Management for Supervision

Two-level informed consent process



Informed Consent: **Supervisee → Client**

- Potential risks of service
- Potential benefits
- Alternatives (if any)
- Limits to Confidentiality
  - especially that info will be shared with supervisor
- Nature and extent of record-keeping
  - including who will be custodian of records, for how long, etc.
- Clinician's education, training, and experience

Informed Consent: **Supervisee → Client**

- Fees, costs, billing procedures
  - e.g., are services provided by unlicensed supervisees reimbursable?
  - Supervisees typically cannot be paid directly
  - Documentation of how supervisees must bill
- Likely length of treatment
- Rights of clients
  - Including right to discontinue services (and potential risks of doing so)
- Emergency access

Informed Consent: **Supervisee → Client**

- That supervisee is NOT licensed
- That supervisee is being supervised by a licensed person
  - NOTE: the consent process and form clearly informs the client of the supervision
- Name, license number and type, contact info for the supervisor
- To whom client should direct questions or concerns

Informed Consent: **Supervisor → Supervisee**

- The supervisory relationship is a contractual one and must be treated as such
- It is necessary to articulate and clarify a range of issues
- This is not simply about the paperwork
  - e.g., hours logs, academic program or state licensing paperwork for supervisors to sign)
- A clear, written ***supervision agreement/contract*** is important
  - beyond the usual licensing board requirements

Supervisory Agreement

1. Timing
   - Should be completed BEFORE supervisee sees any clients
2. Compliance
   - Supervisee will follow all applicable ethical standards, laws, and regulations
3. Disciplinary/remediation/termination procedures
   - Failure to comply is grounds for discipline, including termination from internship

Supervisory Agreement

4. Practice conventions/policies
   - e.g., use of specific intake forms and procedures, assessment methods, record-keeping practices
5. Client notification
   - of supervisee's unlicensed status
   - of supervisor access to client's clinical information
6. Completion of informed consent paperwork with all clients

Supervisory Agreement

7. Practice only within scope of (supervisor's and supervisee's) competence
   - Only provide services that supervisor and supervisee have agreed upon
8. Financial policies
   - supervisee can't accept direct payment
   - supervisee can't pay for rent or supervision
   - supervisees should be employees (not independent contractors)

Supervisory Agreement

9. Supervisee must inform supervisor (or other designated administrator) or any legally-related issues BEFORE taking action
   - receiving subpoenas or requests for records/info
   - possible child, elder, or dependent adult abuse reports
   - concerns about DV
   - possible recovery of memories of abuse
   - imminent separation/divorce (couple/parents/family)
   - any situations where client may be danger to self or others, or gravely disabled
   - use of any experimental or non-traditional methods

Supervisory Agreement

10. Services must be provided on-site
    - If home/community visitation is part of job description, then include methods of assuring supervisee safety
11. Supervisee must maintain required weekly log of hours (e.g., clinical, supervision, etc.) for licensing purposes
    - And provide copies and review logs with supervisor
12. Supervisee has documented training in applicable interventions and modalities (e.g., telepsychology, CBT)
13. Supervisee is expected to record sessions, be observed, keep process notes, etc.

Supervisory Agreement

Supervisor is expected to:

14. Complete scheduled supervision sessions and be willing to provide as much supervision as is needed (regardless of compensation or exceeding legal minimums)

15. Review supervisee's notes and records regularly

16. Keep notes on supervision meetings

17. Avoid multiple role relationships with supervisees

Revisiting Case D

- What could have been done differently?
  - Informed consent process and paperwork
  - DV reporting
  - Use of standard intake protocol

Additional Supervision RM Steps

- **Meet the prospective supervisee BEFORE agreeing to supervise**
- **Schedule and KEEP routine supervision times**
  - cancellations should be rare
  - protect the time like you would a client's session
- **Have (and follow) a clear policy regarding the nature and frequency of the supervisory evaluation process**
  - Including how supervisees will be involved
  - Ongoing routine feedback is best (i.e., not just at the end of the internship)
  - There shouldn't be surprises in final evaluations

Risk Management for **Supervisees**

- What if the supervisor does not keep supervision appointments?
  - Or does not maintain proper boundaries?
  - What are the steps one should take?
- Power differential
  - Supervisees are more vulnerable in this relationship
  - Approaching a supervisor directly can be intimidating

Risk Management for **Supervisees**

- Slow down!
  - Use the decision-making guidance outlined earlier
- Get consultation from other professionals/ colleagues
- Informal, direct approach is ethically appropriate in most situations
- Explain your view
- Refer to the supervisory agreement
- Ask for help from your supervisor

Risk Management for **Supervisees**

- If informal, direct methods do not work, proceed to more formal methods
  - e.g., discuss with the training director
- Professional, solution-oriented approach is likely to be more effective
- Bringing in other professionals should be done after exhausting internal options
  - or receiving consultation that there is no internal solution

SUBPOENAS AND DEPOSITIONS

Case E

The Law Family

Dr. Edu

Potential Areas of Concern

- Clinical Issues
- Ethical Issues
- Legal Issues
- Risk Management Issues

Why Are We So Afraid of Subpoenas?

- Legal vs. ethical conflicts
- Intimidating language
  - *"You are hereby ordered…"*
  - *"Failure to comply will result in..."*
- Lack of control
- Risk no matter what

When Does This Typically Come Up?

- Client is involved in a legal matter:
  - Child custody/divorce
  - Personal injury
  - Workers' compensation
  - Criminal case
  - Child welfare investigation
- Other reasons for records requests:
  - Client's personal use
  - Education/employment accommodations

How Did I Get Pulled Into This?

- In legal, adversarial proceedings, it is necessary for all parties to have access to relevant, reliable, and truthful information
- The process of ***discovery*** allows each side to get information from the other side, prior to trial
  - If the information obtained during the discovery process meets evidentiary requirements, it is then presented to the parties, judge, jury, etc. to assist in deciding the case

How Did I Get Pulled Into This?

- During the discovery process, parties can:
  - Get records from relevant providers
  - Interview people in depositions
  - Require witnesses to testify at a hearing
  - Send interrogatories (i.e., written questionnaires)
- Subpoenas are used to compel people to provide information that is deemed necessary to deciding issues before a court

Destroying Data

- We are required to maintain records of all professional services.
  - Purpose of records?
  - Where does this requirement come from?
  - How long do we have to maintain records?
- Can we destroy records? When?
- Can we alter records?
- Can we amend records?

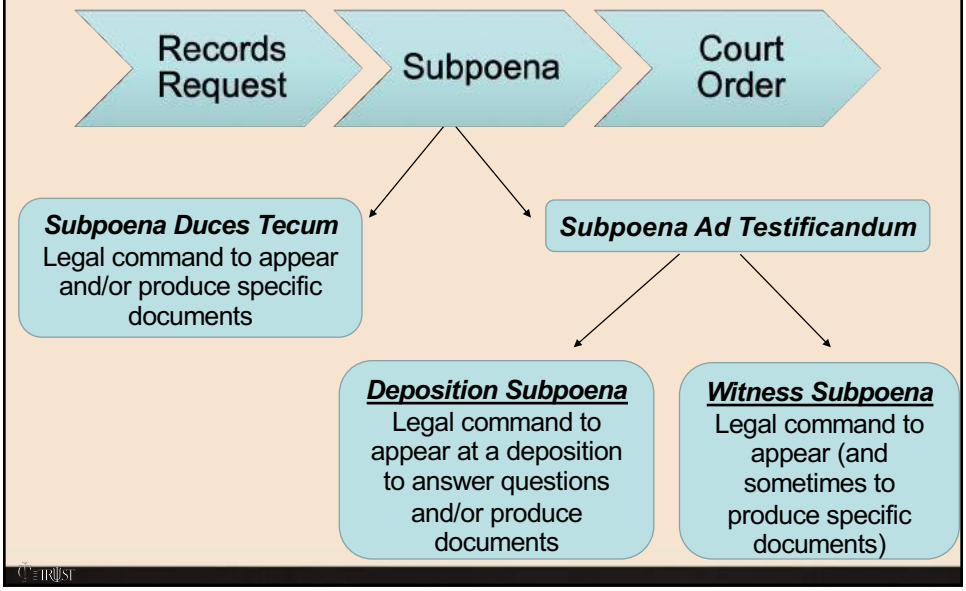
Discovery in a Legal Process

- "Discovery" = each side has a chance to get information from the other side
- Ways to obtain information:
  - Interrogatories (written questions)
  - Records request
  - Subpoenas
  - Depositions (interviews)
  - Testimony

Clarifications

- **Privacy**
  - Legal right
  - Applies to the person
- **Confidentiality**
  - Ethical obligation
  - Applies to the data/information
  - An extension of privacy
- **Privilege**
  - Privileged communication is information that is disclosed in the context of a specific relationship (e.g., psychotherapist-client) and cannot simply be demanded by a third party for legal purposes

Types of Information Requests



Subpoenas

- Is it a court order?
- Do I have to comply?
- Are there valid exceptions?
- Compliance versus response

Subpoena =
a request…with teeth!

Risk Management: *Prior* to Receiving a Subpoena

- Include specific policies in informed consent
  - Policies related to records requests
  - Policies related to legal involvement
  - Associated fees

Risk Management: *Prior* to Receiving a Subpoena

Sample informed consent language:

Confidentiality Section:

- *"In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order."*

https://www.trustinsurance.com/Resources

Risk Management: *Prior* to Receiving a Subpoena

Sample informed consent language:

Child Treatment Agreement:

- *"You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements. Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled."*

https://www.trustinsurance.com/Resources

Risk Management: *Prior* to Receiving a Subpoena

Sample informed consent language:

Billing and Payment:

- *"If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. [I charge $XXX per hour for professional services I am asked or required to perform in relation to your legal matter. I also charge a copying fee of $XXX per page for records requests.]"*

https://www.trustinsurance.com/Resources

Risk Management: *After* Receiving a Subpoena

1. Is the subpoena valid?
2. What is the subpoena requesting?
3. Contact the client
4. Contact the requesting attorney
5. Contact the court
6. Challenge the subpoena
7. Comply with the subpoena

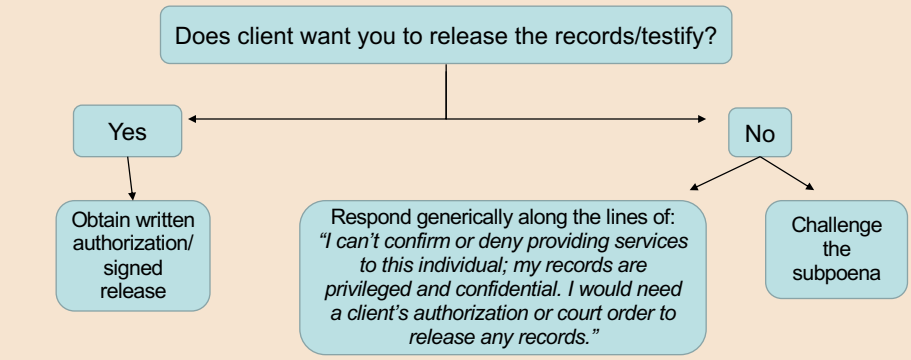
1. Is the Subpoena Valid?

- From outside of jurisdiction?
- Sufficient response time?
- Proper service?
- If subpoena is valid, then a formal response (although not necessarily compliance) IS required
  - Failure to respond can result in sanctions (e.g., accumulating fines, being held in contempt, having to pay attorney's fees, etc.)
- Remember, just because you have been subpoenaed does not mean that you must provide what is requested in the subpoena
  - But, you are legally required to respond

2. What is the Subpoena Requesting?

- Documents
- Testimony
  - At deposition
  - At hearing
- Both

3. Contact the Client



Other Considerations:

- Specific state requirements (e.g., Notice to Consumer forms in CA, minors)
- Can offer to have client review records before deciding
- Issues with providing partial or alternative records (e.g., treatment summary)
- Impact on therapeutic relationship

4. Contact the Requesting Attorney

- Most often—DON'T! But if you must, you can ask:
- Which person or organization do you represent?
- How did you get my name?
- What is the nature of the concerns or proceedings?
- What information do you want?
- Why is this information needed?
- How do you want to receive this information (e.g., written report, telephone/in-person meeting)?
- What is the time frame for the request?

If Client and/or Attorney Does Not Respond…

- Document attempts to contact client/attorneys
- Take a conservative stance of asserting privilege
  - Remember, you can't un-ring the bell!
- Contact your own attorney and obtain assistance in the response

5. Contact the Court

- Seek clarification
- Seek limitation
- If ultimately ordered to provide the records or testify, you should state something for the formal record along the lines of:
  - *"I would like to reiterate for the court my ethical obligation to maintain the confidentiality of the information that [client] has shared with me during the course of our professional relationship. Given my ethical duty, I have serious concerns and disagree with the court's decision, but will comply with the court's order."*

6. Challenge the Subpoena

- Assert privilege
- File a motion to quash (in whole or in part)
  - Invalid subpoena
  - Lack of personal jurisdiction
  - Lack of custody/control of records
  - Potential harmful impact of disclosure
- File a motion for a protective order

7. Comply with the Subpoena

- Information requested
- Limitations
  - Psychotherapy notes
  - Raw test data
  - Test materials
- Deposition coverage

Testimony

When subpoenaed for a deposition, hearing, or trial, you will usually play one of three roles

- A **fact** (“lay” or “percipient”) **witness**
- An **expert witness** (who can provide opinions)
- A **“treating expert”** (who can usually only provide very limited opinions)

Depositions

If clients and their attorneys DO want us to be deposed, then:

- You have to give deposition testimony
- You should carefully review the content of the records with client and discuss potential impact of deposition on the relationship and client’s welfare
- Follow the subpoena instructions for appearing at deposition and/or providing records
- Remember deposition decorum…

Deposition Decorum

- Ask for clarification
- Slow down
- Tell the truth, but don't offer more than is asked
- When you don't know, don't remember, or don't have an opinion, SAY SO
- Stay within the scope of your role
- Keep answers brief and to the point
- Take breaks when you need them
- Review the deposition transcript and make corrections before signing

Deposition Decorum

Release of Raw Test Data

If authorized or ordered, Should Dr. Edu just hand over the raw data and test material to the school attorney?

1. Regarding raw data, clients now usually have access—so unless there's a compelling reason, it will usually be released (see APA EPPCC, 2017, Standard 9.04)
2. APA ethics v. Pearson position regarding test materials

Release of Raw Test Data

APA Code Section 9.04(a): Release of Test Data

- The term test data refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination.
- *Those portions of test materials that include client/patient responses are included in the definition of test data…*
- Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release.

Release of Test Materials

APA Code Section 9.11: Maintaining Test Security

- The term test materials refers to manuals, instruments, protocols, and test questions or stimuli and does not include test data as defined in Standard 9.04, Release of Test Data.
- Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

Release of Test Materials

Pearson Test Publisher:

- "It is the position of Pearson that *any* reproduction of its test or other published materials, whether reproduced on paper or electronically (this includes use intake forms, research, video or audio taping administrations, photos, or any image capturing system), constitutes an infringement of the copyright and other proprietary rights in the tests or other published materials…
- In Pearson's view, reproduction of its test materials without prior written consent DOES NOT fall within the 'fair use' exception of the copyright law."

Release of Test Materials

Protective Orders

- Sample of one company's positions:
  - …before proprietary test materials are released to non-professionals such as counsel, it is essential that the court enter a protective order (a) prohibiting parties from making copies of the materials or from sharing copies of the materials with non-parties; (b) requiring that the materials be returned to the professional at the conclusion of the proceedings; and (c) requiring that the materials not be publicly available as part of the record of the case, whether this is done by sealing part of the record or by not including the materials in the record at all. (PAR)

Specific Settings & Contexts with Varying Obligations

- Schools/Colleges/Universities
- Hospitals
- Employers
- Correctional facilities
- Substance abuse records
- Forensic contexts

Review and Application to Dr. Edu

1. Is the subpoena valid?
2. What is the subpoena requesting?
3. Contact the client
4. Contact the requesting attorney
5. Contact the court
6. Challenge the subpoena
7. Comply with the subpoena
8. Stay within scope of role when providing testimony

Summary

- Remember that subpoenas require a response, but not necessarily compliance
- Your role is usually to try and carry out the client's wishes
  - But, there may be situations where you have conflicting obligations or concerns
- When in doubt, consult:
  - With local attorney
  - With professional liability insurer
    - e.g., Trust RM Advocate Program: (800) 477-1200
  - With state psychological association representative

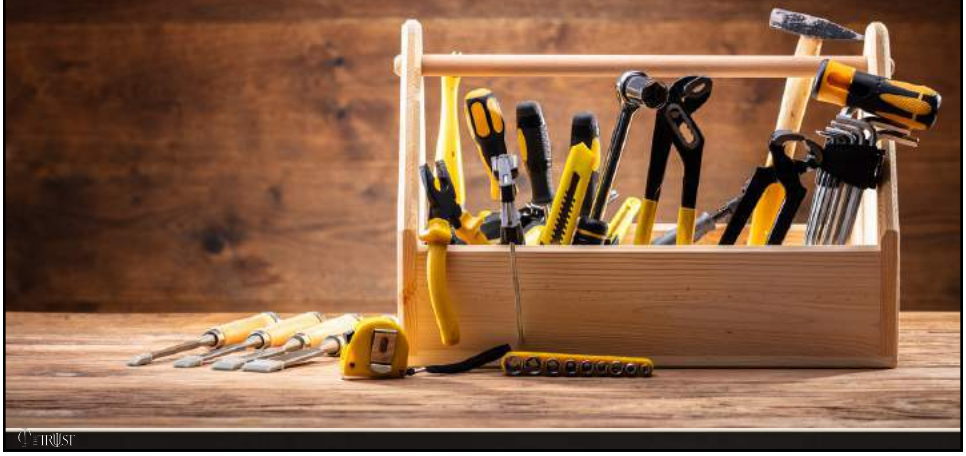
Final Thoughts

Risk Management Reminders

- Know the legal and ethical standards governing practice
- Seek appropriate consultation
- Conduct a conservative evaluation of your intellectual, technical, emotional, and cultural competence
- Provide comprehensive informed consent
- Develop good recordkeeping practices and strategies
- Identify high-risk clients and high-risk situations
- Take all complaints and dissatisfactions seriously
- Notify the insurance carrier and consult with a knowledgeable attorney if a suit or disciplinary complaint is filed against you

Risk Management Reminders

- Informed Consent
- Documentation
- Consultation
- Client Risk Factors
- Situational Risk Factors
- Clinician Risk Factors



Risk Management Reminders

- Festina Lente
- You will make mistakes.
- Be aware of your emotional vulnerabilities.
- You cannot help everyone.
- You will not know everything.
- You cannot go it alone.
- Practice changes and technological developments will continue to present opportunities and risks.
- Humility and a sense of humor are as crucial to risk management as they are to all other aspects of life.


THANK YOU FOR YOUR
ATTENDANCE AND PARTICIPATION!
THE TRUST

SEQUENCE X:
PERPLEXING PROBLEMS IN PSYCHOLOGICAL PRACTICE (P^4):
DECISION SCIENCE, ETHICS, & RISK MANAGEMENT

Case Summaries

HEURISTICS, BIASES, AND ETHICAL DECISION-MAKING

Case A

Mr. Finley was recently in a motorcycle accident and called Dr. Jones to request a private psychological evaluation for his upcoming lawsuit against the driver of the car that hit him. His lawyer thinks it's a good idea for him to fight for emotional damages as well as the physical injuries he suffered. Dr. Jones is an experienced clinician working in a large city and has substantial training and experience in conducting these types of personal injury evaluations.

Dr. Jones engaged in the usual informed consent process when individuals seek these services privately (as opposed to a court-ordered evaluation). He explained that he would do a thorough psychological evaluation and provide Mr. Finley with feedback. He would then ask for Mr. Finley's reasonable corrections and input and would use his judgment in making those corrections that he thought were appropriate, before providing a final draft of the report. It would then be up to Mr. Finley to share or not share the evaluation with his attorney. Though it would likely be used in court, Dr. Jones was not ordered by the court to do the evaluation.

Dr. Jones also described his financial policies, including his requirement for an initial deposit of the approximate amount that the evaluation would cost, against which he charged his usual hourly fee. He described the range of activities for which he charged, including multiple interviews with Mr. Finley, collateral contacts, communications, report writing, feedback meetings, testimony, and a host of other activities.

Mr. Finley balked at the amount Dr. Jones proposed, and after a bit of negotiation, agreed to pay 60% at the outset, and the remainder when Dr. Jones completed his rough draft of the report. He paid the negotiated initial deposit and Dr. Jones scheduled the first interviews. Then, it started to get complicated.

Mr. Finley did not show up for the first interview, and then was angry with Dr. Jones' staff, accusing them of mistakenly making an appointment with him for a time to which he had not agreed. Dr. Jones was a bit embarrassed because he had been having some difficulty with his staff and the scheduling software over the weeks prior to this problem, so he apologized for the error and had his staff reschedule Mr. Finley. Though Dr. Jones typically charged when someone had not attended a scheduled intake or testing session, he did not charge Mr. Finley because he was unsure as about where the problem had occurred.

Unfortunately, Mr. Finley missed the next scheduled session as well, and made the same argument as before with considerable irritation. Begrudgingly, Dr. Jones rescheduled again and did not charge Mr. Finley for the second time, but this time Dr. Jones was fairly certain that it

was not a problem with the software or his staff. When Mr. Finley finally did come as scheduled, his wife could not be there, as Dr. Jones had requested, and they had to reschedule yet again. When Mr. and Mrs. Finley showed up for the next scheduled appointment, they were extremely late. Dr. Jones had been explicit in his description of his fees for the hours he reserved to provide this evaluation, and as agreed, he billed against the deposit that Mr. Finley had provided for the full scheduled time and for the time Mrs. Finley had not come to a scheduled session, but not for the earlier no-shows.

After more back and forth, repeated rescheduling, and two testing sessions in which Mr. Finley arrived very late, the assessment was finally complete. Dr. Jones' findings were fairly clear: Mr. Finley had few, if any, symptoms of posttraumatic stress disorder, anxiety, or any other psychiatric diagnoses following the accident. Dr. Jones completed the rough draft, and sent the draft along with a request for final payment prior to meeting with Mr. Finley and his attorney for the feedback session. Mr. Finley got quite angry at the amount Dr. Jones' said they owed and demanded an accounting of how the deposit had been spent. Dr. Jones sent his billing records and Mr. Finley disputed well over half of the charges. He was particularly incensed over Dr. Jones' charging him for late sessions and ignored the fact that Dr. Jones had forgiven some of the early charges.

Mr. Finley was also frustrated with what he felt was an "unprofessional" report, apparently either misunderstanding or deliberately ignoring the original agreement about the testing, feedback, and completion process. When Dr. Jones reminded Mr. Finley of the agreement they had made (sending a copy of the informed consent form with relevant sections highlighted), and reiterated that he would not meet with the Mr. Finley for a feedback session, nor be able to complete a final draft until he had received the agreed-upon payment, Mr. Finley became outraged and threatened to report Dr. Jones to the licensing board, the Better Business Bureau, and APA, as well as post a scathing online review about Dr. Jones.

Dr. Jones was not only frustrated and more than a little annoyed with Mr. Finley, but was also upset with himself for having changed his usual practice of asking for the estimated amount upfront. He knew from prior experience that parties sometimes did not want to pay for assessments for which they had not gotten the results they had desired, and had disregarded his initial hesitation to bargain with Mr. Finley.

INTERJURISDICTIONAL PRACTICE: "I'M LEAVING FOR COLLEGE"

Case B

Dr. Link has always been interested in sports psychology. She had been an athlete in her teens and 20s. She has worked with adolescents and young adults, and many were also competitive athletes. One of the adolescents with whom she had worked, Bobby Baseball, had become very anxious during his parents' high conflict divorce and custody battle. His athletic skills were significantly hampered by his anxiety. Dr. Link helped Bobby manage and address his anxiety and his performance improved dramatically; so much so that he was offered a four-year athletic

scholarship to a university in a different state.

Around that time, Dr. Link also began to take steps to expand her practice into sports performance coaching and developed a section of her clinical website that was devoted to her sports performance coaching practice. Some local parents were very pleased with the results that they were seeing and, between her advertising and word of mouth, she got four requests for her services from coaches at colleges around the country.

Coincidentally, Bobby went off to one of the same colleges that had contacted Dr. Link. She heard that Bobby seemed to be doing well, according to his parents' occasional reports. However, Dr. Link got a text from Bobby a couple of months later saying that things had been really hard for him in making the adjustment to college, and that he feeling anxious again. He begged Dr. Link to continue working with him and his mother called and said that, as they had done before, Dr. Link could bill his father's insurance. Dr. Link had some minor concerns but, given her past success with Bobby, a good relationship with his parents, and her strong connection with the coach at this college, she agreed. She was very surprised, then, to get an angry call from the Bobby's father asking what Dr. Link was doing billing him for these services, and threatening to complain to the board about the fact that she had not informed him about the services and was practicing without a license in this other state.

When Dr. Link called her liability carrier to let them know about the complaint and the possible licensing board involvement, she was even further distressed to find that they were balking at covering her. As the underwriter said to her when she spoke with her, "you were practicing illegally and it's a criminal act; we do not cover that."

TECHNOLOGY CHALLENGES

Case C

Dr. Connect has a busy private psychotherapy practice, in addition to working as a contract assessor 10 hours a week for a local hospital. He uses an online record-keeping platform for his own practice, and keeps much of the raw data and materials for his assessments on the testing company websites. What remains is kept on his practice record-keeping system and in locked file cabinets in his office. He uploads the completed assessment reports to the hospital's secure online electronic health records system.

Dr. Connect regularly e-mails back and forth with the testing coordinator at the hospital regarding administrative aspects of their work. He is usually careful about not including identifying information in the text of the e-mail. He received an urgent e-mail from the coordinator early one Friday afternoon requesting a copy of each of the last year's assessment reports along with the billing records. The hospitals EHR system had been attacked by a ransomware virus and they were attempting to ensure that they had all of the reports in their backup system.

The coordinator asked Dr. Connect to send her the reports and relevant billing information as soon as he could, and to forward copies to the Director of Psychological Services so they would have more than one backup. Dr. Connect downloaded the reports from his own system, along with the bills he had submitted to the hospital, put them in a zip file, and attached and sent the files via e-mail to the coordinator and director. The 26 reports were at the hospital within an hour after the request and the coordinator was very appreciative.

About 10 days later, Dr. Connect received an upsetting phone call from a patient he had evaluated at the hospital, Ms. Mad. She accused him of breaching her confidentiality and demanded to know why people at her local gym were talking about her psychological report. Dr. Connect was shocked and mystified; he called Ms. Mad back who, between angry outbursts, explained that the director of the gym had approached her and said that she'd read a psychological evaluation about her, and wondered if it was wise that she was working out so much given her diagnosis of an eating disorder.

Dr. Connect initially couldn't figure out what happened; he knew he had definitely not disclosed these records to anyone other than the usual hospital personnel. When he recalled that he had sent the batch of reports the previous week via e-mail, he began to wonder if he might have made an error.

Sure enough, when he went in to look at the e-mail he sent, it turned out that his e-mail program had automatically populated the address section of his e-mail with the name of the director of the local gymnasium to which he belonged and had been recently communicating, in addition to the director of the hospital's psychology clinic. The gym director had the same first name as the hospital coordinator. The gym director must have opened and read at least some of the reports that he had mistakenly sent. Dr. Connect was mortified.

When Dr. Connect realized what happened, he left a voicemail for Ms. Mad and explained that there had been a mistaken e-mail address. He promised he would do his best to protect the information that was disclosed. Ms. Mad appreciated him getting back to her so quickly and, somewhat surprisingly, said "no problem, these things happen." Dr. Connect then contacted the director of the gymnasium, spoke with her and asked if the director could erase the e-mail and no longer review or distribute any information contained in it to anyone. The director reluctantly agreed to delete the email.

Dr. Connect considered contacting the hospital, but because he hadn't heard back from them and knew from the coordinator that they were still struggling with the aftermath of their ransomware problem, he decided to forgo informing them about the breach for the time being. A couple of months passed and Dr. Connect forgot about the incident.

He was then shocked to receive a letter from the Office of Civil Rights (OCR) at the US Department of Health and Human Services, noting that there were two complaints that had been made about a breach of confidentiality. Dr. Connect contacted the OCR representative and asked what he could do. The person on the phone asked for information about what had occurred, the

patients' names and contact information, and the types of services he provided. Dr. Connect didn't know what to do; he was reticent to disclose the information to the OCR, but had remembered hearing that they had a right to information when there was a breach.

SUPERVISION

Case D

Dr. Super runs a clinic where she supervises masters-level interns. Her preferred supervision methods are video- or audio-recorded sessions, or live supervision, which is not often possible. Most supervisees are willing to try, despite initial nerves, recording and live supervision, and find it valuable. One supervisee, Ms. Intern, is particularly nervous about being observed. She says she'll bring in a video recording, then it takes a couple of weeks, and she says the family she is seeing refuses to consent to it. Dr. Super asks for an audio recording; two weeks go by and, once again, Ms. Intern says the family refuses.

Meanwhile, the verbal report is that things are going well for Ms. Intern. She is seeing a family with two children (an 11-year-old from the father's first marriage and a 4-year-old child of father's marriage to stepmother). The 11-year-old is acting out in school; refusing to follow his teacher's directions, and engaging in some fighting. Ms. Intern's hypothesis is that the parents are very divided about how to address limit-setting. The father is saying that "boys will be boys." The stepmother is very concerned, but overly harsh, with her stepson and threatens, but sometimes does not follow through, or father interferes with her imposed discipline. The younger child is the first child of the current marriage, and at 4 years old, is distressed but not symptomatic. Ms. Intern's treatment plan is to help stepmother modulate her harshness, and work with father be consistent in setting limits. It seems like a good, practical approach.

But Ms. Intern still says that video or audio taping is not possible because parents refuse. Dr. Super is a bit suspicious about this but, given the seeming appropriateness of the therapy, she asks instead for process notes; she wants to know about the "blow-by-blow" interactions. Ms. Intern agrees to do that before their upcoming 5th supervisory session. She comes in to the next supervision session with the requested notes and her written work is consistent with her verbal report. Though Dr. Super does notice some gaps, progress seems to be occurring.

During the following week, midway between supervision sessions, Dr. Super gets a call from a very upset Ms. Intern. She reports that things have "blown up" with the family, and describes the following scenario. The 11-year-old was caught with marijuana at school was suspended pending a school attendance review board hearing. Stepmother was very upset and was threatening to kick the 11-year-old out of the house. Father is upset with his son, but is furious with stepmother. When they arrived for their therapy session with Ms. Intern, father blew up at stepmother and physically threatened her. Stepmother became very frightened and also revealed that there had been some intermittent and fairly serious domestic violence in this relationship in the past, including one time where father cracked her rib (this had not been discussed before). Ms. Intern, who had been a behavioral liaison in a general hospital emergency room the year before, told the parents she believed she'd need to report the domestic violence to the police. Father stormed out

saying that family therapy was "BS" and that he was going to file a complaint against the therapist. Ms. Intern then reported the domestic violence to law enforcement.[1]

A few days after talking Ms. Intern down, trying to strategize about if it was possible to re-establish any rapport with father (not likely), and talking about next steps for the family and stepmother (who wants to continue to work with Ms. Intern), Dr. Super received another very distressed call from Ms. Intern. In response to her attempt to re-engage with the father, he had called Ms. Intern and said she can't see his child anymore, that he has called a lawyer, and that he is suing her for violating his confidentiality. Indeed, the summons and complaint that followed said just that. Initially the father sued only Ms. Intern. But, it turns out that that father later amended the complaint to sue Dr. Super as well, and claims misrepresentation, because he said that he did not know that Ms. Intern was just an intern in the clinic, that she had not told him she had a supervisor until the complaint had been lodged. Dr. Super is very surprised, because in the first training she gives to all incoming interns, she instructs them clearly to inform their clients at the beginning of services that they are being supervised, and to give the client the name and contact information for their supervisor. Father is also suing Dr. Super for negligent supervision.

SUBPOENAS AND DEPOSITIONS

Case E

The Laws are parents of a 15-year-old teen; they bring him to Dr. Edu for a school-related independent educational evaluation (IEE). They explain that the school district continues, in their view, to refuse to recognize that their son has an "emotional disturbance," and thus deny him appropriate support and services. In particular, the parents believe he needs a non-public school mental health placement. They want a thorough evaluation, with a focus on his emotional and social functioning and its impact on learning and educational achievement. They also seek any recommendations Dr. Edu might have.

Dr. Edu has done a number of private evaluations of children and adolescents, though this would be one of the few he has done as an IEE. Dr. Edu obtains consent from the parents and proceeds with administering a range of tests, including the MMPI-A and some projective and intellectual tests, along with interviews with the parents, reviewing previous evaluations and school records, and getting observational input from current and prior teachers.

Once he finishes his evaluation, Dr. Edu completes the report and asks the parents to come in for a feedback session, after which he'll send in the final report to the school district once he's made any appropriate changes the parent's or teen might request. He meets with the family to review the results which, in Dr. Edu's view, pretty clearly show that the teen is conduct-disordered and not eligible for emotional disturbance services under the Individuals with Disabilities Education Act (IDEA) and the school district's rules.

[1] For the purposes of this vignette, assume the state only requires such reports in medical settings: this is variable state by state, so it's important to know and explain your state's requirements during the informed consent process.

The Laws are upset with Dr. Edu and accuse him of having been "bought off by the school district, like the other psychologist we hired." They also claim that he has made numerous errors in the report. Dr. Edu offers to correct the two erroneous names of teachers, and a minor historical issue, and clarifies that those corrections do not affect his conclusions or recommendations. He also tries to explain that he was very careful to weigh all the data and not rely heavily on school reports or teacher interviews and assessments, but the parents are not persuaded and leave his office angrily.

They then have their advocate direct Dr. Edu to destroy all of his data and the report and forbid him to send the report to the school district. They, nonetheless, pursue their legal process under the IDEA against the district and find their way to Federal District court after they dispute the findings of the fair hearing officer. Dr. Edu then discovers that he has been subpoenaed by the school district attorneys for all of his records—including raw data, test materials and protocols—and for a deposition. The school district attorney calls Dr. Edu to schedule the deposition. Dr. Edu asks for his usual fee, and the district states that he has not delivered any report and, thus, they do not see him as an IEE. Dr. Edu calls you, his colleague, to consult about whether he can destroy the records or has to send the report without the parent's consent, and how he should handle this deposition.

SEQUENCE X
PERPLEXING PROBLEMS IN PSYCHOLOGICAL PRACTICE (P^4):
DECISION SCIENCE, ETHICS, & RISK MANAGEMENT

References

American Psychological Association. (2013). Guidelines for the practice of telepsychology. Retrieved from http://www.apa.org/practice/guidelines/telepsychology.aspx

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct (2002, Amended June 1, 2010 and January 1, 2017). Retrieved from http://www.apa.org/ethics/code/index.aspx

Bodenhausen, G. V., Sheppard, L. A., & Kramer, G. P. (1994). Negative affect and social judgment: The differential impact of anger and sadness. *European Journal of social psychology*, *24*(1), 45-62.

Damasio, A.R. (1994). *Descartes' error: Emotion, reason, and the human brain*. New York, NY: G.P. Putnam's Sons.

Dudder (1994, September). Supervision: Staying out of trouble. *California Psychologist, 27* (7), 31.

Frijda, N. H. (1987). Emotion, cognitive structure, and action tendency. *Cognition and emotion*, *1*(2), 115-143.

Goldberg, S. B., Babins-Wagner, R., Rousmaniere, T., Berzins, S., Hoyt, W. T., Whipple, J. L., … Wampold, B. E. (2016). Creating a climate for therapist improvement: A case study of an agency focused on outcomes and deliberate practice. *Psychotherapy*, *53*(3), 367–375.

Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. T., & Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. *Journal of Counseling Psychology, 63,* 1–11.

Hickson, G. B., Clayton, E. W., Githens, P. B., & Sloan, F. A. (1992). Factors that prompted families to file medical malpractice claims following perinatal injuries. *Journal of the American Medical Association*, 267 (10), 1359–1363.

Hill, M., Glaser, K., & Harden, J. (1995). A feminist model for ethical decision making. In E. J. Rave, & C. C. Larsen (1995). *Ethical decision making in therapy: Feminist perspectives* (pp. 18-37). New York, NY: Guilford Press.

Hoorens, V. (1993). Self-enhancement and superiority biases in social comparison. European *Review of Social Psychology, 4,* 113-139.

Kachalia, A., Sands, K., Van Niel, M., Dodson, S., Roche, S., Novack, V., … Mello, M. M. (2018). Effects of a communication-and-resolution program on hospitals' malpractice claims and costs. *Health Affairs*, *37*(11), 1836–1844.

Kahneman, D. (2011). *Thinking, fast and slow*. New York, NY: Farrar, Straus, and Giroux.

Kitchener, K. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *The Counseling Psychologist, 12(3-4),* 43-55.

Knapp, S. J., Gottlieb, M. C., & Handelsman, M. M. (2015). *Ethical dilemmas in psychotherapy: Positive approaches to decision making*. Washington, DC: American Psychological Association.

Knapp, S., Younggren, J. N., VandeCreek, L., Harris, E., & Martin, J. N. (2013). Assessing and managing risk in psychological practice: An individualized approach. Rockville, MD: The Trust.

Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (2000). *To err is human: Building a safer health system* (Vol. 6). Washington, DC: National Academy Press.

Koocher, G. P. & Keith-Spiegel, P. (2016). *Ethics in psychology and the mental health professions: Standards and cases (4th ed.)*. New York, NY: Oxford University Press.

Kouchaki, M., & Desai, S. D. (2015). Anxious, threatened, and also unethical: How anxiety makes individuals feel threatened and commit unethical acts. *Journal of Applied Psychology*, *100*(2), 360-375.

Levinson, W., Roter, D. L., Mullooly, J. P., Dull, V. T., & Frankel, R. M. (1997). Physician-patient communication: The relationship with malpractice claims among primary care physicians and surgeons. *JAMA: Journal of the American Medical Association*, *277*(7), 553–559.

McCormick, I.A., Walkey, F. H., & Green, D. E. (1986). Comparative perceptions of driver ability – a confirmation and expansion. *Accident Analysis & Prevention, 18(3),* 205–208.

Pope, K. S., & Vasquez, M. T. (2016). *Ethics in psychotherapy and counseling: A practical guide* (5th ed.). Hoboken, NJ, US: John Wiley & Sons Inc.

Recupero, P. R. & Rainey, S. E. (2007). Liability and risk management in outpatient psychotherapy supervision. *The Journal of the American Academy of Psychiatry and the Law*, *35*(2), 188–195.

Slovic, P., Finucane, M., Peters, E., & MacGregor, D. G. (2002). The affect heuristic. In T. Gilovich, D. Griffin, & D. Kahneman (Eds.), *Heuristics and biases: The psychology of intuitive judgment*. (pp. 397–420). New York, NY: Cambridge University Press.

Slovic, P., & Peters, E. (2006). Risk Perception and Affect. *Current Directions in Psychological Science, 15(6),* 322–325.

Tracey, T. J. G., Wampold, B. E., Lichtenberg, J. W., & Goodyear, R. K. (2014). Expertise in psychotherapy: An elusive goal? *American Psychologist, 69,* 218–229.

Tverseky, A. & Kahneman D. (1974). Judgment under uncertainty: Heuristics and biases. *Science, 185*, 1124-1131.

Walfish, S., McAlister, B., O'Donnell, P., & Lambert, M. J. (2012). An investigation of self-assessment bias in mental health providers. *Psychological Reports*, *110*(2), 639–644.

Related Resources available on The Trust site (www.trustinsurance.com)

- Sample: *Informed Consent Form (with addendum for child/adolescent patient)*
- Sample: *Informed Consent for Telepsychology*
- Sample: *Electronic Communication Policy*
- Sample: *Outpatient Services Agreement for Collaterals*
- Sample: *Coaching Contract*
- Article: *The New Frontier of Coaching*
- Article: *Choosing Encryption Software*
- Article: *Risk Management: Social Media*
- Quick Guide: *Starting a Private Practice: An Early Career Psychologist's Guide*
- Webinars on a variety of topics, including:
    - Telepsychology
    - Retirement
    - Subpoenas
    - Depositions
    - Responding to Licensing Board Complaints
    - Supervision
    - Long-Term Practice Success