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Working with Couples and Families, Risk Management with the Suicidal Patient, and Legal and Ethical Issues presented by Retirement.

6 Hours CE Credit

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Legal and Ethical Risks and Risk Management in Professional Psychological Practice Sequence VII:

Working with Couples and Families, Risk Management with the Suicidal Patient, and Legal and Ethical Issues presented by Retirement

The Trust Risk Management Program

- Workshops
- Advocate Consultation Program
- Assessing and Managing Risk in Psychological Practice
- www.trustinsurance.com
- Case Review Program
- Policy Enhancements

What is Risk Management?

- Risk management is the prospective assessment of retrospective evaluation.

What is Risk Management?

- Risk management for psychologists is primarily designed to avoid adverse disciplinary actions as a result of licensing board complaints.
  - Chance of licensing board complaint 50%
  - Chance of malpractice suit 1-2%
  - Long range negative consequences of disciplinary sanction usually more serious than settled malpractice settlement

What is Risk Management?

- Risk management requires:
  - Evaluation of benefits to patient/client
  - Evaluation of risk to professional and patient/client
- Decision making based upon the risk/benefit analysis

What is Risk Management?

- In responding to a licensing board or ethics committee complaint, your ability to demonstrate knowledge and application of basic ethical principles, your clinical plan, and your risk analysis, as evidenced in your documentation and consultation, is often more important than the clinical outcome.

What is Risk Management?

- Enables psychologist to provide best, most appropriate care to patient
- Increases likelihood of positive outcome
- Creates good alliance with patient
- Allows patient to participate in decision making
- Minimizes anger when the unexpected happens

What is Risk Management?

- Base treatment plan on client's identified problems
- Demonstrate that good care was provided
- Demonstrate that psychologist is a competent, ethical, and prudent professional
- Risk management is a business decision

What is Risk Management?

- Standard of Care: Reasonable and Prudent Psychologist
  - Judicial: How similarly qualified practitioners would have managed the patient's care under the same or similar circumstances. Must have and use the knowledge ordinarily possessed by members of the profession in good standing.

What is Risk Management?

- Ethical: As used in this Ethics Code, the term reasonable means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.

Ethical Fundamentals Beauchamp and Childress, 1998

- Beneficence
- Nonmaleficence
- Autonomy
- Justice
- Rules for Professional-Patient Relations
  - Fidelity
  - Veracity
  - Confidentiality
  - Privacy

Elements of Risk Management

- Know the legal and ethical standards governing practice
- Identify high-risk patients and high-risk situations
- Conduct a conservative evaluation of your competence to perform
  - Intellectual competence
  - Technical competence
  - Emotional competence

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Elements of Risk Management

- Provide comprehensive informed consent
- Develop good recordkeeping practices and strategies
- Seek appropriate consultation
- Pay attention to client relationships
- Understand that you are in a business and will need efficient practices and procedures which interface well with your revenue sources
- Participate in your professional community

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High-Risk Patients

- Patients who organize their internal object world into hated and adored objects
  - Cluster B Personality Disorders (Borderline/Narcissistic)
  - Dissociative Identity Disorder (MPD)
  - PTSD (complex)
  - Patients who were abused as children or are in abusive relationships

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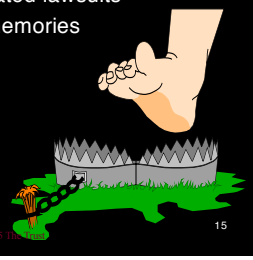
High-Risk Patients

- Potentially suicidal patients
- Potentially violent patients
- Patients involved in unrelated lawsuits
- Patients with recovered memories of abuse



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High-Risk Situations

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

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High-Risk Situations

- Digital World Risks
  - HIPAA breaches
  - Cloud backup
  - Email and text communications
  - The internet is forever
  - EHR oversharing
  - Social media participation and blurring of private and professional roles

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High-Risk Situations

  - Googling and other search activities
  - Online negative reviews
  - Telepsychological service delivery
  - Interjurisdictional practice

Things to Remember

- You will make mistakes.
- You cannot help everyone.
- You will not know everything.
- You cannot go it alone.
- The next few years will be difficult.
- Humility and a sense of humor are as crucial to risk management as they are to all other aspects of life.

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Working With Couples, and Children and Families

Areas of Concern

- Dyadic, group and family therapy are fundamentally different than individual treatment.
- Predominant ethical and legal models are constructed with individual treatment in mind.
- This creates problems in applying such ideas to multi-person treatments.
  - Who is the patient?
  - Informed Consent
  - Conflicts of Interest

Areas of Concern

- Multiple Relationship Conflicts
- Recordkeeping and access
- Confidentiality and Privilege
- Secret keeping

Important Ethical Principles in Conjoint Treatment

Multiple Relationships 3.05, APA 2010

- 3.05 (a) A multiple relationship occurs when the psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has a professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to that person.

Multiple Relationships 3.05, APA 2010

- A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist or otherwise risks exploitation or harm to the person with whom the professional relationship exists.
- Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

Ethical Standard 3.10 APA, 2010

- Requires obtaining informed consent of the individual or individuals using language that is reasonably understandable…(3.10(a)…
- For persons who are legally incapable of giving informed consent, psychologists nevertheless
  - provide an appropriate explanation,
  - seek the individual's assent,

Ethical Standard 3.10 APA, 2010

  - consider such person's preferences and best interests, and
  - obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

Ethical Standard 5.01 APA, 2010

- 5.01(a) Psychologists discuss with persons...with whom they establish a...professional relationship (including, to the extent feasible, minors, and their legal representatives) the relevant limitations on confidentiality, including limitations where applicable in...marital or family therapy….

Ethical Standard 10.02 APA, 2010

- When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset
  - which of the individuals are patients and clients, and
  - the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the service provided or the information obtained.

Ethical Standard 10.02 APA, 2010

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

Multiple Relationships: An example of required risk/benefit analysis

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

Multiple Relationships: An example of required risk/benefit analysis

- Can you reasonably foresee the multiple relationship causing harm to, impairment of/or exploitation of the client?
  - How serious?
  - How likely?
- What are the potential benefits to the client of your entering into the multiple relationship?

Multiple Relationships: An example of required risk/benefit analysis

- What alternative arrangements to the multiple relationship are available for the client?
  - Potential for equivalent benefit
  - Problems for client in accessing them

Multiple Relationships: An example of required risk/benefit analysis

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

Multiple Relationships: An example of required risk/benefit analysis

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

Multiple Relationships: Other Significant Issues

- Provide clear informed consent including what is confidential and what exceptions there are.
- Children are entitled to developmentally appropriate informed consent/assent, including the information to which their parents will have access.
- Define the role of each participant, including who is a client, who is a collateral, and what is the role of the psychologist with regard to each.

Differentiating Collateral v. Conjoint Services

- Ms. Sad enters individual treatment with you because of a longstanding and thus far intractable depression. You ask her partner of 17 years to attend two sessions to provide information because Ms. Sad struggles to describe her day-to-day functioning. You also hope to enlist his support for Ms. Sad's attempts at increasing her activity level.

Differentiating Collateral v. Conjoint Services

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

Differentiating Collateral v. Conjoint Services

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

Differentiating Collateral v. Conjoint Services

- See http://www.trustinsurance.com/ and select "Resources" and Download Documents." You'll see the "Sample Informed Consent Agreement for Collaterals" in that list.
- How does this analysis apply to Ms. Sad's situation and Mr. Stuck's?

OUTPATIENT SERVICES AGREEMENT FOR COLLATERALS
Ken Christianson, Ph.D.

INTRODUCTION

You are participating in therapy because a spouse, member of your family, or a friend has asked you to be involved. Your participation is important, and is sometimes essential, to the resolution of problems. This document is to explain your rights and responsibilities, and the limits of your rights, in your role as a collateral in therapy.

WHO IS A COLLATERAL?

A collateral is usually a spouse, family member, or friend, who participates in therapy with the "identified patient" but is not identified formally as a patient.

THE ROLE OF COLLATERALS IN THERAPY

Your role in this professional arrangement is…

I've Got a Secret

- Dr. Lee begins individual psychotherapy with Ms. Fisher. One of Ms. Fisher's issues is that she is engaging in an extra-marital affair and is very ambivalent about what to do regarding her marriage and this affair. During individual therapy, Ms. Fisher requests that her husband come to some of her individual sessions, which does occur, although she is continuing with the affair during this period. After a few joint sessions, Ms. Fisher requests that she and her husband commence marital therapy with Dr. Lee, but she demands that Dr. Lee not reveal any information to her husband about her affair.

I've Got a Secret

- Dr. Lee decides to begin marital therapy with the Fishers, and this therapy commences. During this period, Dr. Lee meets with the Fishers together, and she also has periodic individual meetings with each of the spouses. In an individual meeting, Ms. Fisher informs her that she continues to have periodic sexual contact with her extramarital partner, but she again directs Dr. Lee to keep this secret from her husband. Dr. Lee notices that the inability to address Ms. Fisher's past affair and her ongoing periodic contact with her paramour in the joint sessions is interfering with the marital therapy.

I've Got a Secret

- The marital therapy terminates after five sessions. Shortly thereafter, the couple separate, and they commence a bitter dispute over the custody of their two children.
- Ms. Fisher contacts Dr. Lee and asks to see her individually, once again. The focus is her distress in the divorce, her guilt about the affair, and her anger with her (soon-to-be) ex-husband for paying so little attention to her and the children during the marriage.

I've Got a Secret

- Five months later, Dr. Lee receives a subpoena from the husband's attorney demanding a complete copy of Dr. Lee's file on both of the Fishers. The subpoena is accompanied by an authorization to release information signed by the husband. Dr. Lee contacts Ms. Fisher, who states that she does not want Dr. Lee to release any information about her – either from her individual treatment or the couples treatment.

Definition of the Patient

- Though there is no hard and fast rule prohibiting treating a couple after working with an individual couple member (still, we strongly discourage it); or treating an individual after working with the couple; there are ethical, clinical, and legal implications.
- Recall APA Ethics standards related to:
  - Defining and clarifying who the client is (10.02(a))
  - Multiple relationships (3.05)
  - Conflicts of interest (3.06)

Definition of the Patient and Consent

- Raises the issue of engaging in informed consent with both members of the couple. For example:
  - Thinking through, for Dr. Lee, and then explaining to Ms. Fisher, the potential impact on an effective couples treatment of having worked with Ms. Fisher individually.
  - Considering whether this conflict of interest would be likely to undermine the effectiveness of the new services (and that in one respect, multi-person treatments have inherent potential conflicts of interest).

Definition of the Patient and Consent

- Clarifying with Ms. Fisher what the potential risks and benefits would be from moving into a couples treatment.

Definition of the Patient

- Defining for both members of the couple that the relationship has become the focus of treatment.
- Articulating the implications – that Dr. Lee, for example, would (or would not) hold secrets (we'll get back to this point in a few minutes).

Definition of the Patient

- Even putting aside the clinical dimensions, that ethically and legally, Dr. Lee would owe duties to both members of the couple, including such things as:
  - minimizing harm to each (e.g., domestic violence; threats to self or others);
  - nature and access to records;
  - response to legal demands for records.

Couples and Privilege

- Underlying bases for privilege:
  - Confidentiality is an ethical and legal duty to protect privacy of clients/patients.
  - Privilege is a statutory exception to normal rules of evidence that any relevant and material evidence should be available to insure most just outcome.
  - Privilege belongs to patient, but can be asserted by psychologist on patient's behalf.
  - Traditional view that privilege should be narrowly applied (i.e., the need for truth in the legal process in order to support just results usually trumps privilege).

Couples and Privilege

- Privilege rules differ from state to state
- Patients only vs. all professional relationships
- Some are referenced to lawyer-client privilege
- Applies only to psychologist him/herself or to others who are present to facilitate the treatment including family members and other collaterals
- Most protect couples treatment, but there are exceptions
- Psychologists should be familiar with state privilege rules but should not attempt to give legal advice about application

Couples and Privilege

- Subpoena for Records/Testimony:
  - Subpoenas are legal demands, usually issued by an attorney which seek to establish a court's jurisdiction over a person or entity;
  - These instruments do demand a response, but NOT immediate disclosure of treatment information;
  - Court orders are issued by a judge who has determined that privilege doesn't apply;
  - When in doubt about which one you have, consult before you act.

Couples and Privilege

- General Advice to Psychologist treating couples:
  - Unless otherwise agreed or unless both members provide authorization, psychologist should claim the privilege on the couples' behalf and let the court decide.
  - Different rules in some states (e.g., California, Virginia), require different strategy.

Couples and Privilege

- Note, also, that there are a variety of exceptions to privilege that might apply (e.g., if a member of the couple is suing someone and putting their own mental state at issue; if the conditions for privilege were not met, etc.).
- But it is not necessary for the clinician to determine whether such exceptions exist in a given situation.

Couples and Privilege

- Better to assume privilege applies, and have the client's attorney and, ultimately, the court, decide whether to an exception exists (e.g., Rost v. State Board of Psychology, 659 A.2d 626, 1995 (PA).

Secret Keeping

- The I've Got a Secret" vignette has as one of its dimensions the long and ongoing debate about how to address secret keeping by clinicians in couple and family therapy.
- Dr. Lee appears to accept Ms. Fisher's initial demand to maintain the secret.

Secret Keeping

- There are essentially three positions that have been discussed in regards to secret keeping (Margolin, 1982):
  - Keep secrets and attempt to navigate treatment, as Dr. Lee did.
  - Do not keep secrets.
  - An intermediate approach, which allows keeping – and disclosing – of secrets at the discretion of the clinician.

Secret Keeping

- All of these approaches have benefits and risks.
- But in our view, keeping secrets and using discretion are much more risky approaches, because the potential for members of a couple or family being or feeling betrayed, becoming angry, ending treatment, and complaining.
- Ultimately, clinicians must decide which balance of risks and benefits best suits their approach to treatment.
- It is very important to decide – and inform – all members of the conjoint therapy about one's policy before beginning treatment.

Informed Consent in Conjoint Treatment

- Include all of the basic information provided to individual clients (see The Trust sample consent form).
- Include the confidentiality parameters of the conjoint relationship imposed by law/ethics
- Discuss participation and access to information by all who attend.

Informed Consent in Conjoint Treatment

- Note that all children are entitled to developmentally-appropriate information about their treatment, including limits to confidentiality and appropriate participation in making decisions about their treatment.
- Establish how the normal conflicts of interest likely to occur in conjoint treatment will be dealt with by the therapist (e.g., when a parent wants a copy of a teen's records).

Informed Consent in Conjoint Treatment

- As previously noted, detail the rules regarding information that an individual conveys to the therapist outside the presence of other participants.
- Acknowledge that no one can predict the course of human relationships, and that it may be necessary to amend prior agreements as the psychologist and participants learn more about each other.
- Describe any modifications and the rationale for them.

Individual psychotherapy with minor children: Who consents?

- There are at least two inter-related issues:
  - Parents' constitutional rights
  - Minors' typically lack legal competence to make their own health care decisions
- Constitutional cases affirm that parents have the fundamental right and obligation to make decisions on behalf of their children.

Individual psychotherapy with minor children: Who consents?

- For example, in Troxel v. Granville (2000), the Court said "the Due Process Clause of the Fourteenth Amendment protects the fundamental right of parents to make decisions concerning the care, custody, and control of their children."

Individual psychotherapy with minor children: Who consents?

- In general, parents are given the responsibility to make decisions about their children, including medical care.
- Their guardianship rights stem from the presumption that minors lack the competence to make these decisions and parents are the best substitute decision makers.
- This usually includes the right to consent to medical treatment and the right to access records of that treatment.

Individual psychotherapy with minor children: Who consents?

- But parent rights are not absolute. They must be balanced against other important public policy issues, such as:
  - Child protective laws
  - Right to independently consent to certain medical procedures
  - Rights to privacy of mental health information

How Does this Relate to Minor Consent?

- Minors do not have the same rights as adults, nor are they typically considered legally "competent" to enter into legally binding contracts, decide on their own education, or give informed consent to health care services.
- But at times, and in keeping with the legal limitations on parental decision making, states have also given rights to minors to consent to services and to psychologists to restrict access to sensitive treatment information (see http://www.ncbi.nlm.nih.gov/pubmed/25870511)

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Minors Consent and Parents Rights

- It is thus fair to assume that parental consent is generally required on behalf of minors.
- If an exception applies, psychologists can provide services—but state law will specify conditions under which that consent is valid, and it must be followed carefully.
- With married parents, this means that either parent can consent to psychological services (though it is not a bad idea to obtain the agreement of both—which we'll get to shortly).
- More complicated situations arise when parents are not married, divorcing, or divorced.

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Parental Consent for Treatment of a Minor Child

- With divorced parents
  - Assume joint custody unless there is a contrary court decree.
  - With joint custody, either parent can legally consent unless the decree mandates otherwise
  - BUT, from a risk perspective, it's best to obtain consent from the non-help-seeking jointly custodial parent (see later slide).

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Parental Consent for Treatment of a Minor Child

- AND – with joint custody, EITHER parent can demand an end to the therapy of his/her minor child.
- Psychologists resist that demand at their own risk - it could result in a disciplinary complaint and sanction.

Parental Consent for Treatment of a Minor Child

- When legal/physical custody is divided:
- Insist on contacting/meeting with both parents unless there are very good reasons not to (e.g., domestic violence, child abuse).
- Where joint custody is the rule, insist on consent of both parents unless there are very good reasons not to.

Parental Consent for Treatment of a Minor Child

- Where parent claims sole legal custody, request a copy of the divorce decree.
- Where a parent is not available or where contact with a parent could seriously damage the treatment of child, record pros and cons of non-contact and be sure to seek consultation.

Parental Consent for Treatment of a Minor Child

- Consent to treatment does not insure payment for treatment.
- There may not be a psychotherapist-patient privilege for the parent, where a parent participates in treatment only for purposes of the child.
  - Information is still confidential and cannot be released without consent.

Parental Consent for Treatment of a Minor Child

- If a parent is not considered a patient, he/she should be specifically informed verbally and in writing, before any professional activities take place (as noted earlier), and should be informed regarding how individual parent meetings with the child's therapist will be handled.

What about Parental Access to a Minor's Treatment Information?

- In ordinary circumstances, parents are presumed to be responsible and to act in their children's best interest.
  - They have the right to make decisions for their minor children.
  - This includes the same right of access to a child's medical and psychological record that a child would have were he/she an adult.
  - But there are many exceptions to this rule depending on the laws and court decisions of the state and the interaction of those laws with HIPAA.

What about Parental Access to a Minor's Treatment Information?

- HIPAA specifically defers to state law when the law explicitly requires, permits, or prohibits parental access to minors medical records:
  - For example, when a minor has the right to consent and she/he holds the exclusive right to disclose (or not disclose) treatment information, and there's no law allowing parent access to that information;
  - Where explicit state law does not exist, HIPAA provides that a psychologist may elect to disclose or not, through the exercise of professional judgment;

What about Parental Access to a Minor's Treatment Information?

- Further, clinicians can choose not to treat the parent as a legal representative if the professionals have reasonable belief that:
  - Child may be/has been subject to abuse or neglect, or…
  - Doing so would endanger child and…
  - Psychologist decides, through exercise of professional judgment, it is not in child's best interest to do so.

Parental Access to a Minor's Treatment Information

- Further, in the absence of explicit state law to the contrary, HIPAA also allows parents to agree to a contract limiting their access to their children's treatment information.
- There is some controversy about the enforcability of these contracts (even among the Trust's Risk Management Consultants).

Parental Access to a Minor's Treatment Information

- If parents insist on violating these agreements, and accessing their children's information, there may be some risk to the therapist if they refuse such requests or defer the matter to court decisions. In this situation, consultation is strongly recommended.

Parental Access to a Minor's Treatment Information

- In the absence of state law to the contrary (e.g., New York), a contract may be used that limits the information provided to parents. For example:
  - Do provide progress summary
  - Encourage child's disclosure when appropriate
  - Report attendance or other problems
  - Summary to parents at termination
  - Inform parents of any dangerousness – give examples
  - Clear statement about clinician willingness or unwillingness to have court involvement

Sharing Information About Child Clients With Court: Sample Terms of the Confidentiality Contract

- Therapy needs to be a safe place for all participants; and parents need to know information that allows them to fulfill their responsibilities as parents.

Sharing Information About Child Clients With Court: Sample Terms of the Confidentiality Contract

- The therapist will keep all information learned from and about a child confidential unless the child agrees that it will be shared, but will encourage and assist child in sharing information with parents where appropriate.
- Parents will get regular reports from therapist re how therapy is going.

Sharing Information About Child Clients With Court: Sample Terms of the Confidentiality Contract

- Parents will receive summary after termination.
- If the therapist believes that a child is at serious risk of harm or is at serious risk of harming another person, he/she may non-consensually breach the child's confidentiality and inform parents and other appropriate parties.
- Discuss what constitutes serious harm with parents and adolescents to avoid confusion.

Sharing Information About Child Clients With Court: Sample Terms of the Confidentiality Contract

- Separation or divorce are hard on everyone, especially kids.
- With parents relationship in turmoil, even more important for therapy to be a safe therapeutic environment.
- This environment is undermined when children worry that what they say in therapy will be revealed in court, & used against a parent.

Sharing Information About Child Clients With Court: Sample Terms of the Confidentiality Contract

- To protect that environment, I want us all to agree that the therapist will not be called as a witness by either party.
- A judge, though, may decide not to honor this agreement and I may be required to be a witness, although I will try to prevent that from happening.

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Sharing Information About Child Clients With Court: Sample Terms of the Confidentiality Contract

- It is unethical of me to give any opinion about custody or visitation arrangements, even if I am compelled to be a witness.
- I request your permission to give information to any court appointed custody evaluator or person representing the legal interests of your children (unless your permission is not legally required; for example, when there is a court appointed GAL or minor's counsel).

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Sharing Information About Child Clients With Court: Sample Terms of the Confidentiality Contract

- I will not make any recommendation about the final decision.

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Records Access when Parents are Disputing Custody

- In most states, parental rights to a minors records treatment do not change merely because a couple is divorcing or re-litigating custody.
- BUT some states, like Massachusetts, make the assumption that parents in that context are less capable of keeping children's interests paramount, and thus courts appoint GALs to help determine whether the minor's privilege should be upheld when parents request their records (see Adoption of Diane, 1987).

Working with Potentially Suicidal Patients

Basic Information about Suicide

- Suicide is a serious public health problem:
  - More than 40,000 American adults die annually from suicide
  - 3.9% (9.4 million people) had serious thoughts of suicide in 2014
  - 0.5% made non-fatal suicide attempts
  - (SAMHSA Report on Suicidal Thoughts and Behaviors among Adults, 2015)

Basic Information About Suicide

- Base Rates:
  - Suicide is a low base rate event
  - 13/100,000 for general population
  - 41,149 reported suicides in 2013
  - 10th leading cause of death in U.S.
  - 2nd leading cause of death for ages 15-24
- Odds for losing a patient:
  - Psychologist 1 in 4
  - Psychiatrist 1 in 2
  - Psychological Trainee 1 in 9
  - (CDC, 2013; Farberow, 2005)

Basic Information about Suicide

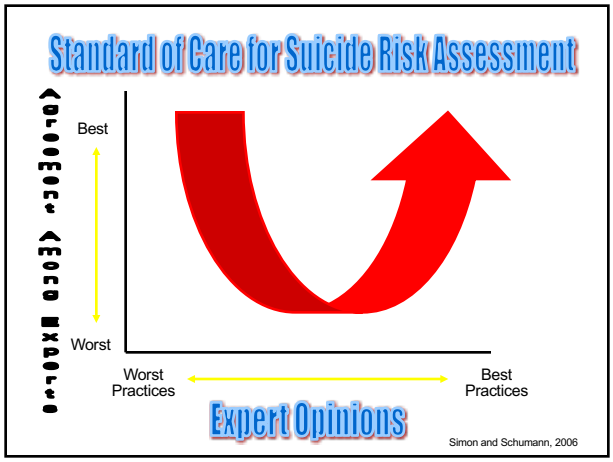
- Client suicide is the most frequently reported fear for therapists (97%)
- Suicide emotionally impacts everyone involved
- Four main causes of distress for clinicians
  - Concern about failure to hospitalize client
  - Concern about a specific treatment decision
  - Disapproval and criticism of other professionals
  - Fear of lawsuit

Basic Information about Suicide

- Standard of Care
  - The provider is not expected to predict suicide and prevent it.
  - The provider is expected to identify clinical factors that are associated with a high risk of suicide.
  - Where elevated risk is identified, the provider is expected to take reasonable professional steps to reduce the risk and protect the patient.
    - Greater control over the patient creates greater responsibility to protect patient.

Basic Information about Suicide

- Standard of Care
  - Standard of care in malpractice cases generally defined as that of an ordinary, reasonably prudent professional in similar circumstances.
  - Standard established by the testimony of "experts."
  - "Expert testimony that a standard model of suicide risk assessment exists is not credible." (Simon & Shuman, 2006)



Basic Information about Suicide

- There are no clear predictors, but there are risk factors with strong empirical support:
  - Mental disorders
  - Previous suicide attempts
  - Social isolation
  - Physical illness
  - Unemployment
  - Family conflict

Malpractice Issues

Basic Malpractice Determination

- Duty: Professional relationship must be formed
- Dereliction: Failure to perform within a standard of care
- Directly Causing: But for the dereliction, the patient would not have been damaged
- Damages: In most cases there must be tangible, measurable harm

Basic Malpractice Issues

- Problems with training focused on avoiding malpractice lawsuits:
  - Realities about suicide cases
    - Many suicide cases do not result in lawsuits. When they do, outpatient providers win 80%.
    - Most cases settle, limited ability to avoid settlements, which are usually confidential.
  - Hard cases make bad law and bad teaching .

Basic Malpractice Issues

- Focus on avoiding lawsuits leads to "defensive practice"
  - Positive: use more care and more risk management
    - Good informed consent
    - Good documentation
    - Good consultation
    - Some evidence that such does decrease errors and lawsuits

Basic Malpractice Issues

  - Negative: avoidance of good decision making out of fear
    - Avoiding patients with suicidal risk factors
    - Premature termination
    - Damage to the alliance caused by providers' anxiety
    - Bad responses to chronically suicidal patient manipulations

Advance Preparations

- Assess competence to treat suicidal patients
  - Competence: Training and experience
  - Emotional: Countertransference, particularly fear
  - Resources: Issues in solo, part time practices
  - Available consultation and willingness to use it
  - Good theoretical model
  - Availability of local crisis team or other resources
  - Knowledge of laws (e.g., involuntary commitment, duty to protect, exceptions to confidentiality)

Assessing Elevated Suicidal Risk

- All patients should be asked about suicidal ideation and past attempts
- No patient is “too healthy” for these questions
- Ongoing monitoring for suicidal ideation
- More thorough evaluation as needed

Assessing Elevated Suicidal Risk

- Various suicide risk assessment models are available, but no real agreement about reliability and validity
- Well-established risk assessment tools include Columbia Suicide Severity Rating Scale (www.cssrs.columbia.edu)
- Suicide Risk Assessment Guide lists other commonly used tools (https://www.oha.com/KnowledgeCentre/Documents/Final%20-%20Suicide%20Risk%20Assessment%20Guidebook.pdf)

General Myths-Facts About Suicide

- Myth: People often die of suicide on a whim.
- Fact: For the most part, they are deeply ambivalent about suicide. Usually they have thought about it for a long time. This should be distinguished from the high risk, impulsive behavior of some depressed individuals, substance abusers and adolescents who follow their impulses despite knowledge of the potential consequences.

General Myths-Facts About Suicide

- Myth: Once people make up their minds to kill themselves, there is little anyone can do.
- Fact: There is considerable research that shows that a caring intervention, even with a minor, one can deter suicide. There are also data that show that when attempters are deterred, they no longer want to commit suicide.

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General Myths-Facts About Suicide

- Myth: Suicide is a selfish and manipulative act.
- Fact: People who commit suicide often believe that on balance, their death will make things better for other people. From their perspective, it is a selfless act. When someone gets to the point of suicide, there are in a state where their focus is narrowed and they are stuck in their own state of mind. They feel they are a burden.

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General Myths-Facts About Suicide

- Myth: Suicide shouldn't be discussed directly and honestly with clients.
- Fact: It should. There is no evidence that talking about suicide increases risk. Providers should be able to empathize while firmly resisting the patients logic and offering help.

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Harris-Younggren Risk Management Taxonomy

- Serious attempter
  - Agitated Depression,
  - Bipolar/psychotic
  - Substance dependence/abuse
  - Rigid thinking, no other way out
  - Usually enters through medical system
  - Psychiatrist managed
  - Acute risk, must be hospitalized
  - With appropriate treatment, medication, suicide risk often substantially reduced

Harris-Younggren Risk Management Taxonomy

- Chronic attempter
  - Cluster B patient
  - Suicide part of character structure as means of escaping intractable pain
  - Attempts often gestures of varying lethality
  - Secondary gain but not the main purpose
  - Dangerous to think this is not part of preparation for lethal attempt

Harris-Younggren Risk Management Taxonomy

  - Often managed by psychologists
  - Frequent risk management calls
  - Very difficult to treat
  - DBT can substantially reduce risk
    - Empirically supported treatments for suicidality include: DBT, CBT, interpersonal therapy, problem-solving therapy, and mentalization-based treatment (Brown & Jager-Hyman, 2014).

The Rudd-Joiner Taxonomy of Suicidal Risk

- Eight Factors to Consider in Assessing Suicidality
  - Predisposition to suicidal behavior (static factors)
  - Previous suicidal behavior
  - Nature of suicidal thinking (resolved plan & preparation)
  - Precipitators or stressors (aggravating factors)
  - Symptomatic Presentation

The Rudd-Joiner Taxonomy of Suicidal Risk

- Hopelessness
- Impulsivity
- Protective Factors
- (Rudd & Joiner,1999)

Protective Factors

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support (connectedness)
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes

Protective Factors

- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation
- (http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html)

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Clinical Factors, cont.

I – ideation
S - substance abuse

P – purposelessness
A - anxiety
T – trapped
H - hopeless

W – withdrawal
A - anger
R – recklessness
M – mood changes

.(Rudd et al., 2006)

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Data on Suicide

- Demographic
- Males/Female completion rate 4:1
- Age: Highest rate in ages 45-64; second highest rate > 85.
- Race/ethnicity: Highest rates among whites; second highest among Native Americans.
- Methods

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Data on Suicide

- Firearms most common method (51%); next most common methods suffocation/hanging (25%).
- Attempts
- Attempt/completion rate 25:1
- Female/male attempt rate 3:1

Data on Suicide

- Mortality rates by disorders (as compared to general population)
  - Eating disorders (23.14 times greater)
  - Major affective disorders (20.35 times greater)
  - Substance Abuse (19.34 times greater)
  - OCD (11.54 times greater)
  - Schizophrenia (8.45 times greater)
  - Personality Disorders (7.08 times greater)
  - Intellectual Disability (.88 times the general population)

Data on Suicide

- Those who are at a higher risk of suicide are older, European American, unmarried (especially widowed or divorced), male, adolescents, or young adults, or members of sexual minorities.
- About 20% of people who die by suicide have made a prior attempt.
- Suicide risk appears to be especially elevated during the days and weeks following hospitalization for a suicide attempt.

Outpatient Clinical Interventions with Suicidal Patients

- Outpatient interventions should include:
  - 24-hour availability
  - daily check-ins
  - increase in frequency of sessions
  - regular psychiatric/medical consultation
  - removal of lethal means
  - coordination with family or significant others
  - documentation of consultations
  - consideration of DBT program or other structured, intensive outpatient program

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Clinical Interventions with Suicidal Patients

- Safety/No Suicide Contracts
  - Have limited value and meaning
  - No empirical support
  - Often is not therapeutic intervention
    - Clients understand who such a contract is protecting
    - Exception with long term clients with good therapeutic alliance
  - Reliance on these contracts can create more liability potential than it will protect against

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Clinical Interventions with Suicidal Patients

- Commitment to treatment/living statement
  - Individualized
  - Concrete and specific
  - Enhances patient responsibility and control over their own lives
  - Includes a commitment to living
  - Includes a crisis response plan

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Model Commitment to Treatment Statement

- "I agree to make a commitment to the treatment process. I understand that this means that I have agreed to be involved in all aspects of treatment including:
  - Attending sessions (or letting you know when I can't make it)
  - Voicing my opinions, thoughts, and feelings honestly and openly whether positive or negative
  - Being actively involved during sessions
  - Completing homework assignments

Model Commitment to Treatment Statement

  - Experimenting with new ways of doing things
  - Taking medication as prescribed
  - Implementing my Crisis Response Plan
- I also understand that, to a large degree, my progress depends on the amount energy I put into treatment. If it's not working, I'll discuss it with my therapist. In short, I make a commitment to living."
- Based on example from Rudd, Mandrusiak & Joiner (2006)

Model Crisis Response Plan

- When thinking about suicide, I agree to do the following:
  - Try to identify what's upsetting me.
  - Write out and review more reasonable responses to my suicidal thoughts, including thoughts about myself, others, and the future.
  - Review all the conclusions I've come to in my treatment log.
  - Do things that help me feel better for about 30 minutes, including listening to music, taking a bath, going for a walk with my dog.

Model Crisis Response Plan

- When thinking about suicide, I agree to do the following:
  - Repeat all of the above.
  - If I do not feel better, I will discuss the matter with my wife or significant other.
  - I will call my therapist.
  - If the thoughts continue, get specific and I find myself preparing to do something, I will call the emergency number, which is XXX-XXXX and go to the Emergency Room of the local hospital.

Risk Management with Suicidal Patients

Risk Management with Suicidal Clients

- Documentation
- Good, ninth grade algebra recordkeeping will protect you more than any other tactic.
  - What you did and why you did it; what you rejected and why you rejected it
- Regular risk assessments
- Formal plan to manage risk

Risk Management with Suicidal Clients

- Demonstration of complexity and uncertainty of patient's emotional issues
- Demonstration of provider's knowledge of patient, caring about patient and investment in patient's well-being

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Risk Management with Suicidal Clients

- Documentation
- Never alter the record
- Get previous treatment records
- Include discussions of medication, hospitalization
- Include summaries of all consultations
  - Demonstrates general professional uncertainty about what is called for in difficult, complex cases
  - Demonstrates prudent professional practice
- Include all conversations with family, managed care personnel, police, etc.

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Informed Consent

- Inform patient of your responsibility and intention to protect
- Include clinician's option to breach confidentiality to protect from serious physical harm to self or others in written informed consent
- If possible, involve patient in safety planning
  - Inform patient of your plans and rationale before you carry them out
  - Research indicates that there are better clinical results when patients are involved in treatment/safety process

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Informed Consent

- Where appropriate, involve patient's family/significant others in treatment/safety process.
  - Most people who die from suicide have communicated their intent in advance, usually to family or significant others.
  - Family members are the potential plaintiffs if patients kill themselves.
    - Data suggest that one of the main correlates with the decision to sue is how the family feels about how much the therapist cared about the patient and how they are treated by that therapist.

Medication

- Patients with suicide potential should be required to seek medication evaluation as a condition of continued therapy
- Meds should be encouraged and monitored
- When treating high risk patients, keep in regular consultation with prescribing physician
- Often a good source of consultation about maintaining safety
  - Note in records successful and unsuccessful attempts to reach psychiatrist

Hospitalization

- If risk is moderate or above, therapist should seriously consider hospitalization
  - Careful, detailed considerations of pros and cons a must for records
  - Malpractice case law shows that rejection of hospitalization for good clinical reasons can protect provider when suicide occurs
  - Note managed care restrictions on hospitalization

Hospitalization

- If risk is severe, patient should be evaluated for hospitalization or monitored at all times
- Hospitalization is considered by some to be the only safe intervention for severe risk
- If possible, voluntary hospitalization is preferable
- If patient is hospitalized, therapist should try to participate as much as appropriate/possible

Consultation

- Consultation helps set standard of care
- Document consultations
- Document contacts with insurance companies and any coverage restrictions or refusals
- Trust policyholders: Call 800-477-1200 for Advocate Consultation Service
- Be careful what you say in non-confidential situations

Dealing with the Chronically Suicidal Borderline Patient

- Number one source of Trust 800 Advocate Service calls involving suicide
- Very difficult patients to treat
  - REQUIRE regular consultation
  - REQUIRE maintenance of appropriate limits
  - REQUIRE regular assessment of therapist's resources and countertransference

Dealing with the Chronically Suicidal Borderline Patient: Termination

- You should terminate treatment if you feel you cannot provide appropriate therapy
- Patient failure to follow clinical advice is a sufficient reason to terminate
- Patient does NOT have to agree
- Ethics 10.10 requires adequate notice and provision of alternative resources (unless precluded by actions of clients or third-party payers)
- Referrals should be appropriate/do not have to be perfect

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Postvention – Self Care

- Data indicate that the loss of a patient can be similar to the loss of a member of the therapist's family.
- The patient's death needs to be fully processed and mourned.
- It is safer to do this in therapy relationships than in consultation.
- Be careful of what you say and to whom you say it
- Self recrimination should be limited to confidential/privileged relationships.

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Postvention-Interactions with Patient's Family

- Post suicide interaction with family very important
  - Be kind and compassionate
  - Data suggest decision to sue strongly impacted by family perception of therapist's caring for deceased patient
  - Anything you say can be used against you
- Give condolences, may attend funeral if invited

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Postvention-Interactions with Patient's Family

- Consider offering to meet with family.
- If family requests consultation/information, respond in a formal yet caring manner.
  - It is possible to talk in general terms about the treatment while protecting important confidential information.
  - Provide resources for suicide loss survivors.

Postvention-Interactions with Patient's Family

- Executor/patient's legal representative generally has the same rights as the patient had regarding access to health records.
  - Check state law
  - May have ability to waive privilege
  - May have access to records
  - Get documentation of legal authority
  - Assert privilege if contrary to deceased wishes

Resources

- American Association for Suicidology (AAS) recommended reading http://www.suicidology.org/resources/recommended-reading
- AAS resources for clinician & loss survivors http://www.suicidology.org/suicide-survivors/clinician-survivors
- American Foundation for Suicide Prevention https://www.afsp.org/

Resources

- Support Groups https://www.afsp.org/coping-with-suicide-loss/find-support/find-a-support-group
- National Suicide Prevention Lifeline 24/7 at 800-273-8255

Retirement

- A full discussion of retirement requires two parts:
  - What are the factors – psychological, financial, and health – that help a professional decide whether, when, and how to retire?
  - What are the legal and professional requirements for a psychologist to retire?

Retirement

- This workshop will focus on the legal and professional aspects of retiring from psychological practice.
- The Trust has created a more comprehensive webinar on retirement at www.trustinsurance.com which we highly recommend.

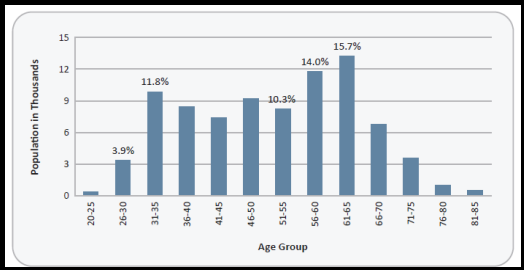
Retirement as a Process

- "Although research on retirement takes many different forms, the consensus is that retirement is not a single event, but rather a process that older individuals go through over a period of years."
- "Psychological Perspectives on the Changing Nature of Retirement"

Psychologists: Active/Semi-Retired/Retired (2013)

83,142	active psychologists	83.3%
7,996	semi-retired psychologists	8.0%
8,657	retired psychologists	8.7%
99,795	total psychologists	100%

Active Psychologists: Age Demographics (2015)



How We Experience Retirement

- Pre-retirement factors that influence how we experience retirement (these factors vary across persons):
  - the role of work and family in our lives
  - the timing of retirement
  - the degree to which work has been satisfying
  - the degree to which retirement is planned for
  - the expectations we have about retirement
  - one's health and sense of financial security

How We Experience Retirement

- Schlossberg, Nancy K. (2009). Revitalizing Retirement: Reshaping Your Identity, Relationships, and Purpose. American Psychological Association.

Cognitive Functioning and Retirement

- Persons whose primary professional work consisted of complex interactions with others (compared to other types of work complexity) showed the greatest preservation of verbal functioning as they aged.
- Persons whose primary professional work consisted of complex interactions with others (compared to other types of work complexity) showed the greatest decline of spatial functioning as they aged.

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Cognitive Functioning and Retirement

- The Role of Occupational Complexity in Trajectories of Cognitive Aging Before and After Retirement. Deborah Finkel & Ross Andel. Psychology and Aging 2009 Vol. 24, No. 3, 563–573.

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Working in Retirement

- 1 in 5 workers has a post-retirement job.
- 75 percent of workers expect to work or transition to a second career at some point after they retire.
- The research found that working retirees report levels of health, wellbeing, and life satisfaction on par with those who have not yet retired – despite age differences.
- People who pursued post-retirement bridge employment in their previous fields report better mental and physical health than those who retired fully.

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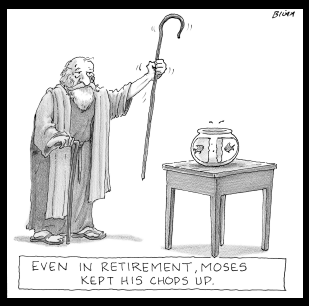
Working in Retirement

- Working in Retirement: A 21st Century Phenomenon (2010)" (http://familiesandwork.org/site/research/reports/workinginretirement.pdf)
- Wang, M. (2009). Journal of Occupational Health Psychology.

PROFESSIONAL RETIREMENT



The Sad Story of Dr. Unprepared

- Dr. Unprepared unexpectedly dies in a car accident. He was healthy and neither he nor anyone else expected that he might pass away.
- As a result, Dr. Unprepared had not considered how his full practice would be administratively handled or how his clients would be informed if he suddenly was incapacitated or died.
- Dr. Unprepared was in solo practice and did not have close relationships with other psychologists.

The Sad Story of Dr. Unprepared

- Dr. Unprepared's wife, Ms. Desperate, is the executor of her husband's will. She is a schoolteacher and knows nothing psychological services.

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The Sad Story of Dr. Unprepared

- Ms. Desperate finds that her husband's pts are showing up at the office for their appointment with Dr. Unprepared, because they are not aware that he has suddenly died.
- Furthermore, Dr. Unprepared's phone keeps ringing, and it seems that he is receiving messages from current and past clients, insurance companies, and other providers who take care of his patients. Ms. Unprepared does not know how to retrieve these messages, and wouldn't know how to respond to them if she did.

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The Sad Story of Dr. Unprepared

- Similarly, Ms. Unprepared does not how to access her husband's business e-mail, but it is clear that he is receiving many such e-mails.

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The Sad Story of Dr. Unprepared

- Ms. Desperate, who is mourning the sudden loss of her husband, finds that she must also try to do something about her husband's practice.
- She does not know how to contact his patients and is not even sure who are the current or the past patients. Dr. Unprepared's records are not well organized.
- Ms. Desperate starts calling patients and telling them that Dr. Unprepared has died and wishing them the best. She has no idea about referring patients to other providers.

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The Sad Story of Dr. Unprepared

- Dr. Unprepared lived in a small town. Ms. Unprepared reads through her husband's patient files and is shocked by some of what she finds out about these patients. Gradually, she begins to share this information with her friends and acquaintances, and this information to spread around the town, seriously embarrassing many of Dr. Unprepared's clients.

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Ethical Issues Regarding Retirement/Cessation of Practice

- Relevant Principles and Sections of the Ethical Principles of Psychologists and Code of Conduct
- 3.04 Avoiding Harm
  Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

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Ethical Issues Regarding Retirement/Cessation of Practice (cont.)

- 3.12 Interruption of Psychological Services
- Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation or retirement, or by the client's/patient's relocation or financial limitations.

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Ethical Issues Regarding Retirement/Cessation of Practice (cont.)

- 6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work
- Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice.

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Preparation for Retirement/Cessation of Practice

- Know your state laws and regulations
  - record retention requirements
  - is notice to public and/or past patients about my closing necessary?
- Know your professional community
  - other professionals who can take referrals or assist for period of time
  - an attorney and accountant to help you wind up your practice
- Have a professional will that covers necessary steps should you become incapacitated

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Preparation for Retirement/Cessation of Practice (cont.)

- Organize your Records
  - secure record storage
  - smooth record retrieval
  - organized and accessible list of current patient contacts and treatment files
- Include Information in the Informed Consent
  - events that might occur should psychologist become suddenly unable to carry out business (e.g., a person will step in, notify, refer, etc.)

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Actions for Retirement/Cessation of Practice

- Tell your patients about your decision to cease practice and stop taking new cases.
- Notify current clients verbally and by letter.
- Change your outgoing voice-mail message and your e-mail to reflect your inability to take new clients and/or the winding up of your practice.

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Notifying Former Patients?

- Some states require notification to former patients.
- But what should you do if this is not required?

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What to Say to Your Current Patient?

- Clients' needs are of primary importance
- Clear and honest, but tailored to client's needs
- Consistent with your treatment approach
- Timing – all clients, some clients

Actions for Retirement/Cessation of Practice (continued)

- Expect a variety of reactions from clients.
- Anticipate and deal with a variety of responses in yourself, which may vary by client.
- Consolidate gains made in treatment and lay out future treatment directions for client to consider.
- Notify the other health professionals who work with your clients.

Actions for Retirement/Cessation of Practice (continued)

- Look at your lease and determine how much notice is necessary to terminate it; contact landlord, and notify, and negotiate if there is a lot of time left and/or seek sublettor.
- Notify insurance companies for which you are a provider and deactivate your listing or indicate not taking new clients.
- Submit claims and collect any outstanding debts/arrears

Actions for Retirement/Cessation of Practice

- Consult with an attorney and accountant to prepare yourself if necessary
  - Begin to formally close your business (This can be more complicated if you are an LLC or PC and may involve specific legal steps)
  - Figure out how people will be able to contact you. Forwarding address, post office box, web site.

Actions for Retirement/Cessation of Practice

- Decide if you wish to keep your license
- Contact your professional liability insurance carrier regarding tail coverage.
  - Remember that any professional activities that you engage in after securing a tail are uncovered, including volunteer work, referrals, doing summaries of records, etc.
  - Activities that are an extension of the actual work you did are covered: testifying at trials which one has been subpoenaed to attend, releasing records

Actions for Retirement/Cessation of Practice (continued)

- Close your office, sell, or donate furniture and office fixtures, be careful to make sure that equipment that contains or holds confidential information is treated to wipe out that confidential information
- Cancel professional memberships, journals, that will not be needed

Records and Retirement

- One of the most common questions is what to do with records when you retire.
  - How do you make sure clients can gain access when they need it?
  - How long do you have to keep them?
  - How do you transfer the authority to maintain them to others, if that is what you choose to do.

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Records and Retirement

- State regulations
  - Where to find them?
- APA Record Keeping Guidelines
  - Useful when no state regulations
  - "In the absence of a superseding requirement, psychologists may consider retaining full records until 7 years after the last date of service delivery for adults or until 3 years after a minor reaches the age of majority, whichever is later."

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Records and Retirement

- Medicare regulations
  - Medicare = 5 yrs, Medicare Advantage = 10 yrs
- Should you keep records longer than the state or Medicare required duration?
- Forensic Record Retention

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Records and Retirement

- Make arrangements for secure record storage at a convenient location for you or the person who will be handling the record requests.
- Can I scan paper records and then destroy the paper?

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What Happens If You Die or Become Suddenly Incapacitated?

- Consider the potential impact on clients should their psychotherapist become incapacitated or die.
- Who would contact patients and let them know?
- Who would coordinate a referral to another professional?
- Who would coordinate the transfer of treatment records?

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What Happens If You Die or Become Suddenly Incapacitated?

- Your professional duties continue even when you are incapacitated by illness or death.
- You remain vulnerable to board complaints and/or lawsuits even when ill, or lawsuits when you have died.
- Your estate (usually represented by your next of kin) remains liable for defending lawsuits and paying judgments against you.

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What Happens If You Die or Become Suddenly Incapacitated?

- The Solution: A Professional Will
- A PW is a professional directive that gives authority and instructions to a Professional Executor about your psychology practice in the event of your incapacitation or death.
- The Professional Executor's role is to take ethically and clinically appropriate actions to close your practice and deal with future demands made on your practice.

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Oregon: Ahead of the Curve?

- Oregon psychology licensing law mandates that all licensees must notify the Board of a "qualified person" who will intercede for client welfare, maintain and access client records to ensure confidentiality, and make necessary referrals in the case of death or incapacity of the licensee.
- The qualified person must be an active or semi-active Oregon licensed psychologist.

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Key Issues in Making a Professional Will

- Choosing the right Professional Executor
- Prior Informed Consent to your clients about your Professional Will/Executor
- Location of Professional Will

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Elements of a Professional Will

- Name and Contact Information for Your Professional Executor
- I,_____, a resident of the County of Nassau, State of New York, do hereby declare this to be my Professional Will. This supersedes all prior Professional Wills, in the event there are any. This is not a substitute for a Personal Last Will and Testament. It is intended to give authority and instructions to my Professional Executor regarding my psychology practice and records in the event of my incapacitation or death.

Elements of a Professional Will

- FIRST
  - I am a licensed practicing psychologist. My license # is _____ My principal office address is_____.
- SECOND
  - In the event of my death or incapacitation, I hereby appoint as my Professional Executor _____ who has agreed to serve in this role. His/her phone number, email and mail address are_____

Elements of a Professional Will

- In the event that_____ is unavailable or unable to perform this function, I hereby appoint as Secondary Professional Executor _____whose phone number, email and mail address are _____
- Statement Giving Authority to Your Professional Executor

Elements of a Professional Will

- THIRD
  - I hereby grant my Professional Executors full authority to:
  - Act on my behalf in making decisions about storing, releasing and/or disposing of my professional records consistent with relevant laws, regulations, and other professional requirements.
  - Carry out any activities deemed necessary to properly administer this Professional Will.

Elements of a Professional Will

  - Delegate and authorize other persons determined by them to assist and carry out any activities deemed necessary to properly administer this Professional Will.
  - The executor of my personal will is _____. His/her phone number, email and mail address are _____.
  - The attorney for my personal will is_____. His/her phone number, email and mail address are _____.

Elements of a Professional Will

  - Instructions to my Professional Executor
- FOURTH
  - First of all, I would like to express my deep appreciation for your willingness to serve as my Professional Executor.
  - I have filed several copies of this Professional Will as follows:
    - One is in your possession.
    - One is filed with my personal will (if I have one).

Elements of a Professional Will

- Please use your clinical judgment and discretion in deciding how you want to notify current and past clients of my death or incapacitation consistent with ethical and legal guidelines.
- If clinically indicated, you may wish to offer a face-to-face meeting with some clients and discuss continuity of care. Additionally, after having contacted the client, you may wish to provide three referrals.
- Instructions to my Professional Executor (continued)

Elements of a Professional Will

- Please arrange for clients' records or copies of their records to go to their new psychologist or other mental health professional, if applicable, with the clients' consent. All remaining records should be maintained according to the relevant state regulations or APA Record Keeping Guidelines.
- Please promptly notify my professional liability carrier of my death and arrange for any additional coverage that may be appropriate.

Elements of a Professional Will

- You may bill my estate for your time and any other expenses that you may incur in executing these instructions. Unless otherwise ordered by the court, the hourly rate of _____ is acknowledged to be reasonable. [It is strongly recommended that you reinforce this commitment by also delineating its specifics in your personal will.]
- [If your practice is a corporation or LLC, you should consult with your attorney regarding whether your estate (instead of the corporation or LLC) should reimburse your Professional Executor.]

Elements of a Professional Will

- Useful Information for my Professional Executor (Files, Passwords, and Contacts List)
- Location of keys to office _____
- Individuals who may be able to assist in locating/accessing my client records and other relevant professional documents
- Name_____
- Relationship (e.g., colleague, office staff, family member)_____

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Elements of a Professional Will

- Address _____
- Phone _____
- Email _____
- Name_____
- Relationship (e.g., colleague, office staff, family member)_____
- Address_____
- Phone _____
- Email _____

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Elements of a Professional Will

- Useful Information for my Professional Executor (Files, Passwords and Contacts List)
- Appointment book/software and client contact information (e.g., phone numbers, email addresses, information on how clients prefer to be contacted)
- Location_____
- Keys (if any) _____
- Passwords (if any) _____

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Elements of a Professional Will

- Current client records
- Location_____
- Keys (if any) _____
- Passwords (if any) _____
- Past client records
- Location_____
- Keys (if any) _____
- Passwords (if any) _____

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Elements of a Professional Will

- Useful Information for my Professional Executor (Files, Passwords and Contacts List)
- Psychological test materials (if applicable)
- Location_____
- Keys (if any) _____
- Passwords (if any) _____
- Professional billing and financial records
- Location_____
- Keys (if any) _____

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Elements of a Professional Will

- Passwords (if any) _____
- Professional liability insurance policy
- Company and policy number _____
- Company phone number/email _____
- Location of policy _____
- Keys (if any) _____
- Passwords (if any) _____

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Elements of a Professional Will

- Useful Information for my Professional Executor (Files, Passwords and Contacts List)
- Computer and other electronic devices on which patient information is stored (including electronic backup if not listed above, e.g., external hard drive, cloud storage)
- Type of computer:_____
- Location: _____
- Password: _____
- Type of device: _____

Elements of a Professional Will

- Location: _____
- Password: _____
- Professional practice telephone, e-mail, and website: _____
- Phone number: _____
- Voicemail access code: _____
- Email address: _____
- Password: _____

Elements of a Professional Will

- Website address: _____
- Password/How to access as an administrator: _____
- Additional professional files, filing cabinets, and/or storage facilities (if any):
- Description, location, and how to access: _____

Guidelines for the Professional Executor

- Following are some guidelines you might wish to consult. They are organized by time periods, since immediate action is usually required surrounding a sudden death or incapacitation, followed by issues of resolution and closure.
- Immediate (same day/next day)
- Welfare of Patients (primary concern)

Guidelines for the Professional Executor

- Contact the family and/or executor of the deceased person's personal will and explain your role as a Professional Executor. Describe the assistance you may need and attempt to coordinate with them. Naturally, it is important to remember that family members will be affected by shock, grief, loss, etc., and to be clinically sensitive to these issues.
- Review the guidelines and directives of the Professional Will.

Guidelines for the Professional Executor

- Immediate (same day/next day)
- Gain access to the deceased psychologist's appointment calendar, phone book, cell phone, and patient records.
- Gain access to psychologist's office and post a notice with your phone number to call. A sample note on the door might read: Dr._____ is unavailable. For further information, please call me: (area code) (phone number). Thank you. (Your signature).

Guidelines for the Professional Executor

- Gain access to voice mail and change greeting with your phone number to call. Sample greeting is similar to above. Dr._____is unavailable. I am Dr._____ and am taking calls for him/her. Please leave a message for me with your phone number and a good time for me to reach you and I will return your call as soon as possible. Thank you.

Guidelines for the Professional Executor

- Immediate (same day/next day)
- Call the same day/next day appointments to cancel. At that time, you will need to explain that the psychologist has become incapacitated or died and offer phone triage to the patient/s, scheduling appointments with you or making referrals to other psychologists, as appropriate.
- Continue with cancellation of the week's, and current month's appointments.

Guidelines for the Professional Executor

- In contacts with all patients offer further contact, consultation and, ultimately, referral to yourself or another psychologist, if desired or clinically indicated.
- Related Professional Practice Issues
- Inform office staff, colleagues, and building management. Some documentation of the psychologist's death may be required.

Guidelines for the Professional Executor

- Short-Term (second week and immediately beyond)
- Welfare of Patients
- Form a liaison with family regarding their wishes for a memorial. Often a notice in the newspaper provides information to the larger community.
- Contact all patients listed in the psychologist's appointment calendar for the past year to notify them.

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Guidelines for the Professional Executor

- Continue contact with current patients in order to facilitate addressing their needs (providing appointments, making referrals, etc.).
- Clinical records should be placed in storage and records or copies of the records should be released upon an appropriately documented request to another mental health provider. (This is recommended in order to avoid any harm that might befall a patient upon reading notes which cannot be processed because the writer is not there).

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Guidelines for the Professional Executor

- Do not read client files unless authorized by the patient.
- Short-Term (second week and immediately beyond)
- Related Professional/Practice Issues
- Inform malpractice carrier as soon as feasible. It is necessary to do this in writing to ensure the addition of a tail to the insurance. Some documentation of death will probably be required.

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Guidelines for the Professional Executor

- Advise the family and/or the executor of the personal will regarding the disposition of the contents of the office.
- Collection of bills is ultimately the personal executor's responsibility. Professional Executor acts in an advisory capacity regarding patients' privacy.
- If your state law requires that a notice of the psychologist's death be published in a newspaper of widest circulation in the county for two weeks at five days a week, arrange for such.

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Guidelines for the Professional Executor

- Intermediate-Term (first few months)
- Welfare of Patients
- Keep phone and voice mail active for at least a year, update greeting as appropriate, check weekly and respond as needed.
- Continue to facilitate referrals and the appropriately documented requests for transfer of records.
- Arrange for longer term confidential storage and disposition of records.

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Guidelines for the Professional Executor

- Related Professional/Practice Issues
- Inform the Board of Psychology with a copy of obituary or death certificate.
- Inform APA and any other professional organizations.
- Cancel journals.
- Long-Term
- Welfare of Patients
- Continue to attend to patient requests as they arise.

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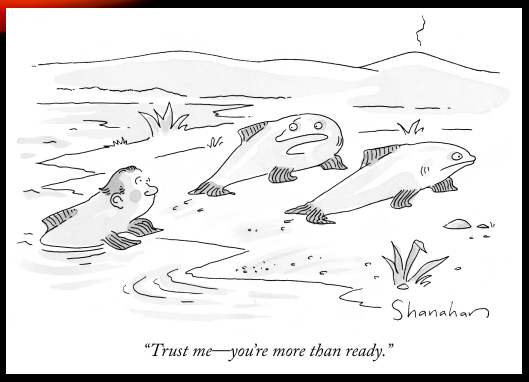

"Trust me—you're more than ready."

RESOURCES

- Professional will templates are available here:
- www.apapracticecentral.org/business/legal/professional/secure/will.aspx
- http://sdpsych.org/professional_will_and_guidelin.php

References/More Resources

- American Bar Association Commission on Law and Aging. Consumer's tool Kit for health care advance planning, 2nd Ed. (2005). American Bar Association. www.abanet.org/aging
- American Psychological Association Committee on Aging. Life plan for the life span. https://www.apa.org/pi/aging/lifespan.pdf
- American Psychological Association Practice Office. Checklist for closing your practice. www.apapracticecentral.org

References/More Resources

- Finkel, D. & Andel, R. (2009). The role of occupational complexity in trajectories of cognitive aging before and after retirement. Psychology and Aging, 24, 3, 563–573.
- Horner, E. (2014). Subjective well-being and retirement: analysis and policy recommendations. Journal of Happiness Studies. 15, 125-144.

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- Matz-Costa, C.; Besen, E.; James, J. & Pitt-Catsouphes, M. (2014). Differential impact of multiple levels of productive activity engagement on psychological well-being in middle and later life. Gerontologist, 54, 277-89.
- Model Professional Will, San Diego Psychological Association, http://sdpsych.org/professional_will_and_guidelin.php

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- Schlossberg, N. (2009). Revitalizing Retirement: Reshaping Your Identity, Relationships, and Purpose. American Psychological Association.
- Shultz, K. & Wang, M. (2011). Psychological perspectives on the changing nature of retirement. American Psychologist, 66 (3), 170-179.
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- Wang, M. (Ed.). (2013). The Oxford handbook of retirement. New York, NY: Oxford University Press
- Working in Retirement: A 21st Century Phenomenon (2010). http://familiesandwork.org/site/research/reports/workinginretirement.pdf
- Zhan, Y., Wang, M. & Liu, S. (2009). Bridge employment and retirees' health: A longitudinal investigation, Journal of Occupational Health Psychology, 14, 4.