Barter, Neglect, Violence Towards Patients, and Patient Outings

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Note: In the February 2014 issue of the AVOIDING LIABILITY BULLETIN, I raised many questions for the reader's thought, research, and discussion with colleagues. The questions were on a variety of topics, arranged alphabetically. Some of those questions, with my answers, follow. The answers are brief and are not intended to be a thorough exploration of the topic.

B. BARTER: What are the legal and ethical limitations upon bartering with clients? May a mental health practitioner properly initiate the idea of barter?

DISCUSSION: With respect to legal limitations, one must refer to state laws and regulations to determine how barter is addressed, if at all. Most states require that a mental health practitioner's fees (or the basis upon which the fee will be computed or determined) be disclosed to patients prior to the commencement of treatment. Other limitations or specifications regarding fees, and advertising about fees, may be specified in law or regulation. Since exploitation of a client is unethical and generally constitutes unprofessional conduct, a barter arrangement that is later the subject of a consumer complaint will surely be examined for its appropriateness and fairness under the circumstances. Barter is more likely directly addressed in the ethical standards of the various mental health professions.

While barter is generally permitted under the ethical standards (codes of ethics) of a variety of professional associations, limitations are specified in most, if not all, codes. For example, at least one profession's standard states that practitioners ordinarily refrain from accepting goods or services in exchange for professional services. This is read by some as a bias against barter. Most if not all standards prohibit barter if the idea is initiated by the mental health practitioner. A written contract that specifies the details of the barter agreement may be required, especially if the barter arrangement involves the performance of personal services by the patient. Exploitation of a patient must of course be avoided (as with situations where barter is not involved!) and the patient's mental condition must be considered. Other cautions or restrictions may be specified in the particular ethical standards. Do your research on this subject if barter becomes a possibility for you, or before it does.

N. NEGLECT: Is there a difference between general neglect and severe neglect in your state's child abuse reporting law? Is a report required if there is a reasonable suspicion of general neglect?

DISCUSSION: California law (as an example) provides that a report is mandatory if the mandated reporter, whenever acting in his or her professional capacity or within the scope of his or her

employment, has a reasonable suspicion (or knowledge) that a child has been neglected – that is, either severe neglect or general neglect of a child has occurred. “General neglect” is defined in the statute as the negligent failure of a person having the care or custody of a child to provide adequate food, shelter, clothing, medical care or supervision where no physical injury to the child has occurred. “Severe neglect” is defined, in part, as those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered (sometimes referred to as child endangerment). Each state will have its own definition of “neglect” and related terms.

Innumerable scenarios arise where the practitioner must determine whether a report is required based upon behaviors in the area of general neglect. When does bad parenting cross the line and become reportable child abuse? A failure to provide adequate supervision can be interpreted quite broadly and perhaps lead to inappropriate reporting. On the other hand, real life situations can quickly spiral downward and practitioners are sometimes critically judged by others who enjoy the benefit of hindsight. Because of this reality, and because the failure to report child abuse is typically a crime and can also lead to civil liability for the practitioner, mandated reporters sometimes lean in favor of filing a report when it is not entirely clear whether the blurry line has been crossed. Moreover, mandated reporters likely receive some degree of immunity from liability under state law when making child abuse or neglect reports, but no immunity when they do not make reports.

Some states may not define the terms “general neglect” or “severe neglect,” but may use and define terms like “physical neglect” or “emotional neglect.” Whatever the nomenclature, it is important for mental health practitioners to know the relevant definitions related to “neglect” and the extent of the mandate to report. Some state laws may not include neglect in their definition of “child abuse,” but may treat “neglect” as a separate category of behavior that must be reported. The relevant laws in California, for example, are found in the Child Abuse and Neglect Reporting Act. The Act defines the different kinds of child abuse, and then defines neglect. Both child abuse and neglect, as defined, must be reported.

Don’t neglect to take a close look at how your state defines and treats the issue of neglect of a child!

V. VIOLENCE TOWARD PATIENT: Is it ever permissible for a mental health practitioner to be physical or violent with a patient, such as pushing, slapping, or striking the patient?

DISCUSSION: Yes. While the question may at first seem implausible or odd, I have discussed this topic with several therapists over the years. Some mental health practitioners may work with patient populations where violence is more likely than with other populations. Violence sometimes rears its ugly head in a variety of circumstances, sometimes unexpected or unpredictable. Mental health practitioners have the right to defend themselves, just like other persons. If an angry patient was attempting to stab his therapist, the therapist would be permitted to punch or otherwise strike the patient – or more. If the violent conduct is not in self defense, and is an uninvited pushing, slapping, or striking of the patient, this likely constitutes an unlawful battery resulting in criminal and/or civil penalties – including a

licensing board enforcement action. There may be exceptions to this general rule (e.g., performing CPR with a patient in apparent need or grabbing/shaking an “out of control” client), but they are rare and would be closely scrutinized.

Z. ZOO TRIP WITH PATIENT: Does it constitute a violation of any law or ethical principle for a therapist or counselor to accompany a patient to the local zoo if this is done for treatment purposes? In such a circumstance, may (or should) the practitioner charge his or her usual and customary fee for the time spent at the zoo? Who should pay for the peanuts?

DISCUSSION: It is not uncommon or unusual for therapists or counselors to “do things” with patients or clients for treatment purposes. One must of course exercise reasonable clinical judgment, and it is always helpful for there to be clinical specialists or experts who would support such activities with patients. There are, of course, limits to such activity. Where the line is drawn depends upon all of the facts and circumstances. I remember reading about a case where the therapist went on a long cruise with the patient. While I don’t remember all of the details, I believe that the licensing board may have found that the totality of the therapist’s actions in that case amounted to unprofessional conduct involving exploitation and dual relationships.

I cannot recall seeing or hearing about any law, regulation, or ethical standard that would prevent a therapist or counselor from accompanying a patient to a particular location if done for appropriate clinical reasons. Therapy is both an art and a science, and therapists and other health practitioners should not (and must not) be unreasonably restrained from a variety of human interactions between patient and practitioner, especially those interactions pursued for treatment purposes. If the trip is in fact for treatment purposes, it would be expected that the practitioner would charge the patient for such services. If the patient was not charged, this might be viewed as convincing evidence that the zoo visit was personal in nature rather than part of the treatment.

The patient should know, well in advance of any planned trip, the fee to be charged for the professional services to be rendered or the basis upon which that fee will be computed. Preferably, this will be specified at the outset of treatment – especially where the practitioner from time to time engages in such activities and has experience to rely upon. The exact manner in which the fee is determined is up to the sound discretion of the practitioner, who has considerable latitude. The practitioner should be able to show, and be confident of his or her ability to do so, that the fees charged were, at a minimum, not exploitative and did not come as a surprise to the patient.

As to the purchase of peanuts, either party may pay since the transaction would likely be viewed as *de minimis* or inconsequential.