Complaints Against Child Custody Evaluators

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Avoiding Liability Bulletin – September 2026

NOTE: This article was first published on the CPH website in February 2020. It appears below with minor changes.

COMPLAINTS AGAINST CHILD CUSTODY EVALUATORS

One of the common complaints against practitioners who are allowed by state law to perform child custody evaluations comes from the parent who believes that the evaluator favored the other parent and failed to adequately perform the evaluation. In some of those cases, there may be allegations that the child custody evaluator wrongly reported child abuse against the complainant or failed to file a child abuse report against the other parent – supposedly the favored parent. In most of those cases, the complaint will allege, among other things, that the evaluator failed to contact one or more persons, or improperly relied upon the word of the other spouse, or reached conclusions that are not supported by the facts. These kinds of cases often amount to nothing more than a picky and inappropriate second-guessing of the evaluator. Cases may be closed by the licensing board when the complainant's behavior demonstrates to the board, during the complaint process, that the complaining witness lacks credibility or evidences questionable behavior.

Licensing board complaints against licensees are quite varied, and complaints stemming from child custody disputes and evaluations are one of the common complaints filed against those licensees who are permitted to perform such evaluations. Many of those complaints turn out to be without merit – and some licensing boards, as in California, are seeking to either limit the number of such complaints that are filed {by educating the public on the requirement to establish a violation by clear and convincing evidence – a heavier burden of proof than the more common burden of a preponderance of the evidence) or simply no longer accept such complaints.

The thinking of these boards is that the complaint might better be addressed by the court in which the report is filed and in which the evaluator testifies in the presence of a judge. The custody evaluator can be cross-examined by the adverse party and any weaknesses in the report or evaluator bias or incompetence can be exposed. Judges who sit in family court routinely hear these kinds of cases and can make whatever finding regarding custody deemed appropriate and can, among other things, recommend that the practitioner no longer be allowed to be on the court's list of acceptable evaluators.

LIABILITY FOR FAILURE TO COMMUNICATE WITH OTHER PRACTITIONERS/FACILITIES

One area of possible liability for practitioners, although not necessarily relevant in many situations, is where it is alleged that the practitioner failed to obtain records or information from prior treatment

providers or health facilities, or failed to communicate or coordinate with other involved practitioners during the course of treatment. In the latter situation, perhaps the practitioner is treating a patient individually, but the patient is also involved in couple or family therapy with another practitioner. With respect to the former situation, there are times when communication with prior health care providers or facilities is important for current treatment purposes.

I have on many occasions written about the laws or regulations, both state and federal (HIPAA), that allow practitioners to communicate with other health care practitioners or facilities for the purposes of the diagnosis or treatment of the patient. This may typically be done without the signed authorization of the patient. The public policy reason undergirding laws or regulations that allow for such an exception to the requirement of confidentiality is based upon the understanding that collaboration is often helpful, sometimes crucial, to the proper care of patients. Many practitioners may be hesitant to initiate communication with others for a variety of reasons and may be instinctively reluctant to share confidential information with licensed health care practitioners who may inquire.

Health practitioners are not expected to treat patients in a vacuum, and some situations may require the treating practitioner to communicate with other practitioners or to obtain prior treatment records, or portions thereof, in order to properly and safely treat the patient. In dangerous patient cases, for example, whether a physical danger to others or a danger of self harm, the practitioner who does not consult or talk with a prior therapist or facility regarding prior indications of dangerousness may be the subject of an allegation that their failure to take appropriate action was the direct result of a failure to inquire into the prior treatment of the patient. Had the practitioner done so, it may be alleged, the practitioner would have had the necessary information that would have influenced a prudent and competent practitioner to act in a different manner.

More awareness of this right to communicate with other health practitioners and facilities for the purpose of diagnosis or treatment of the patient (and the specifics of the state law) may help practitioners avoid an allegation of negligence based upon the failure to obtain relevant information from former or current health care providers. Again, while not relevant in many situations, this important exception to the duty of confidentiality should not be overlooked.

“LOOSE GROUPS”

While many practitioners conduct their psychotherapy practices as sole proprietorships, there are also many who choose to practice in a group setting, whether it is a formal or “true group” or what I call a “loose group.” By using the term “true group,” I am referring to, for example, a partnership or professional corporation, where two or more practitioners have an ownership interest in the entity that hires W-2 employees to work for the entity, which may conduct business under a fictitious business name. Patients typically pay the entity and the entity pays its employees. By using the term “loose group,” I am referring to, for example, a practice that is owned by one person, doing business under a fictitious business name, who leases space to individual practitioners who conduct their private practices at that entity and who are not employees of the entity (the sole proprietorship).

My concern with the “loose group” practice is that if the practitioner is not clear with patients as to who owns the business where the patient is being treated, the patient may be under the wrong impression and that liability may be created for the practitioner who simply leases space to the other practitioners.

Suppose, for example, that a practitioner (Jane Doe – a fictitious name) owns the XYZ Counseling Center (this name is also fictitious) and leases space to several other practitioners. Suppose further that each of the practitioners have business cards and letterhead that contain the name XYZ Counseling Center and their individual names. Some questions that may arise in this scenario follow:

1) What makes this business a “center?” 2) Does use of the word “center’ give patients accurate information as to the nature of the business? 3) Should or must all of the practitioners who lease space at the Center inform patients that the XYZ Counseling Center is owned by Jane Doe, a licensed marriage and family therapist, and that they simply lease space from her to conduct their own practices? 4) Would it be inappropriate or misleading for patients to pay their bills by writing checks made payable to the XYZ Counseling Center, who then pays the treating practitioner, less various administrative fees and other expenses, as an independent contractor? 5) If there is not adequate disclosure, is there a risk that someone might allege that the XYZ Counseling Center should have liability as if it were a partnership?

Because of the passage of a law in California (referred to as AB 5, effective January 1, 2020), primarily intended to assure that companies/businesses treat their workers as employees rather than what the practice had been – treating them as independent contractors – many mental health practitioners in California voluntarily reclassified their status from independent contractor to W-2 employee. The thinking has been that these workers are wrongfully being denied the benefits of employee status so that the employing companies can earn more money while trying to avoid liability. This well-publicized law, primarily aimed at the so-called “gig economy, caused many counseling centers and group practices, whether non-profit or for profit, to reexamine the way they categorized their workers. Some would argue that they should have categorized their workers as employees rather than independent contractors before the passage of AB 5, but that the publicity around AB 5 provided the impetus for change.

Before this law went into effect and for many years prior, many psychotherapy workers were wrongly categorized as independent contractors in order for the employer to avoid the increased costs and increased liability for those categorized as W-2 employees. For many years, even pre-licensed persons like Registered Interns and Trainees in California were often categorized wrongly as independent contractors for the same reasons. Of course, pre-licensed persons cannot practice independently, and must be W-2 employees, where the employing practitioner or entity controls the fees to be charged, the patients to be seen, the hours to be worked, and the quality and nature of the work to be performed under supervision. Each state may treat these matters a bit differently, so it is important to be familiar with state and federal employment laws.