Family Law

written by Richard Leslie | July 7, 2023

Avoiding Liability Bulletin – July 2023

NOTE: The following article was first published on the CPH Insurance website in September 2017. It is republished below, with minor changes, because of the importance of the varied topics to mental health practitioners of all licensures. It hopefully will help practitioners navigate successfully through these thorny issues or avoid them entirely.

FAMILY LAW

One of the most important things for practitioners to know about family law involves the issue of child custody. More specifically, it is important to know the difference between physical custody and legal custody (or terms of similar import), since this will generally determine which parent has the legal authority to consent to the treatment of a child or access a child's treatment records, which parent is authorized to make the decisions regarding the health, education, and welfare of the child, or whether the consent of both parents will be required in order to commence treatment. It is often wise and sometimes necessary to ask a parent to provide the practitioner with a copy of the most recent court order regarding child custody/visitation and to check with that parent's attorney if there are any questions, ambiguities, or suspicions.

What if the parents share legal custody (e.g., joint legal custody) and one of the parents demands that treatment of the 12 year old child/patient cease? May the practitioner lawfully continue to treat with the consent of just one of the parents if the practitioner believes that treatment is essential to the child's mental health? Should the practitioner continue to treat the minor with the consent of just one of the parents? Are there any risks if the practitioner complies with one parent's demand that treatment of the child ceases forthwith? If both parents initially consented to the treatment of the minor, must both parents request/demand a termination in order for the practitioner to cease treatment? The answers to these questions necessarily depend upon state law and upon laws that pertain to the right of a child (in this case, a child who is 12 or older) to consent to mental health care.

FICTITIOUS BUSINESS NAME

Most states allow sole practitioners, partnerships, or professional corporations to conduct business under a fictitious business name. There are various requirements that states typically impose in order for practitioners to properly adopt a fictitious business name, such as "The XYZ Counseling Center" or "Green Tree Counseling." Practitioners must make sure that the name chosen is not false, misleading or deceptive. State law may mandate transparency and provide consumer protection by, for example, requiring those who conduct business under a fictitious business name to inform the client as to the

name or names of the owner(s) of the business and the title of the license or licenses held by the owner(s). Even if not required, such disclosures may help to avoid allegations of deceptive behavior.

What are the penalties or liabilities for doing business under a fictitious business name when there has been no filing of required forms or non-compliant publication by the practitioner? If a sole practitioner conducts business under a fictitious business name that includes the word “center” or “and associates,” might that be viewed by the consumer and the licensing board as misleading? What do the pertinent laws in your state of practice provide with respect to these issues?

PRIVILEGE AND CONFIDENTIALITY

Suppose that a licensed mental health professional reveals to a spouse the identity of a particular patient currently being seen who enjoys some degree of notoriety in the community. Suppose further that the practitioner cautions the spouse about the sensitive and private nature of the information and also discloses a few details about the treatment. Has the therapist breached confidentiality? Is there a husband/wife statutory privilege for confidential communications in the state (there typically is)? Does the fact that the communication between the practitioner and the spouse is privileged help in the defense of the practitioner during a licensing board enforcement action alleging breach of confidentiality? The answers to these questions are dependent upon knowing the difference between the concepts of confidentiality and privileged communication, which I have written about in multiple prior articles here at CPH.

How might the above scenario arise? A bitter divorce/custody battle, for example.

Are all communications between a licensed mental health practitioner and patient confidential?

Are all privileged communications between a mental health practitioner and patient confidential?

SUBPOENAS AND PRIVILEGE

The actions a licensed mental health practitioner takes when served with a subpoena for records or for appearance at a deposition or trial depends upon the particulars of state law and the circumstances extant. Generally, however, the initial instinct should be to resist rather than to comply. I have counseled some who have released records improperly because they thought that the subpoena was a court order and that they had to comply. As soon as “subpoena” is in one’s consciousness, the mind should turn to the issue of privilege. Since the patient is generally the holder of the privilege, the practitioner should typically want to know whether the patient is waiving the privilege or asserting it. Even when the patient improperly asserts the privilege, the practitioner must sometimes work through the situation and resist compliance until the issue is resolved. It is sometimes necessary to get the patient’s attorney to educate the patient as to the fact that the privilege has been waived as a matter of law – as when the patient tenders (puts into issue) their mental or emotional condition in a lawsuit.

TESTIMONY UNDER OATH – CREDIBILITY

Practitioners don't always know when and in what kind of a case their testimony under oath will be required. There are several things that can be done in advance of any such testimony that can help the practitioner avoid problems and maintain credibility. Keeping good records (whatever that means!) can help, and reviewing the records before testifying can help even more. The other thing that can be done, well in advance, is to be very careful when advertising or preparing and distributing your curriculum vitae or resume. I have seen more than a few cases where the practitioner's credibility has been harmed during direct or cross examination by the exposure of false, misleading, or deceptive information (prepared years earlier) in an advertisement or in a resume or curriculum vitae. Sometimes the representation made may be of a relatively minor or non-essential nature – perhaps an exaggeration. Nevertheless, once the practitioner's credibility is called into question upon cross-examination, the patient's case may become compromised. If you would lie about a minor matter, the argument goes, you would likely lie about a more substantial or pivotal manner.

CHILD ABUSE REPORTING

Suppose that your 16 year old client tells you that his mother slapped him in the face during breakfast and before he left for school, and that the slap briefly left some redness on his cheek. Is a child abuse report required to be made? Is some limited form of corporal punishment by a parent against a child allowed in your state of practice? In a case that I was involved with, the client did not want a report to be made (and it wasn't), but when he soon thereafter told his teacher at school about the slap, the teacher filed a report. Later, the focus of attention was on the mental health practitioner for an alleged violation of the child abuse reporting law (failure to report is generally a crime).

The answer to this question (and others) depends upon the totality of the facts and circumstances involved and the nuances and interpretations of state law. In the above referenced case, the sixteen year-old high school football player told his mother to "go f___ yourself" when she questioned him about his grades. She slapped him across the face and told him not to speak to her in such a vulgar manner. My view was that there was no physical injury (e.g., no bruises, burns, or cuts) inflicted by other than accidental means, that the mother's actions were reasonable under the circumstances, and that a report was not required. Reasonable corporal punishment by a parent upon a child was lawful in the state involved.

Generally, the desire of a client that a report not be made should be irrelevant to the determination by the practitioner as to whether a report must be made. Failure to make a mandated report can result in criminal, civil, and administrative liability. Making a child abuse report, whether mandated or permitted, can sometimes result in a claim that the report was not warranted and that a breach of confidentiality occurred. State immunity statutes are likely to protect practitioners from such claims. Moreover, in such breach of confidentiality/privacy complaints made to the Office for Civil Rights, the enforcement arm of the U.S. Dept. of Health and Human Services (re: the HIPAA Privacy Rule), the OCR is not permitted to review the reasonableness of mandated reporters' judgments when making child abuse reports.

What if the mother's instinctive slap in the face left no red mark but instead resulted in a small cut to

her son’s lip? Was the cut lip accidentally inflicted? Is the mother a child abuser?