Licensing Boards-It IS About Enforcement!

written by Richard Leslie | May 31, 2018

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REMINDERS …

I have written in more depth about the reminders covered in this issue of the Avoiding Liability Bulletin. The CPH website archives can be explored for more information related to the topics covered here.

On occasion, a licensed mental health practitioner may be contacted by the investigative arm of the licensing board and a request may be made for the practitioner to come into the office of the investigator to discuss a matter that has been brought to the board's attention. When the practitioner asks what the matter involves and who may be filing a complaint, the investigator may refuse to share such information – just like police detectives may do when investigating criminal activity. It is usually at this time that the practitioner realizes that the licensing board takes its enforcement authority seriously and that consultation with, and representation by, an attorney would be wise.

I recently read an article which stated that licensing boards had dual purposes – that is, to protect the welfare of those seeking care from the regulated practitioners and to protect the interests of the regulated mental health practitioners. I am not aware of any licensing board of mental health practitioners that has as its purpose the protection of the interests of the licensed practitioner. To the contrary – the licensing board, once the license is issued, exists to protect the public from its licensees. The more rules and regulations the board promulgates, and the more requirements imposed upon practitioners, the more fodder the board has to pursue enforcement action. Licensing boards are judged by the Legislature, in large part, by their record of enforcement.

On a related note, I recall the position of the California licensing board for marriage and family therapists, clinical social workers, and educational psychologists regarding legislation proposed and ultimately passed many years ago – the criminalization of sex between a therapist and the patient. The Board reflexively opposed the bill. Why? Because, they argued, that it might jeopardize the investigation and enforcement of their administrative action to suspend or revoke the practitioner's license. Ultimately, they were convinced that their position was, to be kind, ill-advised.

DIAGNOSING/DISPARAGING NON-PATIENTS

An area of practice where mental health practitioners sometimes get in trouble is where they make definitive statements or express professional opinions about someone they have not treated or examined. These statements or opinions sometimes involve the mental/emotional condition or the parenting abilities of persons they may never have seen or examined. These statements and opinions are often made in a sworn declaration (perhaps prepared by the patient's attorney) during the

pendency of a legal proceeding, such as in family law cases involving child custody and visitation issues. Sometimes a letter is written by the practitioner “to whom it may concern,” usually at the request of the patient or the patient’s attorney. Whether in a declaration or in a letter, practitioners must be careful not to diagnose (formally or informally) or disparage someone who they have not treated or examined.

The “diagnosis,” professional opinion, or disparagement may not be apparent to practitioners because they may readily believe, or accept as true and accurate, the information gathered from the patient or others seen collaterally. Not only may practitioners be subject to cross-examination that may weaken their testimony and credibility, but they may subject themselves to ethical and administrative liability if they are not careful. A way to avoid such predicaments is to carefully prepare and review any writing to make sure that it is clear that the practitioner has not treated or diagnosed the other person and that the information reported or the opinion expressed is derived from the patient’s account of the circumstances (e.g., “the patient reported that”… or “based upon the information derived from the patient, it is my opinion that ….”). The limits of the information and the sources upon which the practitioner’s opinions or statements are based should be specified. Letters addressed “to whom it may concern” are generally unnecessary, unwise, and an invitation for criticism.

REQUESTS FOR RECORDS – OPTIONS

An area of practice where mental health practitioners may expose themselves to liability is where they mishandle a patient’s written or oral request for a copy of the patient’s treatment records. Some requests for records are routine and non-problematic, while other requests may be made when there is some dissatisfaction with the services being rendered. One time when such dissatisfaction occurs is when a child is being treated during the course of a marital or custody dispute and one parent requests or demands a copy of the child’s records. In order to deal with such requests successfully it is important to know, among other things, when the time for compliance begins to run (for example, upon receipt of a written request), when a summary may be provided in lieu of providing the actual and full record, when a denial may or must be made, and when the child legally controls parental access to his or her records – even where the requesting parent has court-ordered sole or joint legal custody. A patient request for records should be distinguished from a subpoena for records – they present separate issues.

TERMINATION

What information, if any, do you share with patients at the outset of treatment regarding termination? Do you let patient’s know that they can terminate at any time and for any reason? Do you let patients know that you will not terminate at any time or for any reason? Perhaps the most helpful provisions regarding termination involve the principles that a mental health practitioner may terminate his or her relationship with a patient when it is clear to the practitioner that the patient is not benefitting from the treatment or that the patient’s problem is beyond the ken of the practitioner and that a referral is ethically necessary. Such provisions, and others, should be carefully crafted so that they are consistent with applicable ethical standards or provisions of law or regulation that address termination.

DUAL OR MULTIPLE RELATIONSHIPS

Are all dual relationships unethical or unlawful? Hopefully, a close reading of applicable rules and ethical code provisions will indicate that the answer is “no.” I say hopefully because it is clear that sometimes a dual or multiple relationships will be *de minimis* or will arise unexpectedly – through no fault of the practitioner. What becomes important is how the practitioner handles the dual relationship when it becomes apparent. Practitioners should be intimately familiar with applicable ethical code provisions and relevant laws or regulations dealing with this subject matter. Clinical consultation and careful documentation of the rationale for the action taken is wise and often helpful. The key consideration or question in such cases is whether the dual or multiple relationships could reasonably be expected to impair the practitioner’s judgment or lead to exploitation of the patient.

PRIVILEGE AND WAIVER

Who is the holder of the privilege when the practitioner is treating a child? Who is the holder of the privilege when the practitioner is treating a couple? The answers to these questions are important for the practitioner to know because it is the holder of the privilege who may waive it – either expressly or by operation of law. With respect to “by operation of law,” the primary point to understand is that when the holder of the privilege (for example, an individual patient) is the plaintiff in a lawsuit, the privilege is waived if the patient “tenders” his or her emotional or mental condition in the lawsuit. Thus, if the patient alleges that he or she suffered mental or emotional harm and seeks monetary damages from the defendant(s) who caused such harm, the privilege is waived as a matter of law or “by operation of law.”

Even if the practitioner correctly believes that the privilege has been waived as a matter of law, the patient and the patient’s attorney may direct the practitioner not to release the records. I generally advise that the practitioner abide by the wishes of the patient and the patient’s attorney. The practitioner’s records should be well-documented so that it is clear that the decision to resist was dictated by their wishes. Threats by the opposing attorney (the one who issued the subpoena) to get the court to hold the practitioner in contempt for failure to obey a subpoena can be calmly and confidently countered by letting the threatening attorney know, when and if the opportunity arises, that the attorney for the holder of the privilege is the one who may be vulnerable to contempt – not the practitioner! It may be helpful to ask the patient’s attorney to call the opposing attorney to explain that the practitioner is acting upon the direction of the patient and the patient’s attorney.