Potpourri

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Administrative Due Process – The term "administrative due process" refers to the due process rights of licensed mental health practitioners who are the subjects of enforcement actions taken by state licensing boards. At a minimum, administrative due process refers to the right to be notified of alleged unprofessional conduct and the right to be heard (e.g., at an administrative hearing). Exactly how that is implemented in a particular state depends in large measure upon the state laws that relate to administrative proceedings brought by state agencies against licensees of the state.

On occasion, a licensed mental health practitioner may be contacted by an investigator for the licensing board and may be requested to meet with the investigator about an intentionally unspecified matter. Such a circumstance usually prompts licensees to consult with a lawyer before meeting with the investigator. In California, and I suspect (or hope) in other states, there is a law that generally gives licensees the right to inspect and to obtain copies of their complete file maintained by the licensing board. Under limited circumstances, the board is allowed to delete references to an information source or to provide a comprehensive summary of the substance of the material. Access to the licensee's file will usually provide the licensee and the licensee's attorney with relevant information about the nature of the complaint or investigation.

While the board investigator (often a "peace officer") may seek to catch the licensee unaware and unprepared, this due process protection allows the licensee to respond to the inquiry with the benefit of some degree of preparation. Additionally, the law in California makes clear that the board must ensure that full disclosure is made to the licensee of "any personal information that could reasonably in any way reflect or convey anything detrimental, disparaging, or threatening to a licensee's reputation, rights, benefits, privileges, or qualifications, or be used by a board to make a determination that would affect a licensee's rights, benefits, privileges, or qualifications."

Coaching – Some licensed mental health practitioners ask whether they can conduct their practices as one or another kind of "coach" in order to avoid, among other things (e.g., dealing with health insurers etc.), many of the requirements, strictures, and duties related to the regulated practice of mental health care. Can this be done with some assurance that the licensing board will no longer be able to successfully pursue disciplinary action (assuming that the license has not expired or been properly surrendered) in the event of a complaint being filed? Such a transition must be executed in good faith and with much thought and care – there are a lot of considerations and issues.

There is no magic or quick answer to the above question – but it is important to understand that the manner in which the "practitioner" holds himself or herself out to the public (e.g., advertising,

letterhead, social media) and the nature and extent of the disclosures made to the potential client are critical (but not the only) factors. Of course, the actual services rendered and the facts and circumstances involved will always be scrutinized. For example, has the mental health license been revoked and now the person is practicing as a coach – but arguably doing essentially the same work? If the board believes that the "coach" is practicing mental health care without a license, a criminal referral could be made and an injunction or cease and desist order could be sought. If the license status remains in good standing, the board may assert that the practitioner is subject to enforcement because the transition to "coach" was in name only.

Dual Relationships – Not all dual relationships are unethical or unlawful. Licensing boards sometimes get overzealous about this issue and forget that dual relationships that, for example, do not impair the judgment of the practitioner or that are not likely to lead to exploitation of the client may be clinically and ethically acceptable. The various mental health professional associations each have their respective definitions of the term and provide insight into which dual relationships should be avoided and which may be clinically appropriate or acceptable.

Various extra-therapeutic contacts with a patient that are incidental (but entered into knowingly) or accidental will not necessarily constitute a dual relationship. Most ethical standards also recognize that practitioners can sometimes find themselves in an unexpected dual relationship despite their careful and prudent actions prior to the realization. Thereafter, the practitioner may be required to terminate or to be careful that his or her judgment is not impaired and that there is no exploitation of the patient. Clinical consultation may be necessary and helpful – from both a clinical and legal standpoint.

Termination – Can a practitioner ethically terminate therapy with a patient if the patient is unable to pay for one or more sessions? If the answer is "yes," might the practitioner have to see the patient one or more times in order to terminate therapy properly? If yes, would the relationship then become a dual relationship because a new relationship has been established – that is, a debtor –creditor relationship (since the patient cannot presently pay)? Must or should the practitioner in such a circumstance waive the fee in order to be safe from such an allegation?

Greed/Exploitation – When engaged in long-term therapy, is the practitioner vulnerable to a claim by the patient that the practitioner unethically continued treatment solely because of the desire for continued financial gain? Is it necessary for the treatment records to reflect that the patient is making progress or that the treatment is having a beneficial effect? If no or minimal progress is being made, would it be wise for the treatment records to reflect that a referral to another practitioner was discussed with the patient and that the patient nevertheless wished to continue with the professional relationship?

Immunity – Do you have statutory immunity from liability when you act in a manner specified in the law related to patients who present a serious danger of physical violence to others? Can you act in a manner not specified in the law and nevertheless act in a reasonable manner resulting in no liability? Do you have immunity from liability for making a required child abuse or elder abuse report? What if the child or elder abuse report is not required, but only permitted – is there immunity from liability? Will the

immunity protect you if the patient merely alleges that the report was not required or permitted and that you therefore breached the patient's confidentiality?

Clinical Judgment – Health care practitioners are not necessarily liable for honest errors in judgment. Reasonable minds may differ with respect to clinical decisions or actions taken in a particular case. However, if negligence is found, the health care practitioner may be found to be liable in a civil action. The exercise of clinical judgment is necessary in every case, and licensees should not be expected to be right or perfect all of the time. Documentation of key decision points and the rationale for decisions are important aspects of recordkeeping. Of course, documentation of clinical consultations (whether formal or informal) may be helpful in defending or explaining the actions taken or the conclusions reached. The failure to document key decision points allows the patient to argue that key issues were not recognized and that the practitioner was therefore negligent.

Kickbacks – It is typically unlawful under federal and state laws for licensed health care practitioners to refer patients to others in return for some form of compensation – whether monetary or otherwise. Would an agreement between a mental health practitioner and a massage therapist (or a psychiatrist) to make referrals to one another constitute a violation of such a law? What about mutual referrals between spouses in related health professions or otherwise?

License numbers – Are physicians practicing in your state required to include their license numbers on their letterheads or in advertisements – such as in a business card, sign, TV, radio, or Internet ad – or otherwise? Is the answer the same for LCSWs, LMFTs, or LPCCs in the state in which you practice? If not, why are these licensed health care professionals treated differently from physicians? I assume that licensed plumbers and electricians must use their license number in advertising. I would hope that mental health practitioners are treated the same as physicians – not general contractors or other tradespersons.

Minimum necessary – Mental health practitioners, whether governed by HIPAA regulations or state law, should be in the habit of revealing or providing only the minimum amount of information necessary to accomplish the purposes of a request for information pertaining to the treatment of a patient. Insurance companies and others request information for a wide variety of purposes – and rather than share as much as possible, practitioners should generally abide by the minimum necessary principle. An exception to the "minimum necessary" principle or rule is where there is a written authorization, signed by the patient, to release specified information. In that case, the amount of information released is governed by the content described in the signed authorization form. Ambiguities as to content should be clarified. In dangerous patient situations (danger to self or others), practitioners may need to share more than the minimum necessary in order to assure that an imminent threat of physical violence is clearly understood and that appropriate actions are taken. Finally, the minimum necessary rule or policy generally does not apply to the sharing of information with other health care providers for purposes of the diagnosis or treatment of the patient. In such situations, more information rather than less is typically the norm.

HIPAA – remember, it’s HIPAA, not HIPPA!