

Legal/Ethical Issues Involving Mental Health Counselors in Tennessee

Forward

1. [Sources of Authority and Resolving Conflict](#)
 - a. Distributed justice and power
 - b. Nine sources of authority
 - c. Resolving conflicts between authorities
 - d. Decision schema
 - e. Challenging current law or authority: Contempt of court, civil disobedience and appealing to higher authority
2. [Legal Actions Primer for Counselors](#)
 - a. Board complaints
Look at gathering data by year, type of offense, resulting board action, across multiple boards
 - b. Law suit
 - Timing of a complaint (statute of limitations, discovery)
 - Process of a law suit
 - Costs of litigation
 - c. Insurability, insurance panels and hospital privileges
 - d. What are the odds....?
3. [Mental Health Profession Primer for Lawyers](#)
 - a. Degree types
 - b. Licensed or not
 - c. Certifications
 - d. Types of therapeutic intervention
 - Psychotherapy (insight oriented, psychodynamic, CBT, systems)
 - Medications, ECT
 - Experiential: EMDR, Behavioral (flooding, systematic desensitization)
 - Marital Counseling (attachment, Gottman)
4. [Child Abuse Reporting](#)
 - a. Decision tree
 - b. Minor sexuality
 - c. Who to report, employer/employee considerations (use Sandusky/Paterno example; school employee example)
 - d. Liability for not reporting (civil, licensure risks)
5. [Confidentiality with Adult Clients](#)
 - a. Federal statutory law
 - b. Federal case law
 - c. State statutory law
 - d. State case law

- e. Board rules and regulations
 - f. Putting your emotional state at issue
 - g. Couple counseling and confidentiality
 - h. Releasing records (distinguish between psychotherapy notes, records or a summary of records).
6. [Confidentiality with Minor Clients](#)
- a. Parents' rights to minor's records
 - b. Exceptions (emancipated client, >16 and serious emotional condition)
 - c. HIPPA considerations
 - d. Contested custody hearing and future considerations
 - e. Responding to Guardian Ad Litem requests
7. [Court Testimony](#)
- a. Fact witness v expert witness
 - b. What makes an expert?
 - c. Resolving conflict over pay
 - d. Update your vita
 - e. Prepare for cross examination, hypothetical questions, reference to articles
8. [Responding to a Subpoena](#)
- a. Is it valid?
 - b. Asserting a privilege
 - c. Attorney steps of enforcing a subpoena
 - d. Exemptions from subpoena to trial
 - e. Test data
 - f. Specific steps therapist should take in opposing a subpoena
9. [The Dangerous Client](#)
- a. TCA statues
 - b. Case law
10. [The Suicidal Client](#)
- a. Standard of care
 - b. Comprehensive emergency plan
11. [Elder or Vulnerable Adult Abuse](#) (71-6-102)
12. [Professional Boundaries](#)
- a. Therapist Sexual Misconduct 29-26-201ff
 - b. Non-sexual boundary violations
13. [Custody Evaluations](#)
- a. What is the standard of care?
 - b. Making a report relevant to court decisional criteria
 - c. Parental alienation? Real or not?
14. [Electronic Considerations](#)
- a. Email contact

- b. Skype and tele-therapy
 - c. Recording sessions
 - d. Social media
 - e. Example of informed consent for electronic communication
 - f. In divorce/relationship counseling: expectation of privacy (wiretapping)
15. [Employer Consideration](#)
- a. Background checks required
 - b. Respondeat superior
16. [Documentation](#)
- a. Informed consent (policy statement re couples counseling, social media, online contact)
 - b. Record keeping
 - Office policy statement regarding storage/destruction of records
 - HIPPA psychotherapy notes separate
 - Elements of medical records (TCA 63-2-101 (c) (2) and RR 1180-1-.06 (4)(c))
 - List of releases
 - Minimal disclosure
 - Destroying records
 - Couples/marital record keeping
 - c. Test data and protecting intellectual property of test designers
17. [Other statutory provisions](#)
- a. Mentally Ill and Mentally Retarded Persons TCA 33-1-101ff
18. [Selecting an attorney](#)
19. [Selecting a counselor](#)
20. [Competence](#)

[Appendices](#)

Forward

I had a business associate once say he found he was most valuable when he stood in between two areas of knowledge. My concurrent practice of psychology and law for the past 14 years continues to demonstrate the unique value of cultivating two fields of study. As an adjunct professor of law and ethics to master's level counseling students in Vanderbilt University's Human Development and Counseling program, nowhere has this responsibility of sharing such knowledge seemed more gratifying or important. It has been my pleasure and mission to guide young professional, hoping to bring clarity to their ethical decision-making in light of my understanding of law.

A licensed clinical psychologist since 1984, I decided to attend law school in the mid 90s. Since graduating in 2000, my legal experience has been primarily in the domestic law including custody, divorce and adoption. Other areas of practice include bankruptcy, personal injury, contract disputes, slander, and both medical and legal malpractice. As a psychologist I continue to offer expert opinion on disability claims for the Social Security Administration and the Office of Hearings and Appeals in a half dozen states. I am an expert witness in custody evaluations. Additionally I have conducted professional seminars on the confluence of law and mental health for the Tennessee Psychological Association, Onsite workshops, the Sexual Abuse and Counseling Center of Nashville, and the Nashville Christian Counseling Association. I frequently advise mental health providers on ethical/legal issues that arise in their practice.

As I began to put together some of the ideas for this book which was originally intended for mental health providers, another need became apparent; the legal profession lacks clarifying information on the credentialing of mental health professionals, as well as a thorough summary of the laws that apply to the mental health profession. In my work for the Social Security Administration I review mental health records from many different providers. The number of types of mental health professions and various degrees, licensures and certifications has grown exponentially. I added a chapter on the various degrees I've encountered, and the types of licenses, as well as the professional ethical code associated with each. Attorneys will also benefit from the summary of cases that have holdings regarding some aspect of mental health practice.

I hope you will benefit from my position of standing between two fields of study. Your input is always welcome and trust you will profit from this endeavor.

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Brentwood, TN

Chapter One: Sources of authority and resolving conflict [TOC](#)

Sections:

1. Concept of distributed justice and power
2. Nine sources of authority
3. Resolving conflicts between authorities
4. Decision schema
5. Challenging current law or authority: appealing to a higher authority and civil disobedience

Concept of Distributed Justice/power

Vladimir is a good friend of mine. We run together, play chess, play tennis, and I've helped him put in a new floor. His two children are like my own and I can't imagine Christmas without giving them some gift to warm their hearts. On many of our runs we discuss politics, religion, relationships, whatever fills our thoughts at the moment. One day we were talking governments. Vlad is from Ukraine. When he was a young man he was in the Russian Army during the cold war. He took some flak from his Ukrainian peers when he decided to move to the United States. So I like to pick his brain on various political issues since we grew up differently, vote differently, but share a love for this country. One of our conversations went like this:

Vlad: "I don't understand your government. It is too confusing when the House of Representatives fights with the President, or the courts and the President are in conflict, or the States do one thing that is opposite of the Federal government. It is all too confusing."

Me: "Well Vlad, that is called 'checks and balances.' In the US government the authority is distributed among many individuals and groups. No one person has all the power. How do you resolve conflict in your government?"

Vlad: "That's easy. Just do what the Boss says."

Me: "What if the Boss is wrong... like he tells you do to something illegal?"

Vlad: "The Boss is never wrong. If the Boss tells you to do something, his word **IS** the law."

Now I'd guess that the government in Ukraine or Russia is not quite that simplistic. But, as a mental health professional it sometimes seems alluring to have a system that is simple. Often we wish there was one authority where we could clearly find an answer to our ethical dilemmas. Counselors have multiple sources of authority giving us direction. Not all agree or speak clearly to us. In fact many seem to conflict with each other.

For example let us consider the question of our ethical responsibility toward a dangerous client. Our code of ethics (APA used here) state in 4.05 that “(b) Psychologists disclose confidential information without the consent of the individual **only as mandated by law**, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm...” Thus the ethical code directs the counselor to look to what is mandated by law. However the onus is on the therapist to know what the law is. What law does the ethical code refer to? Tennessee statutory law states we should report if there is a clearly identified victim. TCA §36-3-206 states,

Duty to predict, warn or take precautions to provide protection — Liability. —
IF AND ONLY IF

(1) a service recipient has communicated **to** a qualified mental health professional or behavior analyst an actual threat of bodily harm **against a clearly identified victim**,
AND

(2) the professional, using the reasonable skill, knowledge, and care ordinarily possessed and exercised by the professional's specialty under similar circumstances, has determined or reasonably should have determined that the service recipient has the apparent ability **to** commit such an act and is likely **to** carry out the threat unless prevented from doing so,
THEN

(3) the professional shall take reasonable care to predict, warn of, or take precautions to protect the identified victim from the service recipient's violent behavior.

This statute sets the standard as a “non-Tarasoff” standard: the therapist must have a clearly identified victim before taking warning/protective action. Now let’s look at judicial law which is also called “case law.” In Turner v Jordan (Tenn. Supreme Court, 1997) the court ruled that counselors owe a duty to “foreseeable (unidentified) third party” and duty is to “warn or protect.” The standard of care under the statute (TCA §36-3-206) applies only to a clearly identified victim but the standard under judicial or case law (i.e., Turner v Jordan) applies to unidentified third parties. Which is correct? Both are. In this situation, judicial law has extended the duty of a counselor beyond what is dictated by statute.

The benefit of our system of distributed authority is greater justice and lower potential of abuse of power. Because of distributed authority, an abusive judge can be overturned. The laws of an overreaching legislature can be ruled unconstitutional by the courts. The executive branch can veto laws passed by the legislature. Some rights/responsibilities are reserved for the States and others for the Federal government. Much of government rankling is pushing the boundaries of one branch’s power over another. I think the rock-paper-scissors game simply illustrates the way the three branches of government interact. In rock-paper-scissors, each element has power over one entity but is subject to the other entity; paper covers rock, scissors cut paper, rock crushes scissors. If you are not familiar with that example consider a mosquito, a bear and a salmon.

The salmon eats the mosquito, the mosquito bites the bear, and the bear eats the salmon. No one entity is at the top. All have an opportunity to exert power and are in turn subject to the power of the other entity. In government the legislative branch has the power to create laws and establish funding for the other branches, executive branch has the power to enforce laws and set policy in implementing law, the judicial branch to interpret laws and to set rules in the absence of any statute. Judicial law can be preempted by newly created statutes by the legislature. The executive branch has authority over licensure and the implementation of a profession, but that power is granted by the legislatively created statute. There is no “Boss”. There are many bosses.

Add to this governmental conflict the three non-governmental sources of authority in a mental health counselor’s life: the professional organization you are a part of, the rules of your work or supervisor, and your own personal values. Given that there is a legislative, executive and judicial branch of the state and of the federal governments, in all you have those six sources of authority plus the three non-governmental authorities, and you have nine sources in all. As one colleague emphasized, “that doesn’t even count your spouse, who may trump them all!”

Nine Sources of authority

To briefly recap 8th grade civics class, the legislative branch makes the laws, the executive branch enforces the laws and runs the government, and the judicial branch interprets the laws. Now, that description is a gross oversimplification as all three branches are involved in making rules, interpreting rules and enforcing rules. My table below shows the nine sources of authority and gives an example of the rules produced by that authority.

Nine Sources of Authority in Ethical Decision Making

	State	Federal
Legislative	Tennessee legislature including State Senate, State House [Ex. Tennessee Code Annotated 'TCA']	US Congress including US Senate, US House [Ex. USCA, HIPPA]
Executive	Governor, Departments, Health Board [Ex. Board Rules/Regs]	President, Department of Health and Human Services [Ex. Medicare/Medicaid rules, Health Human Services Rules]
Judicial	State courts: Circuit/Chancery, Appellate, Supreme [Ex. State case law used in State courts]	Federal courts: District, 6th Circuit, Supreme [Ex. Federal case law used in Federal courts]
Professional	AMA, ACA, NASW, APA [Ex. Code of Ethics]	
Work Org.	Supervisor, Corporation [Ex. Work rules, supervisor directives, workplace policy]	
Personal Values	Personal ethics, values	

In taking just one issue like confidentiality we can see the various authorities and examples of the rules they have produced regarding a mental health provider’s responsibility to keep health care confidential.

Nine Sources of Authority in Confidentiality

	State	Federal
Legislative	TCA 63-11-213 psychologists; 63-11-214 LPC, MFT, Pastoral; 63-23-207 Soc Workers; 68-24-601 D&A Counselors	HIPPA: is requester a personal representative; can harm be done to child
Executive	Governor, Departments, Health Board, Board Rules/Regs	President, Department of Health and Human Services, Medicare/Medicaid rules, Health Human Services Rules
Judicial	Herman v Herman; Shaw v Shaw	Jaffee v Redmond
Professional	Codes of Ethics: ACA, NASW, APA; Standard of care	
Work Org.	Work rules, supervisor directives, workplace policy	
Personal Values	Personal ethics, values	

Resolving Conflicts between Authorities

When the various sources conflict the general rules of interpretation and resolution of conflict in authority one should ask themselves:

1. Is there statutory law on point that applies?
2. If no statutory law “on point”, is there case law on point or that is analogous to the current situation? That is, do the facts of your issue have direct application to a previous court decision?
3. Are there competing standards of which one is the higher standard, one that preserves the consumer’s rights to the greater extent?
4. Does Federal law preempt State law?
5. Have the courts already spoken on this issue? *Stare decisis* is a Latin term meaning “to stand by that which is decided” This is the principal that precedent decisions are to be followed by subsequent courts. Unless the court made a wrong decision, subsequent courts should generally follow the decision of the prior court or any higher court. This is specific to the court in question, that is, the Tennessee Middle District Appellate Court should follow previous decisions of the Middle District Appellate Court as well as any the Tennessee Supreme Court.
6. Does the court ruling apply in my jurisdiction? There are 11 federal districts and Tennessee is member of the 6th Circuit Court which includes Michigan, Ohio, Kentucky and Tennessee. At times the different circuit courts will differ in how laws are interpreted. Tennessee appellate court is divided into three divisions, Western, Middle and Eastern divisions. Middle Tennessee trial courts should follow Middle Tennessee Appellate Court decisions, western trial courts should follow Western Tennessee

Appellate Court decisions, etc. If there is no decision in one's jurisdiction but there is in another jurisdiction, then those prior decisions carry some weight with the trial court but they are not bound by them. Thus, where there are parallel courts the lower courts must follow the higher applicable court but not necessarily the decisions of higher courts not in their jurisdiction.

7. Is the case law preempted by subsequent case law? Sometimes the courts will change the basis of making future decisions. So all cases need to be examined to see if any portion of the ruling has been overturned by more recent cases. In law this is called "Shepardizing" a case: the process of using a citator to discover the history of a case or statute to determine whether it is still good law. The expression is derived from the act of using *Shepard's Citations*. An individual checking a citation by shepardizing a case will be able to find out how often the opinion has been followed in later cases and whether a particular case has been overruled or modified.

A therapist often has many factors to consider:

For example, suppose you are a school counselor and you receive a request to release counseling records about a student from a parent. Let's say these parents are divorced. The sources of authority include:

Divorce papers (circuit court), FERPA (Family Educational Rights Privacy Act aka the "Buckley Amendment"), HIPAA ("is the requester a personal representative and does releasing records pose some sort of harm to the minor"), School rules (administrative rules), ACA/APA/AMA rules, TCA code on confidentiality (e.g., "the confidentiality between a client and therapist are on same level as that between an attorney and client") versus code on parental access to health care records (TCA §36-6-110), and case law to include *Jaffee v Redmond* or *Shaw v Shaw*. Depending upon the age of the minor, questions about who owns the records (parent versus minor) emerge as does the applicability of TCA §33-8-202.

Because multiple authorities are suggesting various responses, the therapist must have some way to make a decision. In counselor literature this has been called an "ethical decision-making schema" or "ethical decision-making model."

Decision schema

"Ethics is knowing the difference between what you have a right to do and what is right to do."

--- Potter Stewart, Associate Justice U.S. Supreme Court 1959-1981

More broadly professional ethics is doing **what you have to do**, if not clear then doing **what is right to do** and avoiding acting on **what you have a right to do**. Counselor literature has proffered several ethical decision-making criteria. Corey et al. (1998) suggested:

1. Identify the problem.
2. Identify the potential issues involved.
3. Review relevant ethical guidelines.
4. Know relevant laws and regulations.

5. Obtain consultation.
6. Consider possible and probable courses of action.
7. List the consequences of the probable courses of action.
8. Decide on what appears to be the best course of action.

The American Counseling Association

(http://www.counseling.org/docs/ethics/practitioners_guide.pdf?sfvrsn=2) offers the following steps:

1. Identify the Problem.
2. Apply the ACA Code of Ethics.
3. Determine the nature and dimensions of the dilemma.
4. Generate potential courses of action.
5. Consider the potential consequences of all options and determine a course of action.
6. Evaluate the selected course of action.
7. Implement the course of action.

In the Journal of Counseling and Development (2001) V79, p. 39-45 Cottone laid out a consensus view of ethical decision making that involves the following steps:

1. Obtain information from those involved.
2. Assess the nature of the relationships operating at that moment in time.
3. Consult valued colleagues and professional expert opinion (including ethics code and literature).
4. Negotiate where there is a disagreement.
5. Respond in a way that allows for reasonable consensus as to what should happen or what really occurred.

The last two schemas are typical of what a mental health counselor encounters in the classroom study of mental health law and ethics. They are substantially inadequate and naïve in that they give no place for law, particularly case law to be considered. Another problem with the schemas above is that they do not spell out any hierarchy in resolving conflict. They suggest conflicts be resolved by reaching consensus (e.g., Cottone, ACA) or based on anticipated consequences (e.g., Corey). The most difficult ethical decisions, however, involve conflicts between the sources of authority. The question should be asked, is there a hierarchy of authority in law? The topic of “Conflicts of Law” is vast and is typically a full course of study in law school. For the purposes of most counselors a simplified version can be applied. I give students the following ethical decision schema that examines, in order of hierarchy, the sources of authority. The goal is to apply the guidelines of the highest authority in the most likely place any litigation would apply. Thus, you will need to look at the nature of the issue and know where likely any litigation would ensue, that is, in state or federal court.

1. Examine statutory laws
 - a. Is there a statute on point that clearly dictates a prescribed action? Look at both state and federal statutes.
 - b. Are there cases which litigated the interpretation of the statute that may apply?
2. Examine case law

- a. Are there cases which litigated the issue and did the decision lay out any rules or guidelines in the holding that would apply to the question before you?
- b. Are there conflicts in the holdings across jurisdictions? If so, have those conflicts been litigated up the judicial chain of command?
3. Examine your Professional ethics code
 - a. Does your professional code of ethics (APA for psychologists, ACA for counselors, NASW for social workers, etc.) proscribe certain rules that apply?
 - b. Does your malpractice carrier have any risk management guidelines that would assist in clarifying the professional code?
4. Duty to client as a person (caring, supportive)
5. Greater good

The schema typically ends at third step but I include steps 4-5 to assist newer therapists in their decision making. The error of many new counselors is to judge decisions on “the greater good” criteria. In contrast to the above schemas proposed by Corey, ACA, and Cottone, the point of this schema is to emphasize that we, as counselors, cannot look at “the greater good” when the law prescribes certain actions. For example if the law prescribes that we must report a dangerous client who has threatened a specific person, we can’t make a decision based on the greater good. We can all think of situation where following the law complicates a clinical situation and may do more harm than good. Nevertheless we are required to follow the law. For psychologists the Board of Examiners in Psychology has set out in the Rules and Regulations (1180-1-.09) that “The Board adopts, as if fully set out herein and to the extent that it does not conflict with state law, rules or Board Position Statements, as its ethical standards the specific “Ethical Standards” which are part of the “Ethical Principles of Psychologists and Code of Conduct” published by the American Psychological Association (A.P.A.)” and goes on to say, “In the case of a conflict the state law, rules or position statements shall govern.” (1180-1-.09 (2)). Thus, the APA Ethics Code takes second seat to state laws, rules or Board Position Statements as dictated by state executive branch rules. However the APA Code of Ethics 1.02 states,

“If psychologists’ ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.”

APA Code of Ethics would dictate that their rules take precedence over that of law. Which do you follow? My suggestion is, barring an abridgement of human rights, you follow state law because:

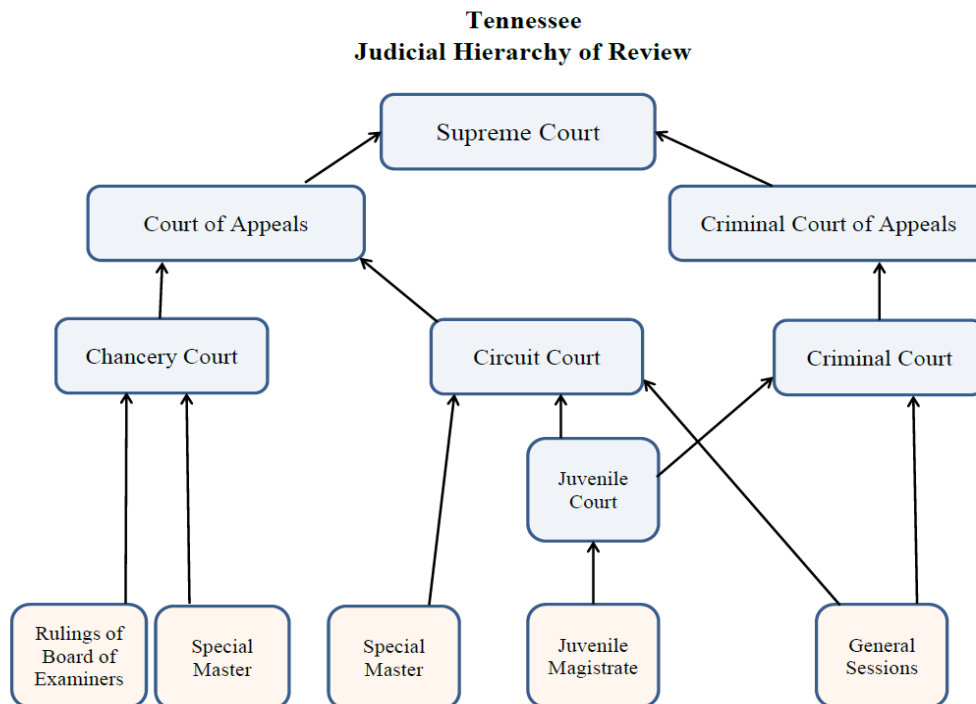
1. State law authorizes you to practice.
2. Any suit against you, including an action by the Board of Examiners to discipline your license would be governed by law first, and the APA Code of Ethics second.

Challenging current law or authority: Contempt of court, civil disobedience and appealing to higher authority

Once a clear decision by a court is made and that decision is based on law (statutory or case law), then a party must decide whether to challenge the court's decision. A court may order you to release records, but should you? Is there a place for challenging the current law or decision? If you believe the court was wrong, the options are: 1) appealing the decision to a higher authority (if you believe the court misapplied the law or that a higher court might change the law), or 2) considering contempt of court and civil disobedience.

Herman v. Herman (2012) illustrates the option of appealing to a higher authority. In this post-divorce custody case, the father sought the counseling records of mother. The judge ordered the records to be submitted to her court, under seal, for her to review. In response, the attorney for the mother filed an appeal. The Court of Appeals overturned the trial court judge, making it clear that the counseling records are protected by statute.

Always consider appealing to a higher authority, keeping in mind your state's court system. For example, in Tennessee the Juvenile Magistrate's decisions are appealed to the Juvenile Judge. Decisions of the Juvenile Judge are appealed to the Circuit Court for non-criminal matters. The Circuit Court decisions are appealed to the Court of Appeals. Below is a chart that shows the hierarchy of the court system in Tennessee.



The court in blue are courts of record. This means that an appeal from those courts will be limited in some manner as described below. There are two types of reviews on appeal:

Full review: Also called a *de novo* review. Here all the facts and applicable law is reviewed or re-tried at the higher level. All the courts that are not courts of record have a right to be reheard *de novo* at a court of record. There is no presumption that the lower court was correct. The chances of reversing the lower court are greater when the higher court is not bound by a presumption that the lower court is correct.

Limited review: The review may be limited in some respect. Usually the upper court examines whether the lower court interpreted the law correctly or abused discretion in the decision they made. There is a presumption that the lower court is correct regarding their interpretation of the facts but the lower court's interpretation of the law is always reviewed *de novo*. Most reviews are after a case is final at the lower level. The party appealing has a limited time to appeal. Infrequently a party may want to appeal a critical decision before the case is final. This is called an interlocutory appeal (an appeal during the course of litigation). For example, if a court ruled that psychotherapy records must be disclosed, the party wishing to protect the records can appeal the decision as an interlocutory appeal... before the case moves on and before they turn over the records.

Appeal to the Supreme Court is discretionary, meaning the Supreme Court does not have to take the case to review. The other appeals are not discretionary; they are an appeal as a right. For example, the Court of Appeals has to take a properly and timely appealed case from the Circuit Court. Appealing a decision should be based on many factors including the cost of appeal and the level of review of the decision. For example, whether records are privileged or not, would involve a relatively inexpensive appeal (an interlocutory appeal) and would involve a *de novo* review which has a better chance of being reversed.

Another rationale in appealing to a higher authority is not that the lower court made a wrong decision based on current law, but that current law needs to change. Here the argument on appeal is based on whether the court should revise the rules they use to decide a case. Often case law from other jurisdictions can be used to persuade the court to change the way future cases will be decided.

Contempt of court and thus civil disobedience should seldom be used. This means that the counselor is refusing to obey the court decision, typically because some civil liberty or human right is being violated. The APA Code of Ethics 1.02 states, "If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights." This language was added following the controversy of

psychologists advising interrogators in Guantanamo on improving the effectiveness of interrogation techniques. The APA directed the psychologists not to participate despite the fact that it was “legal”. APA now posts the following guidelines:

The American Psychological Association's (APA) position on torture is clear and unequivocal:

Any direct or indirect participation in any act of torture or other forms of cruel, degrading or inhuman treatment or punishment by psychologists is strictly prohibited. There are no exceptions.

Clear violations of APA's no torture/no abuse policy include acts such as:

- Waterboarding,
- Sexual humiliation,
- Stress positions, and
- Exploitation of phobias.

In such situations when a court is ordering the mental health provider to act in some way that the provider deems to be a violation of human rights, the counselor may consider, after careful consultation with a seasoned attorney, defying the court order.

Chapter Two: Legal Actions Primer for Counselors

[TOC](#)

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Look at POPE stats

Malpractice (sexual boundary) 20%
Incompetence 13%
Confidentiality 6.4%
Fee Collections 6.2%
Suicide 5.8%
Diagnosis related (wrong or failure to) 5.4%
Custody 2.2%
Dual Relationships .6%
Failure to warn .4%
Abandonment .3%
Failure to refer <.1%

AZ States from Board of Examiners

Psych 1512, Board of bx health examiners 8304 (LPC 2301, LCSW 2071, L. indep sub abuse coun 1611, LMSW 862, L assoc PC 728, LMFT 329, L assoc sub abuse couns 146, LBSW 132, L assoc MFT 87)

Board of psych 5 yrs 1512

2004-2008

Unprofessional conduct 19

Fees 2

Records 1

Custody 1

Another state 1

Evaluations 1

probation violation 1

board of behavior health examiners

unprofessional conduct 155

fraud 75

chem depd 69

crimes 38

sex 26

illness 24

confidentiality 23

probation violation 18

Chapter Two Legal Actions Primer for Counselors

unauthorized practice 7

Chapter Three: Mental Health Profession Primer for Lawyers

[TOC](#)

Sections

- Degree Types
- Licensed or not
- Certifications
- Types of therapeutic intervention

There are many different degrees, certifications and licensures in the mental health field. Understanding with whom you are dealing is critical information. The first question in dealing with a mental health professional is to distinguish between education, licensure and certifications. These are separate issues. Not everyone who has a degree necessarily licensed.

It is easy to get confused by all the letters that follow a name. Assumptions should be avoided. Historically a Ph.D. was assumed to be a psychologist, but now some providers have Ph.D. in psychology are not as a Licensed Psychologist, but rather licensed as a Licensed Professional Counselor. Thus one needs to first understand education and/or degree earned, secondly what licensure applies, and lastly what certifications apply. Uniformity in what is listed after a name is lacking. Some list the degree while others list the license. “Mary Smith, MSW” states that Ms. Smith has a master’s degree in social work. If she were licensed, she might list her name as “Mary Smith, LCSW” stating that she is a licensed clinical social worker.

Degree Types

Below is a list of the types of degrees that are involved in mental health counseling along with the typical abbreviation.

Psychology degrees:

- Ph.D.: Doctor of Philosophy. Within the mental health field most Ph.D.s are licensed as psychologists but this is not necessarily so. A Ph.D. can be earned in English, Biology, Social Work, Chemistry... really most academic pursuits have the Ph.D. as the highest degree. Some have a degree in counseling related field without qualifying to sit for licensure. A Doctor of Philosophy degree in psychology prepares the student to conduct independent research and to provide professional services (consultation, assessment, diagnosis, therapy). To use the title “psychologist”, individuals must meet their state requirements and obtain a license to practice psychology.
- Psy.D.: Doctor of Psychology. A Psy.D. degree is considered the practitioner’s degree while the Ph.D. is a researcher degree. However, before the 1980s there were few programs granting Psy.D. degrees. The major difference in the requirement of independent research and perhaps study of research methodology and techniques.
- Ed.D.: Doctor of Education. Most mental health counselors with an Ed.D. degree have a Doctorate in Education of Psychology. In many states, including Tennessee, if an individual with an Ed.D. has taken the requisite coursework and clinical training, they can be licensed as a psychologist.

Chapter Three Mental Health Profession Primer for Lawyers

LPsy: Licentiate in Psychology or Psychologist: professional title used in EU and Latin American countries and equivalent of PsyD of the US

Social Work degrees:

BSW: Bachelor of Social Work

MSW: Master Social Work or Social Welfare

DSW, Ph.D. or ProfD: Doctor in social work

Master's level counselors:

MA: Master of Arts; typically in psychology, sociology

MS: Master of Science

M.Ed.: Master of Education

Theological degrees:

Some seminaries offer pastoral counseling tracts for students who plan to focus their pastoral career on counseling others.

M.Div.: Master of Divinity

Th.M.: Master of Theology

Medicine degrees:

M.D.: Doctor of Medicine

Psychiatrist: A psychiatrist is a doctor of medicine who has completed a residency in Psychiatry.

D.O.: Doctor of Osteopathy

Pharm.D.: Doctor of Pharmacology

Nursing degrees:

BSN: Bachelors of Nursing

MSN: Master of Science in Nursing

DNP: Doctor of Nursing Practice

DNS or D.N.Sc.: Doctor of Nursing Science

PMHCN: Psychiatric & Mental Health Clinical Nurse Specialist

PMHNP: Psychiatric & Mental Health Nurse Practitioner

PsyNP: Psychiatric Nurse Practitioner

APRN: Advanced Practice Nurse; a post-graduate education in nursing. By 2015 all APRN many programs will require a DNP to enter this advanced training program

Other counselor degrees:

DMFT: Doctor of Marriage and Family Therapy

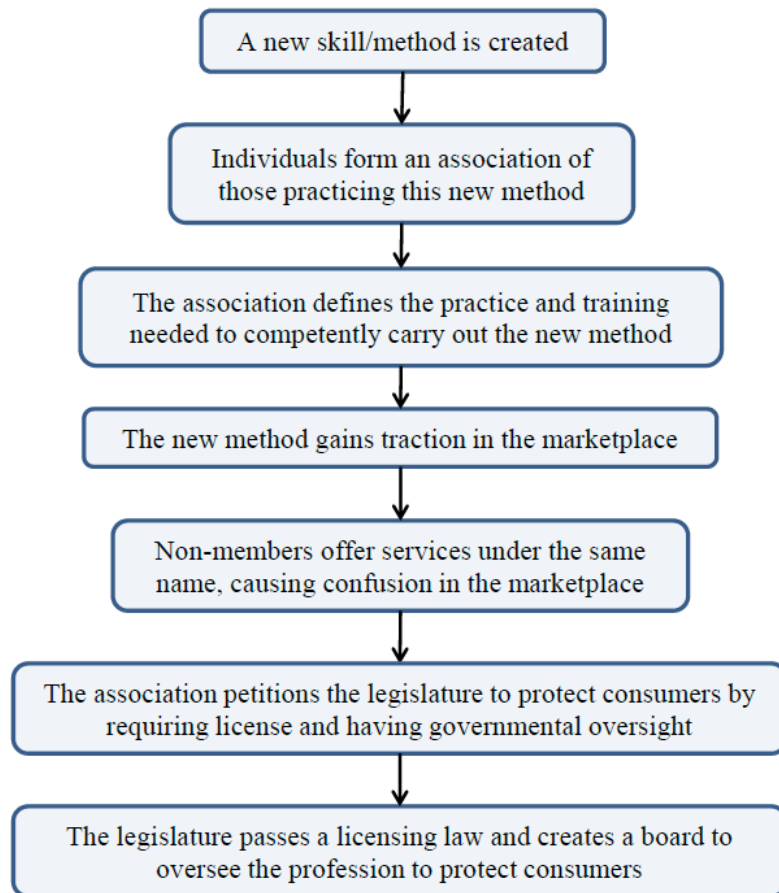
MSC: The Master of Science in Counseling

MPC: The Master of Arts in Professional Counseling

Licensed or Not?

Licensure involves passing criteria that includes an academic component, national board testing, required supervised clinical experience and a background check. The point of licensure is to protect the public by providing government oversight. The development a profession goes something like this: 1) First those are learning about and experimenting with a new type of health treatment form a coalition into a guild or association; 2) The methods become detailed and defined as well as the proper procedures and training needed to competently carry out this treatment are well proscribed; 3) The profession gains traction in the marketplace; 4) Others not associated with the association wish to gain access to the market and may begin offering services

under the same name without the proscribed training; 3) Members of the association petition the state legislature to provide consumer protection of the profession name; 4) The legislature passes laws to create a board that will oversee the profession. The governing entity (i.e., the health board) creates rules and regulations to define how to get and keep a license. Once these criteria are met the individual must apply to the appropriate licensing board in the state to become licensed.



Not all counselors are licensed and there is often confusion in the general public regarding the status of a counselor. The most important distinction is between what degree was earned and what license was obtained, if any.

For example, not every Ph.D. means that the person is a licensed psychologist. The license dictates the scope of practice in which a mental health provider can engage. Some individuals with a Ph.D. are licensed as a professional counselor and cannot do

Benefits of licensure:

- 1) Knowledge that education and experience of provider meets standards
- 2) Government oversight over incompetence
- 3) Privacy of records are legally protected

personality testing by law. ***Licensure offers privacy of records afforded by licensure laws.***

Most professions grant consumers a privilege to protect their psychotherapy records from being accessed by others, even in the legal system. This is not true if a consumer sees a non-licensed counselor. Records could be subpoenaed from a non-licensed professional and there is no provision to protect those records. Also, licenses are determined at the state level. It is the state that authorizes an individual to treat individuals as defined according to the Board of Health rules and regulations. The requirement of the state board involves passing certain national tests that have been developed by national professional organizations. The boards, rules and regulations as well as disciplinary action can be found at <http://health.state.tn.us/boards/boards.htm>. The possible degrees/licenses you may encounter are below with Tennessee granted licenses identified with an asterisk (*):

Medical degrees

* Medical doctor (M.D.)

Professional Organization: American Medical Association (www.ama.org)

Authorizing law: TCA § 63-6

Board rules and regulations: 0880-01 to 0880-14

* Doctor of Osteopathy (D.O.)

Professional Organization: American Osteopathic Association (www.osteopathic.org/)

Authorizing law: TCA § 63-9

Board rules and regulations: 1050-01 to 1050-05

* PA or PA-C Physician's Assistant

Professional Organization: American Academy of Physician Assistants (www.aapa.org)

Authorizing law: TCA § 63-6

Board rules and regulations: 0880-01 to 0880-14

Psychology degrees

Professional Organization: American Psychological Association (www.apa.org)

Authorizing law: TCA § 63-11

Board rules and regulations: 1180-01 to 1180-04

Other: The Board defines HSP "Health Service Provider" as one who delivers services to individuals as distinct from an academic psychologist. The license for one who delivers

Chapter Three Mental Health Profession Primer for Lawyers

health services includes the title “Health Service Provider.” The prior term “Clinical Psychologist” or “Counseling Psychologist” is no longer a part of the licensing paradigm.

* Psychologist (Most list their degree “Ph.D.” or “Ed.D.”)

* Psychological Examiner (P.E.) 1180-03

* Certified Psychological Assistant 1180-04

* Senior Psychological Examiner (SPE) 1180-03

Licensed Senior Psychological Examiner (LSPE)

School Psychologist

PsyA, Psy.A., or Psy.A.: Psychologist Associate (licensed)

LPA: Licensed Psychological Associate

Social Work Degrees

Professional Organization: National Association of Social Workers (www.naswtn.com)

Authorizing law: TCA § 63-23

Board rules and regulations: 1365-01

Other:

* Licensed Clinical Social Worker (LCSW)

LCSW-C: Licensed Certified Social Worker – Clinical (Used in some states; denotes that the social worker is qualified to engage in private practice, unsupervised by a psychologist or psychiatrist, and bill claims to patients’ insurance companies.)

LICSW: Licensed Independent Clinical Social Worker

LMSW: Licensed Master Social Worker

LAPSW: Licensed Advanced Practice Social Worker

Nursing Degrees

Professional Organization: National Council of State Boards of Nursing, Inc.

(www.ncsbn.org)

Authorizing law: TCA § 63-7

Board rules and regulations: 1000-01 to 1000-05

Other:

* LPN: Licensed Practical Nurse

* RN: Registered Nurse

* APN: Advanced Practice Nurse

Pharmacy Degrees

Professional Organization:

Authorizing law: TCA § 63-10

Board rules and regulations: 1140-01 to 1140-13

Other:

* Pharm.D. or D.Ph. Doctor of Pharmacy. Some of the mental health centers utilized Pharm.D. for medication monitoring.

Other Counselor Degrees

* Licensed Marriage and Family Therapist (LMFT)

Professional Organization: American Association for Marriage and Family Therapy

(www.aamft.org)

Authorizing law: TCA § 63-22

Board rules and regulations: 0450-02

Other:

* Licensed Professional Counselor (LPC)

Chapter Three Mental Health Profession Primer for Lawyers

Professional Organization: National Board for Certified Counselors (www.nbcc.org)

Authorizing law: TCA § 63-22

Board rules and regulations: 0450-01

* Licensed Pastoral Counselor

Professional Organization: American Association of Pastoral Counselors (www.aapc.org)

Authorizing law: TCA § 63-22

Board rules and regulations: 0450-03

* LADAC: Licensed Alcohol and Drug Abuse Counselors

Professional Organization: National Association of Alcoholism and Drug Abuse Counselors (www.naadac.org)

Authorizing law: T.C.A. § 68-24-606

Board rules and regulations: 1200-30-01

Other: There are two levels LADAC-I and LADAC-II. The former minimum degree is a high school degree, and for Level II is a master's degree.

LMHC: Licensed Mental Health Counselor (LPC in some states)

LPC-BE: Licensed Professional Counselor, Board Eligible- This is someone who is in the process of getting an LPC. They can bill for services, but not as much as an LPC.[verify this]

LCAT: Licensed Creative Arts Therapist (state by state basis)

Professional Certifications

There are two types of certifications; one that identifies specialists within a licensed profession and a second that is granted for completing a specified training program, apart from any profession. The former is typically termed a "Board Certified" practitioner. The later certifications are often used by individuals but do not require any special degree prerequisites. This professional identification tells the consumer that they have had specialized training in some area of mental health by a professional association. These "boards" are not state oversight boards but association boards.

Certifications indicating a specialist within a licensed profession:

Board Certified Psychiatrist: A medical doctor is granted after completing medical school. After medical school doctors must complete a residency in some specialty (e.g., Internal medicine, Radiology, Ophthalmology, Surgery). One such specialty is psychiatry. A psychiatry residency is a four-year program. Upon completion of the residency the M.D. is now a "psychiatrist." Board certification is a further accomplishment that is done by undergoing professional review and submitting case material and taking an advanced test on psychiatric theory, diagnosis and treatment.

APN-BC: Advanced Practice Nurse-Board Certified

ABPP: American Board of Professional Psychology

ABCP: American Board of Clinical Psychology

Certifications indicating specialized training only:

CSAT: Certified Sex Addiction Therapist

CASAC: Certified Alcohol and Substance Abuse Counselor or Credentialed Alcoholism and Substance Abuse Counselor

CRC: Certified Rehabilitation Counselor

BCaBA: Board Certified Assistant Behavior Analyst® (BCaBA®)

BCBA: Board Certified Behavior Analyst® (BCBA®)
 EMDR-Level I-Level III training (Eye Movement Desensitization and Reprocessing)
 treatment for dealing with Post Traumatic Stress Disorder
 NCC: National Certified Counselor; granted by the National Board of Certified
 Counselors (www.nbcc.org). Criteria for begin granted this certification are similar to
 many state boards, requiring a master’s degree, certain core curriculum, limited
 supervised experience. Those with an NCC can get specialty certifications:
 MAC: Masters of Addiction Counseling
 CCMHC: Certified Clinical Mental Health Counselor
 NCSC: National Certified School Counselor

"Certified" does not mean "licensed"

	License	Prescribe Independently	Prescribe under supervision	Diagnose	Treat maladaptive behavior	Mental Health Counseling	Psychological Testing
Medicine	Medical Doctor	x		x	x	x	
	Doctor of Osteopathy	x		x	x	x	
	Physician Assistant		x	x	x	x	
Nursing	Licensed Practical Nurse			x			
	Registered Nurse						
	Advanced Practice Nurse		x	x	x	x	
Parmacy	Pharmacist		x		x		
Psychology	Psychologist			x	x	x	x
	Senior Psychological Examiner					x	x ¹
	Psychological Examiner					x	x ²
	Certified Psychological Assistant						x ³
Social Work	Clinical Social Worker			x		x	
Professional Counselor	LPC- Health Service Provider			x	x	x	x ⁴
	LPC					x	x ³
Other	Marriage and Family Therapist			x		x	x ⁶
	Pastoral Counselor					x	
Alcohol and Drug Counselor	LADC-Level I					x	x ⁷
	LADC-Level II					x	x ⁷

Psychologists: 1080-2-.01(5) “Psychological testing and/or the evaluation or assessment of personal characteristics, such as intelligence, personality, mental status, psychopathology, abilities, achievement, interests, aptitudes and neuropsychological functioning; Behavior analysis; Psychological testing and/or the evaluation or assessment of personal characteristics, such as intelligence, personality, mental status, psychopathology, abilities, achievement, interests, aptitudes and neuropsychological functioning.”

¹ Senior Psychological Examiner: “Independently: Interviewing or administering and interpreting tests of mental abilities, aptitudes, interests and personality characteristics for such purposes as psychological evaluations, or for educational or vocational guidance, selection or placement, including establishment of intellectual level of functioning or learning deficit for school

placement; or Psychological research services to industrial, business and corporate organizations; or Overall personality appraisal or classification, including psychological testing, projective testing, evaluation for disability or vocational purposes, and diagnosis of nervous or mental disorders; or Personality counseling, psychotherapy, behavior analysis, or personality readjustment techniques.”

² Psychological Examiner: “Independently: Interviewing or administering and interpreting tests of mental abilities, aptitudes, interests and personality characteristics for such purposes as psychological evaluation or for educational or vocational guidance, selection or placement, including establishment of intellectual level of functioning or learning deficit for school placement; or Psychological research services to industrial, business and corporate organizations. Under supervision of psychologist HSP: Overall personality appraisal or classification, including assessment and diagnosis of psychopathology or mental illness; or personality counseling, psychotherapy, behavior analysis, or personality readjustment techniques.”

³ Certified Psychological Assistant 1080-04-.01 “restricted to psychological assessment, psychological testing, and related activities, with no certified psychological assistant allowed to engage in psychotherapy or any other form of therapeutic intervention”

⁴ Licensed Professional Counselor with a Mental Health Service Provider designation: ”Conduct assessments and diagnoses for the purpose of establishing treatment goals and objectives within the limitations prescribed in T.C.A. § 63-22-150(1);”

⁵ Licensed Professional Counselor 0450-01-.02(1)(c) “Selecting, administering, scoring, and interpreting instruments designed to assess an individual’s aptitudes, achievements, or interests, which are used to understand, measure or facilitate such individual’s normal human growth and development, but shall not include the use of projective techniques in the assessment of personality, nor the use of psychological or clinical tests designed to identify or classify abnormal or pathological human behavior, nor the use of individually administered intelligence tests. Consistent with each counselor’s formal education and training, licensed or certified professional counselors may administer and utilize appropriate assessment instruments which measure and/or diagnose problems and/or dysfunctions within the context of human growth and development as part of the counseling process or in the development of a treatment plan.”

⁶ Marriage and Family Therapist 0450-02-.02(4) “Nothing in these rules shall be construed as permitting any person certified or licensed as a MFT to perform psychological testing intended to measure and/or diagnose mental illness. Consistent with each therapist’s formal education and training, licensed marital and family therapists may administer and utilize appropriate assessment instruments which measure and/or diagnose cognitive, affective and behavioral problems and dysfunctions of individuals couples and families as part of the therapy process or in the development of a treatment plan (in the context of marital and family systems).”

⁷ Licensed Drug and Alcohol Counselor 1200-30-01-.02 “Nothing in this chapter shall be construed as permitting any person licensed as a Licensed Alcohol and Drug Abuse Counselor to perform psychological testing intended to measure and/or diagnose mental illness. Consistent with each counselor's formal education and training, licensees may administer and utilize appropriate assessment instruments which identify elements of perceptual inability to recognize

empirical facts, problems of appropriately displaying emotions and inappropriate responses to the environment of individuals, couples and families as part of the alcohol and other drugs of abuse therapy process or in the development of a treatment plan in the context of chemical abuse systems.”

Types of therapeutic intervention

There are many different approaches that a mental health provider may take to improve or treat a mental health condition. It would take many pages to address the details of any one intervention listed below. I have provided a broad overview of approaches. These include:

- Psychotherapy (insight oriented, psychodynamic, Cognitive Behavioral Therapy, and Systems, Anger Management). Psychotherapy involves generally one-on-one talk therapy. The different types generally have different theoretical underpinnings. For example “psychodynamic” counseling generally looks for unconscious conflicts that may be impacting present behavior or experience. The focus is also on the relationships with the therapist attempting to help the client experience relationships in a different manner. Cognitive Behavioral Therapy focuses on thoughts that need to change.
- Medications, Electro-convulsive Therapy (ECT). Medications can be broadly classified as anxiolytics (anti-anxiety), antipsychotic, anti-depressant and mood stabilizing medication. Together this set of medications are called *psychotropic* medications. Many times a combination of medications addressing anxiety, depression, mood and psychosis may all be prescribed at the same time. Also some psychotropic medications are used off-label, meaning they are used to treat some other problem not listed by the FDA as the medication’s primary use. For example, bupropion (an antidepressant marketed as Wellbutrin) is widely used to aid in smoking cessation. Also Trazodone, an antidepressant, is frequently prescribed to aid in sleeping.
- Experiential: EMDR, Behavioral (flooding, systematic desensitization). The goal with experiential modalities of treatment is to directly reprogram the client’s emotional reaction and experience. EMDR (eye movement desensitization and reprogramming) was developed in the early 1990s and has been used successfully in the treatment of trauma experience including post-traumatic stress disorder (PTSD).
- Marital Counseling: Generally a couple is seen together to work out relational disruption. Two prominent theories that have undergone considerable research and are deemed as effective are by Susan Johnson and John Gottman. Susan Johnson’s secure marital attachment theory which looks at the way an individual attaches and focuses on improving attachments together. John Gottman’s relationship counseling is based on laboratory research of couples and involves exercises as well as insight focusing on proven patterns/principles demonstrated by healthy couples.

Chapter 4 Child Abuse Reporting

Chapter Four: Child Abuse Reporting [TOC](#)

Chapter Five: Confidentiality with Adult Clients [TOC](#)

- a. Federal rule
- b. State code
- c. State case law
- d. Board Rules and Regulations
- e. Putting your emotional state at issue
- f. Couple counseling and confidentiality
- g. Releasing records (distinguish between psychotherapy notes, records or a summary of records).
- h. Clergy

An attorney needs to take special precaution in addressing the release of your client's mental health records. Depending upon a counselor's style and detail in recording details of a counseling session, some of the data is irrelevant, damaging, may put your client in a negative light with the trier of fact, and may ultimately be more damaging in the hands of a legal adversary. Because of the sensitive nature of mental health counseling, many would be reluctant to attend and divulge information to the provider if they believed that information would be accessible to others. Because of the need for trust in the confidential nature of mental health treatment, case law and statutes have been supportive of protecting the counseling information.

Therapist ethics require non-disclosure

Federal Statutory Law

Whereas most states, which govern the licensing of professionals, have confidentiality laws regarding the release of records from mental health professionals, the Federal statutes do not delineate any confidentiality standards. There are standards regarding the release of records contained in HIPPA (Health Insurance Portability Protection Act). HIPPA regulations specify:

1. The requirement to keep medical records separate from psychotherapy notes
2. A separate release for psychotherapy notes must be submitted.
3. The therapist must record the date and party of releases.
4. Minimum disclosure is always required.

What are "medical records" versus "psychotherapy notes"?

Medical records are specified to have the following:

1. Date, start and stop times
2. Clinical test results
3. Medications prescribed
4. Diagnosis
5. GAF
6. Treatment plan (e.g., psychodynamic, CBT)
7. Modality and frequency of treatment (e.g., individual counseling one time/week)
8. Prognosis and progress to date
9. Symptoms

Any other information that is not in the list above is a part of psychotherapy notes. There is no HIPPA requirement to keep psychotherapy notes, but if they are kept, they must be kept

Chapter 5 Confidentiality with Adult Clients

separately and require a separate release. There are special provisions regarding releasing the records of minors which will be covered in Chapter Six.

Federal Case Law

To briefly summarize, in Federal Courts the US Supreme Court addressed in detail the psychotherapy privilege in *Jaffee v Redmond*, 518 U.S. 1 (1996). A good source for the case and its' progeny (the cases that follow the original decision and further clarify the decision) is www.jaffee-redmond.org/. Broad ... footnote...summarize some of the progeny

State Statutory Law

For state courts an attorney should start with the statutory proscriptions. For example TCA 63-11-213 states, "For the purpose of this chapter, the confidential relations and communications between licensed psychologist or, psychological examiner or, senior psychological examiner or certified psychological assistant and client are placed upon the same basis as those provided by law between attorney and client; and nothing in this chapter shall be construed to require any such privileged communication to be disclosed." The language is similar for other professions:

63-22-114 marriage and family counselors, LPC, pastoral counselors

63-23-107 Social Workers

68-24-601-609 Drug and Alcohol Counselors

"are placed upon the same basis as those provided by law between attorney and client, and nothing in this part shall be construed to require any such privileged communication to be disclosed."

TCA 36-6-106 Factors to determine custody

(5) The mental and physical health of the parents or caregivers. The court may, when it deems appropriate, order an examination of a party pursuant to Rule 35 of the Tennessee Rules of Civil Procedure and, if necessary for the conduct of the proceedings, order the disclosure of confidential mental health information of a party pursuant to § 33-3-105(3). The court order required by § 33-3-105(3) shall contain a qualified protective order that, at a minimum, expressly limits the dissemination of confidential protected mental health information for the purpose of the litigation pending before the court and provides for the return or destruction of the confidential protected mental health information at the conclusion of the proceedings;

33-3-105 Disclosure of confidential information without consent.

Information that is confidential under § [33-3-103](#) may be disclosed without consent of the service recipient if:

...

(3) As a court orders, after a hearing, upon its determination that disclosure is necessary for the conduct of proceedings before it and that failure to make the disclosure would be contrary to public interest or to the detriment of a party to the proceedings;

Herman: “Title 33 deals with mentally ill and retarded individuals in the care and custody of the State” and doesn’t apply to

State Case Law

Culbertson v Culbertson

Herman v Herman (Tenn. App., 2012). This case was a domestic case in which the ex-spouse sought to get the mental health records of their spouse in post-divorce custody litigation. The Appellate Court found that the statutory protection trumped any custodial concerns, and that the spouse seeking records must address their concerns without the confidential records.

Shaw v Shaw (Tenn. App., 2011). This case was also a domestic case in which the Father sought the mental health records of the Mother and his teenage daughter. The court protected the Mother’s records but allowed the Father access to the daughter’s records in line with TCA 36-6-101.

Rights of non-custodial parents. – (a) Except when the juvenile court or other appropriate court finds it not to be in the best interests of the affected child, upon petition by a non-custodial, biological parent for whom parental rights have not been terminated, the court shall grant the following parental rights:

* * *

(5) The right to receive copies of the child’s medical records directly from the child’s doctor *or other health care provider*, upon written request that contains a current mailing address and upon payment of reasonable costs of duplication. . . .

(b) Any of the foregoing rights may be denied in whole or in part by the court upon a showing that such denial is in the best interests of the child.

A short fall of this case is that there was no consideration of releasing minor’s records and HIPPA safeguards that are discussed in Chapter 6.

Kirchner v Mitsui (184 F.R.D. 124, 43 Fed.R.Serv.3d 110) When a client has put their emotional condition at issue, as in pleading for compensation based on pain and suffering, the courts historically have given access to prior mental health records to assist in determining what portion of an injury was pre-existing and what portion should be ascribed to the present cause of action. In *Kirchner*, the Court looked at the records *in camera* and redacted those records to that which was relevant to the case at hand.

Further discussion of these cases and national trends can be found in Chapter’s 5 and 6. The area of protecting minor’s records from encroachment in a contested custody case has been changing across the country. Notwithstanding *Shaw v Shaw*’s results, Tennessee may be ripe for a challenge as to parental access to minor’s records during a contested custody case.

Chapter 5 Confidentiality with Adult Clients

Culbertson II

1. By declaring oneself to be stable mentally, that does not constitute a general waiver of privilege.
2. Acknowledging treatment with a specific provider does not constitute a waiver of privilege.
3. Giving some records to an independent evaluator does not constitute a general waiver.
4. Allowing an independent evaluator to speak with a confidential treating source does not constitute a general waiver.
5. If evaluating professional asks for access to privileged records, the patient may decline.
6. Any records given to the independent evaluators are deemed to have been waived of any privilege.
7. The new custody statute (TCA 36-6-106(a)(5)) states,

“The mental and physical health of the parents or caregivers. The court may, when it deems appropriate, order an examination of a party pursuant to Rule 35 of the Tennessee Rules of Civil Procedure and, ***if necessary for the conduct of the proceedings, order the disclosure of confidential mental health information of a party pursuant to § 33-3-105(3)***. The court order required by § 33-3-105(3) shall contain a qualified protective order that, at a minimum, expressly limits the dissemination of confidential protected mental health information for the purpose of the litigation pending before the court and provides for the return or destruction of the confidential protected mental health information at the conclusion of the proceedings . . .”

8. This statutory language “necessary to the proceedings” requires the showing that they are necessary. The reference to TCA 33-6-105 may imply that this only applies to mentally ill/retarded individuals in the custody of the state (court did not rule on this but stated that this argument was an “an interesting argument” and “would require us to apply the traditional rules of statutory construction to ascertain whether the legislature intended for the amendment to apply only to parents who are either mentally ill or retarded and are in the custody of the state.” The Court did not reach any conclusion about this.
9. The Court cannot see the records in camera. The court reversed the Culbertson I decision that allowed the judge to review the records.

Board Rules and Regulations

Timing of release:

- Psychologists: 1180-1-.13 must be released within “ten (10) working days of receipt of a written request from a patient or the patient’s authorized representative.”
- LPC, MFT

24-1-206. Clergy -- Communications confidential -- Waiver -- Misdemeanor offense.

(a) (1) No minister of the gospel, priest of the Catholic Church, rector of the Episcopal Church, ordained rabbi, or regular minister of religion of any religious organization or denomination usually referred to as a church, over eighteen (18) years of age, shall be allowed or required in giving testimony as a witness in any litigation, to disclose any information communicated to that person in a confidential manner, properly entrusted to that person in that person's professional capacity, and necessary to enable that person to discharge the functions of such office according to the usual course of that person's practice or discipline, wherein such person so communicating such information about such person or another is seeking spiritual counsel and advice relative to and growing out of the information so imparted.

(2) It shall be the duty of the judge of the court wherein such litigation is pending, when such testimony as prohibited in this section is offered, to determine whether or not that person possesses the qualifications which prohibit that person from testifying to the communications sought to be proven by that person.

(b) The prohibition of this section shall not apply to cases where the communicating party, or parties, waives the right so conferred by personal appearance in open court so declaring, or by an affidavit properly sworn to by such a one or ones, before some person authorized to administer oaths, and filed with the court wherein litigation is pending.

(c) Nothing in this section shall modify or in any way change the law relative to "hearsay testimony."

(d) Any minister of the gospel, priest of the Catholic Church, rector of the Episcopal Church, ordained rabbi, or any regular minister of religion of any religious organization or denomination usually referred to as a church, who violates the provisions of this section, commits a Class C misdemeanor.

Consent to supervise, consent to staff intake at center: informed consent.

Chapter Six: Confidentiality with Minor Clients [TOC](#)

1. General rule of parent's having rights to minor's records
 2. Excepts (emancipated client, >16 and serious emotional condition)
 3. HIPPA considerations
 4. Contested custody hearing and future considerations
 5. Responding to Guardian Ad Litem requests
2. Are they an emancipated minor? Refuse request unless from minor.
 3. Is the requestor a "personal representative" (parent, legal guardian, guardian ad litem)
 4. Not a HIPPA violation

HIPPA violations #1: [45 CFR 164.502\(g\)](#)

If (i or ii) and iii, then deny request

- i. If minor has or may be subject to domestic violence, abuse or neglect by same personal representative, or
- ii. Treating the requester as a personal representative could endanger the individual, and
- iii. Not in the best interests of minor to treat requester as a personal representative

"Should a Psychotherapist be Compelled to Release an Adolescent's Treatment Records to a Parent in a Contested Custody Case?" Professional Psychology: Research and Practice, 2009, Vol. 40, No. 6, 557-563

APA Ethics Guide 1.02 "if psychologists' ethical responsibilities conflict with law, regulations, or other legal governing authority, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict"

Cases: emphasize harm to child

TCA 33-8-202 Rights of child sixteen (16) years of age or older. —

(a) If a child with serious emotional disturbance or mental illness is sixteen (16) years of age or older, the child has the same rights as an adult with respect to outpatient and inpatient mental health treatment, medication decisions, confidential information, and participation in conflict resolution procedures under this title except as provided in part 3 of this chapter, or as otherwise expressly provided in this title. If the child's parent, legal guardian, legal custodian, or treating professional believes that the child's decision to terminate treatment, other than a request for discharge under chapter 6, part 2 of this title, will have severe adverse effects on the child, the conflict resolution procedures under chapter 2, part 6 of this title shall be used. **(b)** An outpatient

Chapter Six Confidentiality with Minor Clients

facility or professional may provide treatment and rehabilitation without obtaining the consent of the child's parent, legal guardian, or legal custodian.

Chapter Eight: Responding to a Subpoena [TOC](#)

SUBPOENA DEFINITION

The obligation of the individual to attend the court as a witness is enforced by a process of the court, particular process being the subpoena *ad testificandum*, commonly called the subpoena in the United States. This writ, or form, commands the witness, under penalty, to appear at a trial to give testimony. Thus, the subpoena is the mechanism for compelling the attendance of a witness.

DUCES TECUM

“Bring with thee.” A writ commonly called a subpoena *duces tecum*, commanding the person to whom it is directed to bring with him some writings, papers, or other things therein specified and described, to a deposition, to counsel for litigants in an action, or before the court.

In general, all relevant papers in the possession of the witness must be produced, but to this general rule there are exceptions. E.g., attorneys and solicitors who hold the papers of their clients cannot be compelled to produce them, unless the client could have been so compelled; neither can documents that are covered by the 5th Amendment's protection against self-incrimination.

A subpoena is created by an attorney, signed by a clerk, and has no judge input.

TENNESSEE RULES FOR CIVIL PROCEDURE (TRCP)

Parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action, whether it relates to the claim or defense of the party seeking discovery or to the claim or defense of any other party

- 1) Who is sending the subpoena?
- 2) Is it a subpoena for records, deposition or court testimony?

TCA 24-9-101. Deponents exempt from subpoena to trial but subject to subpoena to deposition — Award of fees and expenses if court grants motion to quash. —

(a) Deponents **exempt** from subpoena to trial but subject to subpoena to a deposition are:

- (1) An officer of the United States;
- (2) An officer of this state;
- (3) An officer of any court or municipality within the state;
- (4) The clerk of any court of record other than that in which the suit is pending;
- (5) A member of the general assembly while in session, or clerk or officer thereof;

(6) A practicing physician, psychologist, senior psychological examiner, chiropractor, dentist or attorney;

(7) A jailer or keeper of a public prison in any county other than that in which the suit is pending; and

(8) A custodian of medical records, if such custodian files a copy of the applicable records and an affidavit with the court and follows the procedures provided in title 68, chapter 11, part 4, for the production of hospital records pursuant to a subpoena *duces tecum*.

(b) If the court grants a motion to quash a subpoena issued pursuant to subsection (a), the court may award the party subpoenaed its reasonable attorney's fees and expenses incurred in defending against the subpoena.

- 3) Signed by clerk of court?
- 4) In state or out of state?
- 5) Personally served to you or your office?
- 6) Contacting client to ascertain their response to the subpoena (supporting versus opposing it)
- 7) Contact the attorneys involved
- 8) Tactics with subpoena by your client's attorney
 - a. Clarify Whether you will be a Fact versus Expert Witness
 - b. Clarify compensation
 - c. Discuss, following contact with your client, the substance in the record that may work against your client
- 9) Tactics with subpoena authored by someone other than your client's attorney
 - a. Inform client's attorney about privilege
 - b. Inform client's attorney about need to file Motion to Quash
 - c. Inform client's attorney that not asserting the privilege can result in a waiver of the privilege
 - d. Inform opposing attorney of statutory privilege
 - e. Inform opposing attorney of pertinent case law opposing the release
 - f. Inform opposing attorney of any HIPPA limitations to release
 - g. Inform opposing attorney of any limits to testimony in court
 - h. Inform opposing attorney of client's opposition to release
- 10) Filing a Motion to Quash

TENNESSEE RULES FOR CIVIL PROCEDURE (TRCP) 26

When a party withholds information otherwise discoverable under the rules by claiming that it is privileged or subject to protection as trial preparation material, the party shall make the claim expressly and shall describe the nature of the documents, communications, or things not produced or disclosed in a manner that, without revealing

Chapter Eight Responding to a Subpoena

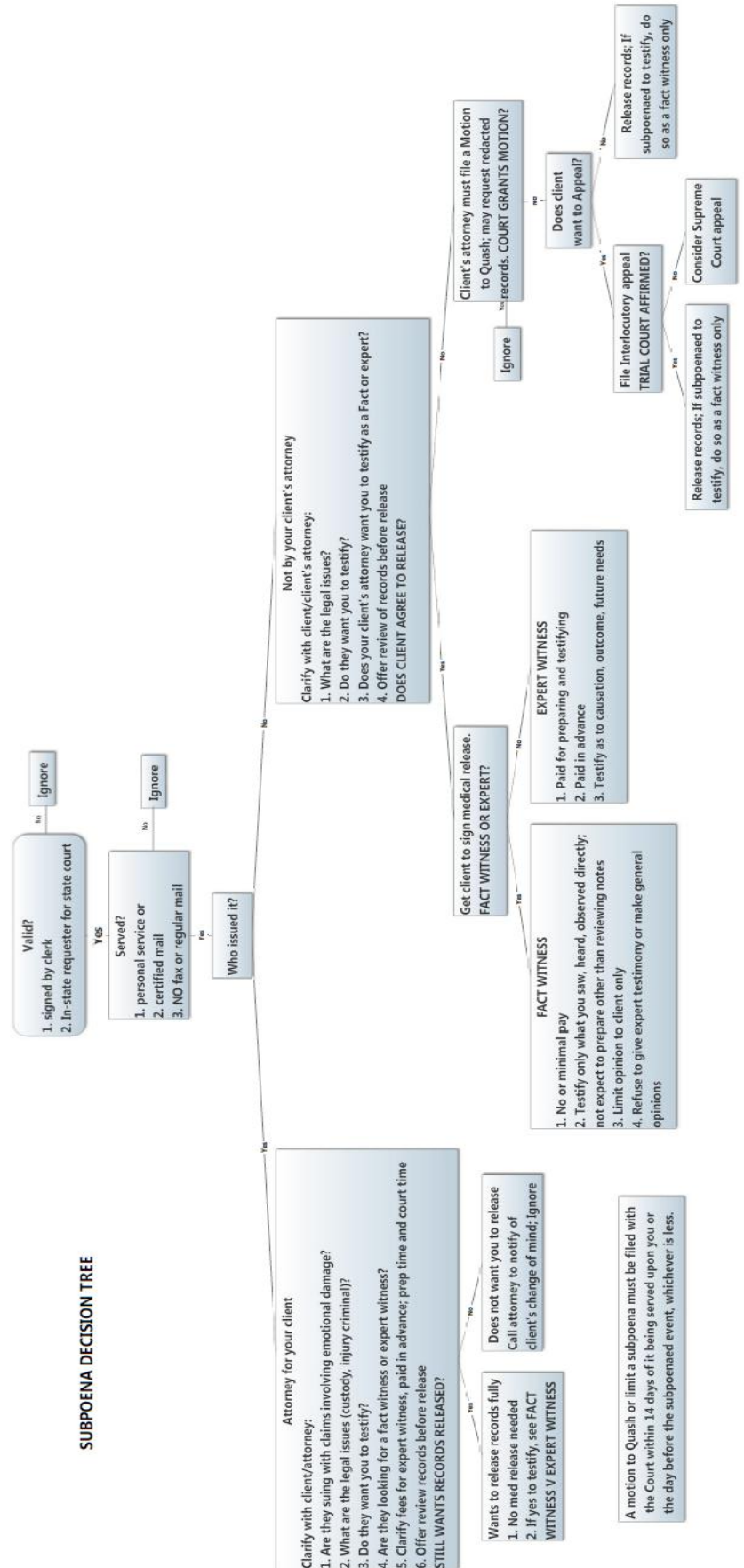
information itself privileged or protected, will enable other parties to assess the applicability of the privilege protection

TENNESSEE RULES FOR CIVIL PROCEDURE (TRCP)

Unless manifest injustice would result, (i) the court shall require that the party seeking discovery pay the expert a reasonable fee for time spent in responding to discovery under subdivisions (4)(A)(ii) and (4)(B) of this rule.

[insert pdf on subpoena flow chart]

SUBPOENA DECISION TREE



Chapter Nine: The Dangerous Client [TOC](#)

Although taking action due to a client being dangerous to others is not a very frequent event, it is one that society has granted special duty to mental health providers to protect individuals who are targeted or to protect the community at large. A brief review of some of the recent mass shooting cases show the destructive nature of mental illness and danger to the community:

Sandy Hook: On November 30, 2012, Adam Lanza killed 28 people, mostly young children in first grade. An anonymous law enforcement official and friends of Nancy Lanza reported that Adam had been diagnosed with Asperger syndrome. Kathleen A. Koenig, a nurse at the Yale Child Studies Center, said Lanza had symptoms of obsessive-compulsive disorder. He was known to frequently wash his hands and change his socks up to 20 times a day, to the point where his mother did three loads of laundry a day. He would go through a box of tissues in one day because he could not touch a doorknob with his bare hand. Lanza's father noted that his son began to change during middle school, becoming more withdrawn, being socially awkward, unable to sleep, with reduced concentration, and quitting enjoyable activities.

Virginia Tech: On April 16, 2007 a student shot and killed 32 students and injured 17 others. Cho had previously been diagnosed with a severe anxiety disorder. During much of his middle school and high school years, he received therapy and special education support. In eighth grade, Cho was diagnosed with severe depression as well as selective mutism, an anxiety disorder that inhibited him from speaking. Cho had psychotherapy therapy periodically throughout middle school and high school. Early reports also indicated Cho was bullied for speech difficulties in middle school. Supposedly, high school officials had worked with his parents and mental health counselors to support Cho throughout his sophomore and junior years. Cho eventually discontinued therapy. The Virginia Tech Review Panel detailed numerous incidents of aberrant behavior beginning in Cho's junior year of college. Several of Cho's former professors reported that his writing as well as his classroom behavior was disturbing, and he was encouraged to seek counseling. He was also investigated by the university for stalking and harassing two female students. In 2005, Cho had been declared mentally ill by a Virginia special justice and ordered to seek outpatient treatment. On April 18, 2007, NBC News received a package from Cho time-stamped between the first and second shooting episodes. It contained an 1,800-word manifesto, photos, and 27 digitally recorded videos, in which Cho likened himself to Jesus Christ and expressed his hatred of the wealthy. He stated, among other things, "You forced me into a corner and gave me only one option...You just loved to crucify me. You loved inducing cancer in my head, terror in my heart and ripping my soul all this time".

Columbine: On April 20, 1999, twelve students at Columbine High School were shot by two fellow students, Eric Harris and Dylan Klebold. Eric Harris was being treated for depression by

a psychiatrist who had prescribed two medications, Zolft and Luvox. Later reports of several psychiatrists said that Harris was a psychopath and that Klebold suffered from depression.

Other school shootings: In 2002 the Secret Service published a report that examined 37 US school shootings. They had the following findings:

- Incidents of targeted violence at school *were rarely sudden, impulsive acts*.
- Prior to most incidents, *other people knew about the attacker's idea* and/or plan to attack.
- Most attackers did not threaten their targets directly prior to advancing the attack.
- There is no accurate or useful profile of students who engaged in targeted school violence.
- *Most attackers engaged in some behavior prior to the incident that caused others concern* or indicated a need for help.
- Most attackers had *difficulty coping with significant losses or personal failures*. Moreover, *many had considered or attempted suicide*.
- *Many attackers felt bullied, persecuted, or injured by others* prior to the attack.
- Most attackers had access to and had used weapons prior to the attack.
- In many cases, other students were involved in some capacity.
- Despite prompt law enforcement responses, most shooting incidents were stopped by means other than law enforcement intervention.

While such events are not likely to be encountered by a given therapist, the consequence of missing an opportunity to avert such a catastrophe should give every therapist pause. Most states, following the ***Tarasoff*** (*Tarasoff v. Regents of the University of California* 17 Cal.3d 425, 131 Cal.Rptr. 14, 551 P.2d 334) decisions in a California case have come up with rules that require therapists to warn or protect victims and grant therapists protection from liability. This protection from liability is for taking action that violates a client's confidentiality when the therapist reasonably believes the client is at risk of harming others. In Tennessee TCA 33-6-206 is the statute that addresses preventing harm against others:

TCA § 33-3-206. Duty to predict, warn or take precautions to provide protection — Liability.

IF AND ONLY IF

(1) a service recipient has communicated to a qualified mental health professional or behavior analyst an actual threat of bodily harm against a clearly identified victim,

AND

(2) the professional, using the reasonable skill, knowledge, and care ordinarily possessed and exercised by the professional's specialty under similar circumstances, has determined or reasonably should have determined that the service recipient has the apparent ability to commit such an act and is likely to carry out the threat unless prevented from doing so,

THEN

(3) the professional shall take reasonable care to predict, warn of, or take precautions to protect the identified victim from the service recipient's violent behavior.

The original case (commonly called “Tarasoff I”) (1974) was decided by the Supreme Court of California. In that decision the Court held that a therapist had a duty to warn others of a client’s threat to cause serious bodily harm. In 1976 the case was re-heard and the Tarasoff II decision held that a therapist has a “duty to protect” *unidentified* victims, thereby broadening the duty of a therapist. This statute is modeled after the Tarasoff I decision, by only addressing the scenario when there is a clearly identified victim. However, in 1997 a case heard by the Supreme Court in Tennessee extended the duty to the Tarasoff II ruling, that a therapist has a duty to protect unidentified third parties from the violent acts of their clients. Turner v Jordan (957 S.W.2d 815) holds that we owe a duty to “foreseeable (unidentified) third party” and that duty is to “warn or protect.” In this case a bipolar and manic patient severely beat a nurse, Emma Turner, who ultimately sued the treating psychiatrist, Harold Jordan, for his failure to protect her. Some of the language of the decision should be repeated here for illustrative purposes.

[T]his duty does not extend to the protection of others from the dangerous conduct of third persons unless the defendant "stands in some special relationship to either the person who is the source of the danger, or to the person who is foreseeably at risk from the danger." – Turner, p. 818

Therapists have a special relationship with clients, and that relationship creates a special responsibility to act when the client becomes dangerous.

The majority of courts, applying Tarasoff principles, have held that where a psychiatrist, in accordance with accepted standards of the profession, knows or reasonably should know that a mentally ill patient poses an unreasonable risk of harm to a foreseeable third party, he or she must take reasonable steps to prevent that harm... We reject the notion that the psychiatrist's duty to third persons is limited to those against whom a specific threat has been made. We hold that the standard originally suggested in Tarasoff is properly applicable to psychiatrists. When a psychiatrist determines, or under applicable professional standards reasonably should have determined, that a patient poses a serious risk of violence to others, the psychiatrist has a duty to exercise reasonable care to protect the foreseeable victim of that danger. The foreseeable victim is one who is said to be within the zone of danger that is subject to probable risk of the patient's violent conduct. – Turner, p. 818

We stress that we are not requiring psychiatrists or physicians to possess perfect judgment or a degree of clairvoyance in determining whether a patient poses a risk of harm to a third person. Instead, we merely hold that a duty of care may exist where a psychiatrist, in accordance with professional standards, knows or reasonably should know that a patient poses an unreasonable risk of harm to a foreseeable, readily identifiable third person. – Turner, p. 820-21

This a case where judicial law goes above and beyond what the statutory law requires. The statute only requires notifying identified victims but the judicial law requires protecting unidentified victims. The above language in *Turner* “in accordance with professional standards” raises the question: “what is the standard?” While most professional articles stress the importance of seeking professional consultation and being aware of the client’s past actions via obtaining past medical records, some situations do not afford the therapist time to engage in a consultation.

A paper entitled Assessing Violence Risk in Tarasoff Situations: A Fact-Based Model of Inquiry in Behavioral Sciences and the Law Journal (Behav. Sci. Law 19: 375-385, 2001) authors Randy Borum, Psy.D. and Marisa Reddy, Ph.D., offer the following framework for guiding a fact-based risk inquiry. This five-factor framework forms the acronym “ACTION.”

- Attitudes that support or facilitate violence
- Capacity
- Thresholds crossed
- Intent
- Others’ reactions and responses
- Noncompliance with risk reduction

Attitudes include antisocial, misogynistic and patriarchal beliefs as well as the view that the use of violence is justified under a low threshold of circumstances. Also considered is their realistic assessment of other individual’s provocation, as well as belief about the likely success of a violent reaction. **Capacity** includes the means to carry out the acts they have threatened or suggested might occur. Physical and intellectual capacity, access to means and access to the target are all considered under capacity. **Thresholds crossed** include any behaviors in furtherance of a plan to act, especially any thresholds that are illegal. Ask, “What steps have you taken to carry out the plan?” **Intent** can be inferred by plan specificity, access to means, any behaviors that further implement the plan, and lack of focus on alternative lines of action. For example if one is angry and considering harming another, does (s)he ever consider alternative lines of action like taking legal action, writing a letter of protest, or working to defeat errant power in a legitimate manner. The lack of focus on alternative lines of action raised the level of intent. **Others’ reactions** assesses whether significant others have encouraged or discouraged violent behavior, or whether the client’s behavior has alarmed others. Information about others’ reactions may be given by the client themselves in their recounting the responses of others. **Noncompliance with risk reduction** looks at a client’s willingness to participate in alternative risk-reducing behaviors and their general insight into the seriousness of their violent thoughts.

Predicting violent acts is not easy. Since the base rates of violence by clients is very low, prediction is very difficult without significant “false-positives”. A false positive in this situation is defined as identifying someone as dangerous and at risk of harming others when in fact they are not. When attempting to identify any highly infrequent event like homicidal behavior, the only way the clinician can make sure to not miss an event is to include many cases that are similar to the targeted event but are false.

A TCA statute delineates the duty as:

§ 33-3-207. Discharge of duty. —

The duty imposed by § 33-3-206 may be discharged by the professional or service provider by:

- (1) Informing the clearly identified victim of the threat;**
- (2) Having the service recipient admitted on a voluntary basis to a hospital;**
- (3) Taking steps to seek admission of the service recipient to a hospital or treatment resource on an involuntary basis pursuant to chapter 6 of this title; or**
- (4) Pursuing a course of action consistent with current professional standards that will discharge the duty.**

“Pursuing a course of action consistent with current professional standards” could include admitting the client to a hospital on a voluntary basis and also alerting appropriate staff of the need for invoking involuntary status should the client change their mind about the admission.

It is important that secretarial and answering service personnel understand the importance of transmitting threats.

§ 33-3-208. Duty of employees who transmit or record patient communications. IF AND ONLY IF

- (1) an employee of a service provider is normally responsible for transmitting or recording communications from a service recipient to a qualified mental health professional or behavior analyst, AND**
- (2) the employee receives a communication from a service recipient of an actual threat of bodily harm against a clearly identified victim,**
THEN
- (3) the employee shall communicate the threat to such a professional employed by the service provider.**

A search of TCA § 33-3-206 in Tennessee legal cases only resulted in one case being referenced, *Stewart v Fakhruddin* (Tenn. App. 5/26/2010) in 2010 where a man receiving outpatient treatment from a psychiatrist shot and killed his wife and himself. Patient's daughter filed wrongful death actions on behalf of her mother and her father and a negligence action on her own behalf. The Court concluded that Tenn. Code Ann. § 33-3-206 does not apply in this case because both the daughter and the wife were quite aware of husband's violent tendencies. The Appellate Court cited two factors, the lack of a specific threat and the outpatient status, as being factors that mitigated the duty of § 33-3-206 in that case. That is, there must be a specific threat communicated. Also, the Tennessee Appellate Court (Middle District) held that the outpatient status of the husband did not provide the therapist the control over the patient that an involuntary commitment would have provided. This does not mean that any threats made by outpatient clients do not create a duty. The Court stated, “*This language does not, however, preclude a duty with respect to victims of violence by outpatients. Rather, the court found the absence of a specific threat and outpatient status to be factors to be considered in determining whether a duty exists*” (*Stewart*, p. 9). It should be noted that, though TCA § 33-3-206 did not apply in this case, the lawsuit continued on a malpractice claim.

Various courts around the nation have taken a varied approach to *Tarasoff* warnings, some broadening the privilege, some rejecting totally the duty and others putting restrictions on the duty that look at the victim's knowledge of the tendencies of the mental health client, the lack of control the therapist has over the client (outpatient or voluntary inpatient treatment versus involuntary inpatient treatment), the difficulty of warning the general public when a non-specific threat is discovered. A good review of these variations in defining the *Tarasoff* duty can be found in Current Analysis of the Tarasoff Duty: an Evolution towards the Limitation of the Duty to Protect in Behavioral Sciences and the Law Journal (Behav. Sci. Law 19: 325-343, 2001).

Below is a summary of the varied approaches:

Broadened foreseeability based on history of violence

9th Circuit Court (*Jablonski v. United States*, 1983): this Federal court broadened the duty by ruling that specific threats were not the only indicator of foreseeability; rather, the patient's history of violence towards a specific victim or class of victims served as an indicator as well.

Broadened foreseeability of victims to the zone of danger

Arizona (*Hamman v. County of Maricopa*, 1989)

8th Circuit Court (*Limpari v. Sears, Roebuck and Co.*, 1980)

4th Circuit Court (*Currie v. United States*, 1986)

Tennessee Supreme Court (*Turner v Jordan*, 1997)

Limited foreseeability to only specific threats, no zone of danger

California Supreme Court (*Thompson v. County of Alameda*, 1980) reversing *Tarasoff II*

Michigan Supreme Court (*Cannon v. Thumudo*, 1988)

Maryland Appellate Court (*Falk v. Southern Maryland Hospital, Inc.*, 1999)

No duty to warn

Iowa Supreme Court (*Leonard v. Iowa*, 1992)

Mississippi (*Evans v. US*, 1995) Federal court interpreted no duty to warn statute as creating no duty

South Carolina Court of Appeals (*Sharpe v. South Carolina Dept of Mental Health*, 1987)

Texas Supreme Court (*Thapar v. Zezulka*, 1999)

New York Appellate Court (*Adams v. Elgart*, 1995) facts very similar to *Turner*

Duty only when therapist has control (involuntary commitment)

Florida Court of Appeals (*Boynton v. Burglass*, 1991)

Virginia Supreme Court (*Nasser v. Parker*, 1995)

Alabama Supreme Court (*King v. Smith*, 1989) therapist had only minimal contacts

No duty to warn if victim knew or should have known of patient's violent tendencies

Georgia Appeals Court (*Jacobs v. Taylor*, 1989)

North Carolina Federal Court (*Moye v. United States*, 1990)

Kansas Supreme Court (*Boulanger v. Pol*, 1995)

Chapter Nine The Dangerous Client

What do you do when a third party tells you that your patient is going to harm someone? Does any duty to warn arise? This scenario was litigated in Michigan and California with opposite outcomes. In a Michigan case, *Martin v. Renaissance West Community Health Services* (Michigan Court of Appeals, Docket No. 249651, 12/9/04), a plaintiff father sued Dr. Shin, a psychiatrist treating the plaintiff's son (Terry). Early in the day the plaintiff brought son Terry to see Dr. Shin, at which time the father communicated Terry's suicidal and homicidal threats. Terry never communicated the threats to Dr. Shin. Dr. Shin did not warn the police or take any action. Later that day Terry fatally shot his brother Timothy and wounded the plaintiff father. The Michigan statute states that the therapist has no duty to warn a third party of a threat, except where "...a patient communicates to a mental health professional, who is treating the patient, a threat of physical violence against a reasonably identifiable third person..." (Mich. Comp. Laws 333.1946). The Court dismissed the lawsuit, finding that a patient communication was necessary and that third-party communications did not give rise to a duty.

In California the outcome was opposite. California also adopted a duty to warn statute, Cal. Civ. Code 43.92 which states that there is no duty to warn of a patient's threatened behavior, except where "...the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims." This legislation is nearly identical to that in Michigan. However, in *Ewing v Goldstein* (120 Cal.App.4th 807, 819; 15 Cal.Rptr.3d 864, 2004), the California Court of Appeals held that a communication from a patient's family member to a therapist made for the purposes of advancing the patient's treatment is a patient communication triggering the duty to warn in Section 43.92. In this case Dr. Goldstein was treating a patient, Geno Colello, regarding difficulties with Geno's former girlfriend. On June 21 Geno told his father, Victor, that he was going to harm the new boyfriend (Ewing) of his former girlfriend. Victor communicated the threat to Dr. Goldstein who persuaded Geno to admit himself to a psychiatric hospital. On June 22nd, the hospital discharged Geno against the urging of Dr. Goldstein. On June 23rd, Geno murdered Ewing. Ewing's parents sued Dr. Goldstein for breaching his duty to warn Ewing pursuant Section 43.92 and the Court held that such third-party communication met the definition of being a "patient communication" for purposes of the duty to warn statute. In a second case based on the same events, Ewing's family alleged that the father, Victor, had communicated to the hospital social worker the threat Geno made. The Court of Appeals, in *Ewing v North Ridge Hosp Med Ctr* (120 Cal App. 4th 1289, 1296-1297; 16 Cal. Rptr. 3d 591, 2004) ruled that the duty to warn under Section 43.92 was potentially triggered by the father's communication of the threat to the social worker who in turn made no warning to Ewing.

Tennessee's duty to warn statute is very similar to both Michigan and California statutes. The language in our statute, "If and only if a service recipient has communicated to a qualified mental health professional" seemingly requires the communication to be directly from the patient. There is no recorded case in Tennessee that has litigated the issues in *Martin* or *Ewing* leaving therapists without any guidance.

Immunity when Reporting

Therapists can be held responsible for the acts of clients in harming others. Clearly that was the result of the *Turner* case. A therapist cannot be held liable for violating confidentiality when protecting intended victims or those in the zone of danger. Therapists are immune from suit for

actions they take necessary to effectuate a warning. One can only imagine that it would be a difficult legal task to win a lawsuit from a therapist who has warned others of potential danger.

§ 33-3-209. Immunity from liability where duty satisfied. —

If a professional or an employee has satisfied the person's duty under § 33-3-206 or § 33-3-208, no monetary liability and no cause of action may arise against the professional, an employee, or any service provider in whose service the duty arose for the professional or employee not predicting, warning of, or taking precautions to provide protection from violent behavior by the person with mental illness, serious emotional disturbance, or developmental disability.

Impact of *Tarasoff* Warnings

An empirical analysis of the unintended effect of *Tarasoff* warnings was conducted by Griffin Edwards of the Department of Economics, Emory University in 2010.* Using sophisticated statistical analysis of data from the National Center for Health Statistics and Uniform Crime Report data, the author evaluated the impact of *Tarasoff* legislation. He found that mandatory duty to warn laws leads to an increase in homicides of 8.9%. This is equivalent to one additional homicide per 131,000 people. The magnitude of the estimated effects increases by 2%-7% when the analysis was restricted to homicides by non-strangers. Why would warnings of potential victims increase homicide rates? Here are suggested reasons:

1. When therapists give informed consent, they tell the client the scenarios where they must breach confidentiality. This may put a chilling effect on a client to refrain from discussing homicidal thoughts.
2. Perhaps therapists are less likely to delve into homicidal thoughts, knowing that it could mean a requirement to breach confidentiality and risk the losing of a client.
3. Perhaps clients having greater risk of committing violence are seen less frequently due to the added burden upon therapists.

*Doing their duty: An empirical analysis of the unintended effect of *Tarasoff v Regents* on homicidal activity, unpublished study, Griffin Sims Edwards, Emory University, January 2010.

Chapter Ten: The Suicidal Client [TOC](#)

33-3-201. Liability of counselor for suicide or attempted suicide of person counseled.

A counselor, while acting within the scope of responsibilities assigned by a counseling center, is not liable civilly or criminally for the suicide or attempted suicide of any person consulting the counselor.

33-3-201. Liability of counselor for suicide or attempted suicide of person counseled. —

(a) As used in this section, unless the context otherwise requires:

(1) “Counseling center” means any nonprofit service operated at least partially with volunteer assistance that provides counseling, assistance or guidance, either in person or by telephone, to persons with mental illness or serious emotional disturbance; and

(2) “Counselor” means any psychiatrist, psychologist, licensed psychologist with health service provider designation, certified or licensed marital and family therapist, certified or licensed professional counselor, certified or licensed social worker, or other professional trained in the field of psychiatry or psychology or any nonprofessional person acting under the guidance or supervision of the professionals.

(b) A counselor, while acting within the scope of responsibilities assigned by a counseling center, is not liable civilly or criminally for the suicide or attempted suicide of any person consulting the counselor.

Duty (Standard of care)

- Know risk factors
 1. APA (<http://www.apa.org/monitor/feb00/suicide.html>)
 2. Suicide Prevention Resource Center (<http://www.sprc.org>)
- Develop, implement and document a comprehensive emergency plan
 1. Consider criteria for involuntary hospitalization
 2. Offer voluntary hospitalization
 3. Offer referral for medication and/or adjustment of medication
 4. Offer increased counseling sessions
 5. Offer emergency contact numbers and back up numbers
 6. Contract for non-suicide
 7. Arrange for contact with client in between counseling sessions
 8. Structure activities and contacts with others

Vickroy v Pathways: (TN Court of Appeals, 2004)

Don't sign a commitment paper unless you personally have examined the client.

“the physician, psychologist, or designated professional shall immediately examine the person and decide whether the person is subject to admission to a hospital or treatment resource under Section 33-6-403” and noted that his acts “we construe as a claim for false imprisonment” and “denial of due process”. Sought \$4,500,000.

Shelburne v Frontier: (TN Supreme Court, 2003)

Chapter 10 The Suicidal Client

While Frontier is a non-profit community health center and it's employees are immune from prosecution, the center itself is not.

Drake v Williams: (TN Court of Appeals, 2008)

Suicide itself is not a “superseding, intervening cause”; cited case where client was “prematurely discharged in light of his continuing active suicidal ideation, based on improper considerations of insurance coverage, and an inappropriate reliance on his non-suicide contract with his parents.”

Harris v Jain: (TN Court of Appeals, 2009)

In order for the plaintiff to get to trial, they have to provide an expert witness that can testify to what the standard of care is, and that the defendant breached that standard. The expert must be from TN or an adjoining state, must be familiar with the standard of care in the community, and standard of care of a similar professional like the defendant. Here they used an internist to testify against a pediatric psychiatrist.

Atkinson v St. of Tennessee: (TN Court of Appeals, 2010) No expert testimony was offered to establish the standard of care in addressing suicidal inmates. Case was dismissed. They cited another case, *Cockrum v. State* 1992 case:

“These precautions included increased observation, cell searches, increased restraints, increased medication, removal of potentially harmful objects, and the use of paper clothing”

Bates v Denny: (No. 89 CA 0401 1990)

Bates was chronically suicidal. Was sent to the ER after falling down flight of stairs. Mother told ER physician about recent suicide attempts. ER evaluated him and ultimately discharged him home, telling the family to keep a close eye on him and remove weapons. Bates died next day from self inflicted GSW to head.

MD found not negligent because:

1. Bates was not actively suicidal evaluation
2. Not psychotic
3. Could not involuntarily hold him
4. Scheduled a follow-up appointment
5. Informed the family of his needs

Stepakoff v Kantar: (393 Mass. 836 1985)

Chapter 10 The Suicidal Client

Husband has been suicidal in past but treated by Dr. Kantor for 15 months. Wife decides to divorce and tells Dr. Kantor that this is going to happen. Kantor has an emergency meeting with Husband. Kantor goes on vacation 2 days after wife's warning.

Found not negligent because

1. Husband did not meet the legal standard for involuntary hospitalization
2. A treatment plan was developed to care for Husband at emergency meeting

Chapter Eleven: Elder or Vulnerable Adult Abuse (71-6-102) [TOC](#)

Intro.

Define Elder

Define vulnerable abuse

Compare vs child abuse

- **Physical abuse**
- **Sexual abuse**
- **Denial of services.....Neglect**
- **Financial abuse (exploitation of funds)**

having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report

duty to warn includes imminent intention to act vs reporting past abuse (like child abuse reporting, does not require future intent)

report to organization vs department

abuse criteria vs imminent danger criteria (duty to warn/protect)

71-6-101. Short title -- Legislative intent.

(a) This part may be cited as the "Tennessee Adult Protection Act."

(b) (1) The purpose of this part is to protect adults coming within this part from abuse, neglect or exploitation by requiring reporting of suspected cases by any person having cause to believe that such cases exist. It is intended that, as a result of such reports, the protective services of the state shall prevent further abuse, neglect or exploitation within the limitations set out in this part.

(2) It is recognized that adequate protection of adults will require the cooperation of many agencies and service providers in conjunction with the department of human services due to the often complex nature of the risks to this adult group, and that services to meet the needs of this group will not always be available in each community. However, it is desirable that the following services, as well as other services needed to meet the intent of this part, be available: medical care, mental health and developmental disabilities services, including in-home assessments and evaluations; in-home services including homemaker, home-health, chore, meals; emergency services including shelter; financial assistance; legal services; transportation; counseling; foster care; day care; respite care; and other services as needed to carry out the intent of this part. 71-6-102. Part definitions.

As used in this part, unless the context otherwise requires:

(1) "Abuse or neglect" means the infliction of physical pain, injury, or mental anguish, or the deprivation of services by a caretaker that are necessary to maintain the health and welfare of an adult or a situation in which an adult is unable to provide or obtain the services that are necessary to maintain that person's health or welfare. Nothing in this part shall be construed to mean a person is abused or neglected or in need of protective services for the sole reason that the person relies on or is being furnished treatment by spiritual means through prayer alone in accordance with a recognized religious method of healing in lieu of medical treatment; further, nothing in this part shall be construed to require or

authorize the provision of medical care to any terminally ill person if such person has executed an unrevoked living will in accordance with the Tennessee Right to Natural Death Act, compiled in title 32, chapter 11, and if the provision of such medical care would conflict with the terms of such living will;

(2) "Adult" means a person eighteen (18) years of age or older who because of mental or physical dysfunctioning or advanced age is unable to manage such person's own resources, carry out the activities of daily living, or protect such person from neglect, hazardous or abusive situations without assistance from others and who has no available, willing, and responsibly able person for assistance and who may be in need of protective services; provided, however, that a person eighteen (18) years of age or older who is mentally impaired but still competent shall be deemed to be a person with mental dysfunction for the purposes of this chapter;

(3) "Advanced age" means sixty (60) years of age or older;

(4) "Capacity to consent" means the mental ability to make a rational decision, which includes the ability to perceive, appreciate all relevant facts and to reach a rational judgment upon such facts. A decision itself to refuse services cannot be the sole evidence for finding the person lacks capacity to consent;

(5) (A) "Caretaker" means an individual or institution who has the responsibility for the care of the adult as a result of family relationship, or who has assumed the responsibility for the care of the adult person voluntarily, or by contract, or agreement;

(B) A financial institution is not a caretaker of funds or other assets unless such financial institution has entered into an agreement to act as a trustee of such property or has been appointed by a court of competent jurisdiction to act as a trustee with regard to the property of the adult;

(6) "Commissioner" means the commissioner of human services;

(7) "Department" means the department of human services;

(8) "Exploitation" means the improper use by a caretaker of funds that have been paid by a governmental agency to an adult or to the caretaker for the use or care of the adult;

(9) "Imminent danger" means conditions calculated to and capable of producing within a relatively short period of time a reasonable probability of resultant irreparable physical or mental harm or the cessation of life, or both, if such conditions are not removed or alleviated. However, the department is not required to assume responsibility for a person in imminent danger pursuant to this chapter except when, in the department's determination, sufficient resources exist for the implementation of this part;

(10) "Investigation" includes, but is not limited to, a personal interview with the individual reported to be abused, neglected, or exploited. When abuse or neglect is allegedly the cause of death, a coroner's or doctor's report shall be examined as part of the investigation;

(11) "Protective services" means services undertaken by the department with or on behalf of an adult in need of protective services who is being abused, neglected, or exploited. These services may include, but are not limited to, conducting investigations of complaints of possible abuse, neglect, or exploitation to ascertain whether or not the situation and condition of the adult in need of protective services warrants further action; social services aimed at preventing and remedying abuse, neglect, and exploitation; services directed toward seeking legal determination of whether the adult in need of protective services has been abused, neglected or exploited and procurement of suitable care in or out of the adult's home;

(12) "Relative" means spouse; child, including stepchild, adopted child or foster child; parents, including stepparents, adoptive parents or foster parents; siblings of the whole or half-blood; step-siblings; grandparents; grandchildren, of any degree; and aunts, uncles, nieces and nephews; and

(13) "Sexual abuse" occurs when an adult, as defined in this chapter, is forced, tricked, threatened or otherwise coerced by a person into sexual activity, involuntary exposure to sexually explicit material or language, or sexual contact against such adult's will. Sexual abuse also occurs when an adult, as defined in this chapter, is unable to give consent to such sexual activities or contact and is engaged in such activities or contact with another person.

71-6-103. Rules and regulations -- Reports of abuse or neglect -- Investigation --

Providing protective services -- Consent of adult -- Duties of other agencies.

(a) The commissioner has the discretion to adopt such rules, regulations, procedures, guidelines, or any other expressions of policy necessary to effect the purpose of this part insofar as such action is reasonably calculated to serve the public interest.

(b) (1) Any person, including, but not limited to, a physician, nurse, social worker, department personnel, coroner, medical examiner, alternate care facility employee, or caretaker, having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made in accordance with this part. Death of the adult does not relieve one of the responsibility for reporting the circumstances surrounding the death. However, unless the report indicates that there are other adults in the same or similar situation and that an investigation and provision of protective services are necessary to prevent their possible abuse, neglect or exploitation, it shall not be necessary for the department to make an investigation of the circumstances surrounding the death; provided, that the appropriate law-enforcement agency is notified.

(2) If a hospital, clinic, school, or any other organization or agency responsible for the care of adults has a specific procedure, approved by the director of adult protective services

for the department, or the director's designee, for the protection of adults who are victims of abuse, neglect, or exploitation, any member of its staff whose duty to report under this part arises from the performance of the staff member's services as a member of the staff of the organization may, at the staff member's option, fulfill that duty by reporting instead to the person in charge of the organization or the organization head's designee who shall make

the report in accordance with this chapter.

(c) An oral or written report shall be made immediately to the department upon knowledge of the occurrence of suspected abuse, neglect, or exploitation of an adult. Any person making such a report shall provide the following information, if known: the name and

address of the adult, or of any other person responsible for the adult's care; the age of the adult; the nature and extent of the abuse, neglect, or exploitation, including any evidence of previous abuse, neglect, or exploitation; the identity of the perpetrator, if known; the identity of the complainant, if possible; and any other information that the person believes might be helpful in establishing the cause of abuse, neglect, or exploitation. Each report of known or suspected abuse of an adult involving a sexual offense that is a violation of §§ 39-13-501 -- 39-13-506 that occurs in a facility licensed by the department of mental health and substance abuse services as defined in § 33-2-402, or any hospital shall also be made to the local law enforcement agency in the jurisdiction where such offense occurred.

(d) Upon receipt of the report, the department shall take the following action as soon as practical:

(1) Notify the appropriate law enforcement agency in all cases in which the report involves abuse, neglect, or exploitation of the adult by another person or persons;

(2) Notify the appropriate licensing authority if the report concerns an adult who is a resident of, or at the time of any alleged harm is receiving services from, a facility that is required by law to be licensed or the person alleged to have caused or permitted the harm is licensed under title 63. The commissioner of health, upon becoming aware through personal knowledge, receipt of a report or otherwise, of confirmed exploitation, abuse, or neglect of a nursing home resident, shall report such instances to the Tennessee bureau of investigation for a determination by the bureau as to whether the circumstances reported constitute abuse of the medicaid program or other criminal violation;

(3) Initiate an investigation of the complaint;

(4) Make a written report of the initial findings together with a recommendation for further action, if indicated; and

(5) After completing the evaluation, the department shall notify the person making the report of its determination.

(e) Any representative of the department may enter any health facility or health service licensed by the state at any reasonable time to carry out its responsibilities under this part.

(f) Any representative of the department may, with consent of the adult or caretaker, enter any private premises where any adult alleged to be abused, neglected, or exploited is found in order to investigate the need for protective services for the purpose of carrying out this part. If the adult or caretaker does not consent to the investigation, a search warrant may issue upon a showing of probable cause that an adult is being abused, neglected, or exploited, to enable a representative of the department to proceed with the investigation.

(g) If a determination has been made that protective services are necessary when indicated by the investigation, the department shall provide such services within budgetary limitations, except in such cases where an adult chooses to refuse such services.

(h) In the event the adult elects to accept the protective services to be provided by the department, the caretaker shall not interfere with the department when rendering such services.

(i) If the adult does not consent to the receipt of protective services, or if the adult withdraws consent, the services shall be terminated, unless the department determines that the adult lacks capacity to consent, in which case it may seek court authorization to provide protective services.

(j) (1) Any representative of the department actively involved in the conduct of an abuse, neglect, or exploitation investigation under this part shall be allowed access to the mental and physical health records of the adult that are in the possession of any individual, hospital, or other facility if necessary to complete the investigation mandated by this chapter.

(2) To complete the investigation required by this part, any authorized representative of the department actively involved in the conduct of an investigation pursuant to this part shall be allowed access to any law enforcement records or personnel records, not otherwise specifically protected by statute, of any person who is:

(A) A caretaker of the adult; or

(B) The alleged perpetrator of abuse, neglect or exploitation of the adult, who is the subject of the investigation.

(3) (A) If refused any information pursuant to subdivisions (j)(1) and (2), any information from any records necessary for conducting investigations pursuant to this part may be obtained upon motion by the department to the circuit, chancery or general sessions court of the county where such records are located, or in the court in which any proceeding concerning the adult may have been initiated or in the court in the county in

which the investigation is being conducted.

(B) The order on the department's motion may be entered ex parte upon a showing by the department of an immediate need for such information.

(C) The court may enter such orders as may be necessary to ensure that the information sought is maintained pending any hearing on the motion, and to protect the information obtained from further disclosure if the information is made available to the department pursuant to the court's order.

(4) (A) The department may be allowed access to financial records that are contained in any financial institution, as defined by § 45-10-102(3):

(i) Regarding:

(a) The person who is the subject of the investigation;

(b) Any caretaker of such person; and

(c) Any alleged perpetrator of abuse, neglect or exploitation of such person;

(ii) By the issuance of an administrative subpoena in the name of the commissioner or an authorized representative of the commissioner that is:

(a) Directed to the financial institution; and

(b) Complies with §§ 45-10-106 and 45-10-107; or

(iii) By application, as otherwise required pursuant to § 45-10-117, to the circuit or chancery court in the county in which the financial institution is located, or in the court in which any proceeding concerning the adult may have been initiated or in which the investigation is being conducted, for the issuance of a judicial subpoena that complies with the requirements of § 45-10-107; provided, that the department shall not be required to post a bond pursuant to § 45-10-107(a)(4).

(B) Nothing in this subdivision (j)(4) shall be construed to supersede the provision of financial records pursuant to the permissible acts allowed pursuant to § 45-10-103.

(5) Any records received by the department, the confidentiality of which is protected by any other statute or regulation, shall be maintained as confidential pursuant to such statutes or regulations, except for such use as may be necessary in the conduct of any proceedings pursuant to its authority pursuant to this part or title 33 or 34.

(k) (1) If, as a result of its investigation, the department determines that an adult who is a resident or patient of a facility owned or operated by an administrative department of the state is in need of protective services, and the facility is unable or unwilling to take action to protect the resident or patient, the department shall make a report of its investigation, along with any recommendations for needed services to the commissioner of the department having responsibility for the facility. It shall then be the responsibility of the commissioner for that department and not the department of human services to take such steps as may be necessary to protect the adult from abuse, neglect, or exploitation and, in

such cases, the affected administrative department of the state shall have standing to petition the court.

(2) (A) Notwithstanding subdivision (k)(1) or any other provision of this part to the contrary, the department of human services shall not be required to investigate and the department of mental health and substance abuse services or the department of intellectual and developmental disabilities, or their successor agencies, shall not be required to report to the department of human services any allegations of abuse, neglect or exploitation involving any person that arise from conduct occurring in any institutions operated directly by either the department of mental health and substance abuse services or the department of intellectual and developmental disabilities.

(B) Allegations of abuse, neglect or exploitation of individuals occurring in the circumstances described in subdivision (k)(2)(A) shall be investigated, respectively, by investigators of the department of mental health and substance abuse services and the department of intellectual and developmental disabilities, or their successor agencies, who have been assigned to investigate the allegations.

(l) In the event the department, in the course of its investigation, is unable to determine to its satisfaction that sufficient information is available to determine whether an adult is in imminent danger or lacks the capacity to consent to protective services, an order may be issued, upon a showing of probable cause that an adult lacks capacity to consent to protective services and is being abused, neglected, or exploited, to require the adult to be examined by a physician, a psychologist in consultation with a physician or a psychiatrist in

order that such determination can be made. An order for examination may be issued ex parte upon affidavit or sworn testimony if the court finds that there is cause to believe that the adult may be in imminent danger and that delay for a hearing would be likely to substantially increase the adult's likelihood of irreparable physical or mental harm, or both, and/or the cessation of life.

71-6-104. Remedies -- Injunctive relief.

(a) Any court with jurisdiction under this part may upon proper application by the department issue a temporary restraining order or other injunctive relief to prohibit any violation of this part, regardless of the existence of any other remedy at law.

(b) The court may enjoin from providing care for any person, on a temporary or permanent basis, any employee or volunteer, who the court finds has engaged in the abuse, neglect or exploitation of an adult as defined in this part, in any situation involving the care of such adult by such employee or volunteer, whether such actions occurred in an institutional setting, in any type of group home or foster care arrangement serving adults, and regardless of whether such person, facility or arrangement serving adults is licensed to provide care for adults.

**71-6-105. Reporting or investigating parties -- Immunity from liability --
Protection from job discrimination.**

Any person making any report or investigation pursuant to this part, including representatives of the department in the reasonable performance of their duties and within the scope of their authority, shall be presumed to be acting in good faith and shall thereby

be immune from any liability, civil or criminal, that might otherwise be incurred or imposed.

Any such participant shall have the same immunity with respect to participation in any judicial proceeding resulting from such report or investigation. Any person making a report

under this part shall have a civil cause of action for appropriate compensatory and punitive

damages against any person who causes a detrimental change in the employment status of the reporting party by reason of the report.

71-6-106. Privilege for confidential communications.

Notwithstanding the existence of the privilege for confidential communications between husband and wife, the chancellor at the hearing may compel testimony if, in the chancellor's opinion, disclosure is necessary in the interest of the adult.

71-6-107. Provision of protective services without the consent of the adult.

(a) (1) (A) If the department determines that an adult who is in need of protective services is in imminent danger if that adult does not receive protective services and lacks capacity to consent to protective services, then the department may file a complaint with

the court for an order authorizing the provision of protective services necessary to prevent imminent danger of irreparable physical or mental harm, or both, and//or the cessation of life. The judge or chancellor shall hear the complaint ahead of any other business then

pending in court or in chambers. This order may include the designation of an individual or

organization to be responsible for the personal welfare of the adult and for consenting to protective services in the adult's behalf. The complaint must allege specific facts sufficient to

show that the adult is in imminent danger if the adult does not receive protective services and lacks capacity to consent to protective services. Prior to filing a complaint with the court

for an order authorizing removal of an adult from that adult's chosen place of residence, the

department shall make reasonable efforts to exhaust all practical alternatives to the removal of such adult from such place of residence.

(B) In situations where the department must present a petition for emergency removal of an adult in imminent danger and a chancellor or circuit judge is unavailable, the department may present petitions to judicial officers with general sessions jurisdiction. Further proceedings shall be conducted in chancery or circuit court.

(C) For the purposes of this section, "sexual abuse," as defined in this chapter, shall provide grounds for the department to obtain custody of an adult who lacks capacity to consent when such abuse relates to sexual activity or contact.

(2) The judge or chancellor or the general sessions court judge, prior to entering the order, must find that the adult is in imminent danger if the adult does not receive protective services and lacks capacity to consent to protective services.

(3) Within seven (7) days of entering an order pursuant to this section, or for good cause shown, then up to fifteen (15) days, the court shall hold a hearing on the merits. If such a hearing is not held within such time, the order authorizing the provision of protective services shall be dissolved.

(4) (A) The adult alleged to be in need of protective services and any person to/or the cessation of life. The judge or chancellor shall hear the complaint ahead of any other business then

pending in court or in chambers. This order may include the designation of an individual or organization to be responsible for the personal welfare of the adult and for consenting to protective services in the adult's behalf. The complaint must allege specific facts sufficient to show that the adult is in imminent danger if the adult does not receive protective services and lacks capacity to consent to protective services. Prior to filing a complaint with the court for an order authorizing removal of an adult from that adult's chosen place of residence, the department shall make reasonable efforts to exhaust all practical alternatives to the removal of such adult from such place of residence.

(B) In situations where the department must present a petition for emergency removal of an adult in imminent danger and a chancellor or circuit judge is unavailable, the department may present petitions to judicial officers with general sessions jurisdiction. Further proceedings shall be conducted in chancery or circuit court.

(C) For the purposes of this section, "sexual abuse," as defined in this chapter, shall provide grounds for the department to obtain custody of an adult who lacks capacity to consent when such abuse relates to sexual activity or contact.

(2) The judge or chancellor or the general sessions court judge, prior to entering the order, must find that the adult is in imminent danger if the adult does not receive protective services and lacks capacity to consent to protective services.

(3) Within seven (7) days of entering an order pursuant to this section, or for good cause shown, then up to fifteen (15) days, the court shall hold a hearing on the merits. If such a hearing is not held within such time, the order authorizing the provision of protective services shall be dissolved.

(4) (A) The adult alleged to be in need of protective services and any person to whom the adult is lawfully married, if known and reasonably available, must be served with a copy of the complaint at least forty-eight (48) hours prior to the hearing, unless for good cause shown, a shorter time is allowed by the court. The adult and the adult's spouse have a right to be present and represented by counsel at the hearing. Failure to serve a copy of the complaint on a lawful spouse of the adult, if the spouse is not known or is not reasonably available as determined by the court, shall not prevent the provision of protective services, as ordered by the court, that may be necessary to prevent the adult from suffering imminent harm.

(B) If the adult alleged to be in need of protective services is indigent or, in the determination of the judge or chancellor, lacks capacity to waive the right to counsel, then the court shall appoint counsel for the adult alleged to be in need of protective services.

(C) If the adult alleged to be in need of protective services is indigent, court costs and the cost of representation of the adult shall be borne by the state; otherwise, the costs shall be borne by the adult. The state shall not be liable for the cost of counsel or court costs for the spouse of the adult; provided, however, that if the court finds that the department or an

agency acting under subdivision (a)(7) has, without good cause, failed to serve a copy of the complaint on the lawful spouse of the adult, the court may assess attorneys fees for the spouse of the adult and court costs to the department or agency acting under subdivision (a)(7) not to exceed a total of two thousand dollars (\$2,000); provided further, however, that the court may exceed the two thousand dollar (\$2,000) limit upon making a specific finding of fact that the failure of the department or an agency to serve the complaint resulted in financial hardship upon the spouse or adult in excess of two thousand dollars (\$2,000) and that the interests of justice require that the limit be exceeded in the particular case.

(D) If a court determines that appointment of a guardian ad litem is necessary, and if the adult is indigent, the cost for the guardian ad litem shall be borne by the state; otherwise the costs shall be borne by the adult.

(5) (A) Protective services necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life authorized by order pursuant to this section may include, but are not limited to, taking the adult into physical custody in the home, a medical or nursing care facility, or, if available, an alternative living arrangement exclusive of a developmental center operated by the department of intellectual and developmental disabilities; provided, that the court finds that such custody is for the purpose of medical examination and treatment necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life or protection from abuse or neglect necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life, and that the court specifically authorizes such custody in its order. In determining what specific custodial authority to grant under this

section, the court shall consider whether the imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life is relatively mild or severe and authorize such custody as is appropriate under the circumstances. The department shall review the decree at least annually to determine whether the prerequisites for custody still exist.

(B) Within a reasonable period of time after an adult is taken into physical custody and placed other than in a medical or nursing care facility, the department shall cause an appropriate examination to be made of the adult to determine the cause or causes resulting in the adult's lack of capacity to consent, if such determination had not been made at the time of the final hearing.

(6) (A) In the event that the adult has sufficient resources to defray the costs of a medical or nursing care facility, or an appropriate alternative living arrangement, as decreed by the court pursuant to this subsection (a), and that without such resources the adult would be unable to enter such facility or alternative living arrangement, then the court may appoint a temporary guardian for such period as necessary to secure and disburse the adult's resources for that purpose, but for no longer than six (6) months from the entry of the order authorizing provision of protective services. However, the court in its discretion may extend such period for a period no longer than an additional six (6) months. The guardian appointed pursuant hereto shall file an accounting with the court as to the resources used.

(B) The court in its order may authorize the temporary guardian to exercise a limited

power of attorney over any accounts the adult has in a bank, credit union, or other financial

institution. The temporary guardian so designated shall deliver a copy of the order of the court to the financial institution prior to taking any action with regard to the accounts. The limited power of attorney shall authorize the temporary guardian to withdraw money from or freeze or unfreeze the account.

(C) Concurrent with the order of the court appoiwhom

the adult is lawfully married, if known and reasonably available, must be served with a copy

of the complaint at least forty-eight (48) hours prior to the hearing, unless for good cause shown, a shorter time is allowed by the court. The adult and the adult's spouse have a right to be present and represented by counsel at the hearing. Failure to serve a copy of the complaint on a lawful spouse of the adult, if the spouse is not known or is not reasonably available as determined by the court, shall not prevent the provision of protective services, as ordered by the court, that may be necessary to prevent the adult from suffering imminent harm.

(B) If the adult alleged to be in need of protective services is indigent or, in the determination of the judge or chancellor, lacks capacity to waive the right to counsel, then the court shall appoint counsel for the adult alleged to be in need of protective services.

(C) If the adult alleged to be in need of protective services is indigent, court costs and the cost of representation of the adult shall be borne by the state; otherwise, the costs shall be borne by the adult. The state shall not be liable for the cost of counsel or court costs for the spouse of the adult; provided, however, that if the court finds that the department or an

agency acting under subdivision (a)(7) has, without good cause, failed to serve a copy of the complaint on the lawful spouse of the adult, the court may assess attorneys fees for the spouse of the adult and court costs to the department or agency acting under subdivision (a)(7) not to exceed a total of two thousand dollars (\$2,000); provided further, however, that the court may exceed the two thousand dollar (\$2,000) limit upon making a specific finding of fact that the failure of the department or an agency to serve the complaint resulted in financial hardship upon the spouse or adult in excess of two thousand dollars (\$2,000) and that the interests of justice require that the limit be exceeded in the particular case.

(D) If a court determines that appointment of a guardian ad litem is necessary, and if the adult is indigent, the cost for the guardian ad litem shall be borne by the state; otherwise the costs shall be borne by the adult.

(5) (A) Protective services necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life authorized by order pursuant to this section may include, but are not limited to, taking the adult into physical custody in the home, a medical or nursing care facility, or, if available, an alternative living arrangement exclusive of a developmental center operated by the department of intellectual and developmental disabilities; provided, that the court finds that such custody is for the purpose of medical examination and treatment necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life or protection from abuse or neglect necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life, and that the court specifically authorizes such custody in its order. In determining what specific custodial authority to grant under this

section, the court shall consider whether the imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life is relatively mild or severe and authorize such custody as is appropriate under the circumstances. The department shall review the decree at least annually to determine whether the prerequisites for custody still exist.

(B) Within a reasonable period of time after an adult is taken into physical custody and placed other than in a medical or nursing care facility, the department shall cause an appropriate examination to be made of the adult to determine the cause or causes resulting in the adult's lack of capacity to consent, if such determination had not been made at the time of the final hearing.

(6) (A) In the event that the adult has sufficient resources to defray the costs of a medical or nursing care facility, or an appropriate alternative living arrangement, as decreed by the court pursuant to this subsection (a), and that without such resources the adult would be unable to enter such facility or alternative living arrangement, then the court may appoint a temporary guardian for such period as necessary to secure and disburse the adult's resources for that purpose, but for no longer than six (6) months from the entry of the order authorizing provision of protective services. However, the court in its discretion may extend such period for a period no longer than an additional six (6) months. The guardian appointed pursuant hereto shall file an accounting with the court as to the resources used.

(B) The court in its order may authorize the temporary guardian to exercise a limited

power of attorney over any accounts the adult has in a bank, credit union, or other financial

institution. The temporary guardian so designated shall deliver a copy of the order of the court to the financial institution prior to taking any action with regard to the accounts. The limited power of attorney shall authorize the temporary guardian to withdraw money from or freeze or unfreeze the account.

(C) Concurrent with the order of the court appointing a temporary guardian, the court shall issue a subpoena directed to the financial institution in compliance with the Financial Records Privacy Act, compiled in title 45, chapter 10, requesting the names of any co-owner

or additional authorized signatories on the accounts, unless the temporary guardian has actual knowledge of any co-owners or additional authorized signatories. Upon receipt of the

response to the subpoena, or upon actual knowledge of the co-owners or additional authorized signatories, the temporary guardian shall send a copy of the order to any person

who is a co-owner of or authorized signatory on the deposit account within ten (10) days of receiving the names of the co-owners or signatories. Nothing in this subdivision (a)(6)(C) shall preclude the temporary guardian from making immediate expenditures from the accounts of the adult necessary to provide protective services for the adult in imminent danger, as defined in this part, pending the response by the co-owners or other signatories to the accounts.

(D) If the court finds that the temporary guardian has, without good cause, failed

the adult is indigent, the cost for the guardian ad litem shall be borne by the state; otherwise the costs shall be borne by the adult.

(3) If the judge or chancellor finds that the adult is in need of protective services and lacks capacity to consent to protective services, then the judge or chancellor may enter a decree authorizing the provision of protective services. This decree may include the designation of an individual or organization to be responsible for the personal welfare of the adult and for consenting to protective services in the adult's behalf.

(c) An individual or organization appointed pursuant to subsection (a) or (b) to be responsible for the personal welfare of the adult and for consenting to protective services in the adult's behalf or to serve as temporary guardian shall have only specific authority as the court shall provide in its order. Such authority shall be limited to the authority to consent to specified protective services, including medical care if ordered, and if ordered pursuant to subsection (a), may arrange for, and consent to, appropriate custodial care and gain access to and disburse the adult's resources. If the adult is in need of a person to manage the adult's affairs or to have other responsibilities not addressed in this section, the procedures and requirements for appointment of a conservator pursuant to title 34, chapter 1 or 3, must be followed. Nothing in this section shall be construed as requiring the department to initiate proceedings for the appointment of a conservator or a temporary guardian or to accept such appointment if proceedings are instituted or to initiate proceedings under title 34, chapter 1 or 3.

71-6-108. Prohibitions.

No adult may be adjudicated incompetent or committed to a mental institution under this part.

71-6-110. Violation of duty to report.

Any person who knowingly fails to make a report required by this chapter commits a Class

A misdemeanor.

71-6-117. Willful abuse, neglect or exploitation prohibited -- Penalty.

(a) It is an offense for any person to knowingly, other than by accidental means, abuse, neglect or exploit any adult within the meaning of this part.

(b) A violation of this section is a Class E felony.

Chapter Twelve: Professional Boundaries [TOC](#)

- a. stats
- b. Therapist Sexual Misconduct 29-26-201ff
- c. Ethics code
- d. Cases TN
- e. Cases other
- f. Prevention

Stats:

80% male clinician-female client
13% female clinician-female client
5% male clinician- male client
2% female clinician-male client Gutheil & Brodsky (2008)

False claims:

Pope & Vetter 1991 4%
Revenge, competition, fantasy, delusion, extortion, escape from treatment, financial gain,
Borderline PERSONALITY DISORDER

Vulnerability of Clinicians

Naïve to sociopathic

Assessment Bulletin of the Menninger Clinic vol 56(2), Spring 1992 150-166

32 self-assessment questions:

- Generalized boundary violations: role conflicts blurring lines
- Eroticism: self-gratifying romantic feelings re client
- Exhibitionism
- Dependency: therapist gets emotional needs met by client continuing in tx
- Power seeking: mastery/control over client
- Greediness: financial benefit
- Enabling: rescue fantasies

axioms

1. Responsibility for setting and maintaining boundaries belongs solely to counselor
2. To any degree client participated/encouraged/initiated is of no count due to #1
3. Fiduciary relationship of therapist to client
4. Payment <> client

Cautionary signs:

1. Extended sessions

Chapter 12 Professional Boundaries

2. Odd hour sessions
3. Phone/email contact between sessions
4. Gifts
5. Non-therapeutic contact
6. Collusion re fraudulently billing
7. Sliding scales not uniformly enacted
8. Limit setting re payment
9. Insider information
10. Barter
11. Self-disclosure

Non-sexual dual relationships

Necessary?

Exploitative?

Who benefits from duality?

Risk of damage

Document decision process

Informed consent

Chapter Thirteen: Custody Evaluations [TOC](#)

- g. What is the standard of care?
- h. Making a report relevant to Court decisional criteria
- i. Parental alienation? Real or not?

“Critical review of Child Custody Evaluation Reports”, Family Court Review Vol. 40 No 2, April 2002

“Child Custody Cases: A Content Analysis of Evaluations and Practice” Professional Psychology: Research and Practice 2002: Vol. 33 No 6, 557-565

36-6-106. Child custody. —

- (1) The love, affection and emotional ties existing between the parents or caregivers and the child;
- (2) The disposition of the parents or caregivers to provide the child with food, clothing, medical care, education and other necessary care and the degree to which a parent or caregiver has been the primary caregiver;
- (3) The importance of continuity in the child's life and the length of time the child has lived in a stable, satisfactory environment; provided, that, where there is a finding, under subdivision (a)(8), of child abuse, as defined in § 39-15-401 or § 39-15-402, or child sexual abuse, as defined in § 37-1-602, by one (1) parent, and that a nonperpetrating parent or caregiver has relocated in order to flee the perpetrating parent, that the relocation shall not weigh against an award of custody;
- (4) The stability of the family unit of the parents or caregivers;
- (5) The mental and physical health of the parents or caregivers;
- (6) The home, school and community record of the child;
- (7) (A) The reasonable preference of the child, if twelve (12) years of age or older;
(B) The court may hear the preference of a younger child on request. The preferences of older children should normally be given greater weight than those of younger children;
- (8) Evidence of physical or emotional abuse to the child, to the other parent or to any other person; provided, that, where there are allegations that one (1) parent has committed child abuse, as defined in § 39-15-401 or § 39-15-402, or child sexual abuse, as defined in § 37-1-602, against a family member, the court shall consider all evidence relevant to the physical and emotional safety of the child, and determine, by a clear preponderance of the evidence, whether such abuse has occurred. The court shall include in its decision a written finding of all evidence, and all findings of facts connected to the evidence. In addition, the court shall, where appropriate, refer any issues of abuse to the juvenile court for further proceedings;
- (9) The character and behavior of any other person who resides in or frequents the home of a parent or caregiver and the person's interactions with the child; and
- (10) Each parent or caregiver's past and potential for future performance of parenting responsibilities, including the willingness and ability of each of the parents and caregivers to facilitate and encourage a close and continuing parent-child relationship between the child and both of the child's parents, consistent with the best interest of the child.

Chapter 13 Custody Evaluations

Tennessee Cases

36-6-101

[“Critical review of Child Custody Evaluation Reports”, Family Court Review Vol. 40 No 2, April 2002](#)

1. Most did classic report (83%) versus letter to judge or attorneys; Brief summary and detailed report.
2. Median 10 hours of work
3. 88% Court ordered
4. Interviewed parents, children, testing, collateral contacts (chart)
5. Observation of parent-child interaction (76%)
6. Reports too long and narrative doesn't fit the criteria

[Schroedel v Bumgarner:](#) (TN Court of Appeals, 2010)

Mother sought more time with minor child and employed Sr. Psych Examiner to evaluate Mother and Stepfather who were accused of being abusive. MMPI, interviews (4 hrs), and called DCS re abuse allegations. Court didn't comment on evaluation but did not substantially change the parenting arrangement.

[Keller v Keller:](#) (TN Court of Appeals, 2008) Here the Father took the minor to a psychologist who testified that Mother's frequent moves was created a material change in circumstances. The trial court did not agree. The Mother did not provide expert testimony so the Appellant Court overruled the Trial Court.

Bottom line: better to have a court ordered evaluation, but don't go to court with only one side having an expert.

[In re Madison N.J.M.:](#) (TN Court of Appeals, 2008) Case where grandmother was the primary custodial parent d/t mother's neglect. Father instituted proceedings to gain more parenting time. Court order co-parenting therapy for the grandmother-Father "parents."

[Gentile v Gentile:](#) (TN Court of Appeals, 2010) Court ordered on it's own a forensic parenting assessment which involved a psychiatrist and psychologist team. Father hired his own psychologists who did not meet with the parties or the minor. Court gave more credibility to the court-ordered evaluation.

[Everett v Everett:](#) (TN Court of Appeals, 2009) Knoxville case. They utilize a Special Master who court-ordered a custody evaluation. The parties had filed exceptions to the

Master's report. At trial, judge admitted he had not read the transcript of the Master's hearing, including the testimony of the psychologist. He did read report only. Trial court erred in not reading the testimony of the psychologist and merely relying on the report.

[Adams v Adams](#): (TN Court of Appeals, 2008) Gibson County.

Father sought change of custody. Psychologist evaluated mother, father and his new wife, the minor children, and conducted collateral interviews. 33-page report. Brickland Perceptual Scales to children to see how they perceived parents and stated results coincide with Court's opinion in 97% of time. While results favored mother, father was awarded the change in custody, with the psychologist not making a recommendation.

**Bricklin Perceptual Scales™ (BPS™)
by Barry Bricklin, Ph.D.**

Since its publication in 1984 the BPS has become the premier custody evaluation test in use today. It has been administered more than 50,000 times, used in all 50 states, and accepted and relied upon by courts throughout the United States and Canada.

This unique and efficient data-based test is widely used by professionals who must make decisions regarding child custody. The Bricklin Perceptual Scales (BPS) is designed primarily for children who are at least 6 years old. The test assesses the child's perception of his or her parents in four major areas: Competence, Follow-up Consistency, Supportiveness, and Possession of Admirable Personality Traits.

The child responds to two sets of parallel questions, 32 pertaining to the mother and 32 to the father. Each question is printed on a separate card. On the back of each card is a response continuum—a long black line with a “Very Well” printed at one end and “Not so Well” at the other. The examiner reads the question, and the child gives a spoken response. The examiner then asks the same question, worded a little differently, and the child answers by punching a hole in the card somewhere along the response continuum. This second response, considered the more important of the two, reflects the child's nonverbal assessment of the parent in question.

BPS results have been validated against the decisions of independent mental health professionals, opinions of courtroom judges, and scores on the Perception-of-Relationships Test.

[Ghayoumi v McMillan](#): (TN Court of Appeals, 2006)

Court-ordered evaluators have absolute judicial immunity from prosecution to “be free from intimidation and harassment by a dissatisfied litigant.”

Burden v Burden: (TN Court of Appeals, 2007) Knoxville Case. Parties had a week-to-week arrangement. Here the Father selected psychologist and Mother consented. Psychologist evaluated the parties and submitted report but did not testify. No objection was made and no other expert testified. Evaluation favored the Mother. Court ignored it and left the visitation “as is.” Appeals Court took great exception to judge’s ignoring psychologist recommendations in the absence of an other expert and not citing evidence why.

Chaffin v Ellis: (TN Court of Appeals, 2005) Williamson County

Good read. Court appointed psychologist and Father also employed two psychologists; all did evaluations. Court-ordered psychologist did not testify at trial. Mother also hired a psychiatrist to testify about her emotional condition. Father sued judge, her attorney, the supervising entity, and court-ordered psychologist. Case dismissed but Father had to pay \$92,000 in attorney fees to the defendants.

Cone v Cone: (TN Court of Appeals, 2010) Robertson County. Mother accused Father of sexual abuse on numerous occasions, all unfounded by DCS. Mother got a TRO based on new allegations. GAL ordered psych evaluation of all parties and minor. They found no sexual abuse. Mother employed psychologist who reviewed records. Court based decision on work of GAL-appointed evaluators.

Covill v Covill: (TN Court of Appeals, 2009) Hamilton County. Court-ordered psychologist spent 19 hrs evaluating parties, utilized the ASPECT test. Father had been PRP and continuation of this was the recommendation. Mother hired psychologists to review the report. She attacked the ASPECT but the court agreed with the court-ordered psychologist.

Very few cx lead to discipline

tn have judicial immunity if court ordered

informed consent: letting client know they are not in tx,

case in which txpist called judge based on info given to txpist from mom.... Was this reporting of potential abuse or a custody evaluation... careful not to make comments about a party not evaluated

Chapter 14: Electronic Considerations [TOC](#)

1) Overview

- a. Electronic communication with clients
- b. New social media
- c. Recording conversations
- d. Recording others/electronic snooping: Concerns re unauthorized access to other's email/computer

2) Statutes

3) Cases

4) Professional ethics

Overview

Most ethical and legal guidelines were created in a time when face-to-face, mail or a telephone call were the only ways to communicate. Email, video conferencing (e.g., Skype, FaceTime) are newer methods for connecting the professional and individuals. Also, the “new social media”, including websites or applications exist to connect members socially. Facebook, Facebook chat, Twitter, LinkedIn, Google+, Pinterest, Tumblr, Flickr, G-chat, and Instagram and are a few of the prominent sites/applications. In addition are blogs which invite an open dialogue over the Internet. The statutory law and case law on these electronic avenues of communication between a mental health professional and their client are non-existent or in their infancy of development. While new social media certainly poses an opportunity for inexpensive advertising unheard of for previous generations, the opportunities for danger abound. This chapter addresses email, video conferencing, social media sites and considerations in recording conversations. Chapter highlights:

- 1) The possibility of unintentionally waiving privilege by the communication of privileged information to third parties.
- 2) To be privileged, the communication must be expected to be private.
- 3) Employer email accounts have no expectation of privacy.
- 4) If client-therapist information is waived in one setting, it will be waived in all.
- 5) There is no expectation of privacy in posting to social media sites; this is true if either the therapist or client makes the posting.
- 6) It is illegal to intercept electronic communication (e.g., phone conversations, email) without consent. There are criminal and substantial civil penalties for violating this.
- 7) It is illegal to video record others where there is an expectation of privacy.
- 8) It is legal to record your own conversation with anyone personally (not on phone) without their permission. Some states require both parties of a phone conversation to give consent to record. Tennessee requires that one party give consent.
- 9) A parent can give consent on their minor child's benefit to record conversations between the minor and others.
- 10) If a client posts a negative review about you online, ignore it. Any attempt to refute, oppose will likely be a breach of confidentiality.
- 11) Professional rules about tele-counseling are beginning to emerge.

Electronic Communication with Clients

Email communication with clients are problematic in that general email is not secure, if the client accesses email through an employer email system, there is no expectation of privacy and the asynchronous aspect of email robs both the client and the therapist of normal visual information that face-to-face communication provides. Despite wiretapping laws, email accounts and communication are subject to hacking by third parties including family members.

Generally communication with clients electronically shares the same characteristics as communication face-to-face. That is, there is an expectation of privacy, a privilege exists and the therapist must protect confidentiality of the communication. This is true if the communication is merely communication versus conducting therapy via electronic means. When initiating non-face-to-face contact with a client, a therapist should familiarize themselves to several published guidelines: 1) APA Ethics Committee 1997 Statement on Services by Telephone, Teleconferencing, and Internet; 2) American Psychological Association “Ethical principles of psychologists and code of conduct”, *American Psychologist*, 57(12), 1060-1073; 3) American Counseling Association (1999) ACA Code of Ethics; 4) American Mental Health Counselors Association “Code of Ethics of the American Mental Health Counselors Association, Principle 14, Internet on-Line counseling”; 5) American Telemedicine Association (2009) “Practice Guidelines for Videoconferencing-Based Telemental health”; 6) eRisk Working Group for Healthcare (2002) “Guidelines for Online Communication”.

The issues raised include:

Security

1. Clients are informed about technology limitations and impact on confidentiality.
2. Services provided on secure website using encryption technology.
3. Authentication of communications to assure that the therapist is communicating with the client and not someone posing as the client.

Disability

4. Technology is barrier free for clients with disabilities

Informed Consent

5. Information about the risks of electronic communication is given
6. Client notified if they need encryption technology, and if therapist will provide it.
7. Client is informed and consents if communication is stored.
8. Client is informed about the possible misunderstandings when visual cues are absent.
9. Client is informed about possible technological/communication delays.

Other

10. Other methods of contacting client are obtained.
11. Therapist is aware of resources local to client to address emergency situations.
12. Record of electronic communication are made apart of medical records.
13. Client is informed of alternative treatment should electronic not be appropriate.
14. Services are not performed where client resides in a state in which the therapist is not licensed.
15. The appropriateness of this method of treatment fits both client and therapist.

If a client of yours that resides in your state moves to a different state that you are not licensed in, you cannot treat them via electronic means as a way to bypass getting licensed in that state. It would be permissible to treat someone on vacation that is domiciled in your state. Some therapists offer psycho-educational workshops for the public. That is a legitimate undertaking. A therapist can offer a workshop even to out of state participants, but must be careful to not allow individualized exchange that leaves the normal public question and answer format and transition to a private discourse that is therapeutic in nature.

New Social Media

Social media sites offer individuals many ways to communicate socially. Three ethical issues arise; 1) if the client or therapist posts confidential information on a social media website, they are waiving privilege; 2) if a client posts negative information about a therapist on a social media website, how can/should the therapist respond; and 3) if a therapist has a social media page, how should they respond to client contact. To address the first issue we must first discuss privilege. Most of the privilege statutes for therapists as discussed in chapter five are likened to that between an attorney and client. Let's look at that privilege. TCA §23-3-105 states,

No attorney, solicitor or counselor shall be permitted, in giving testimony against a client, or person who consulted the attorney, solicitor or counselor professionally, to disclose any communication made to the attorney, solicitor or counselor as such by such person, during the pendency of the suit, before or afterwards, to the person's injury.

Case law has demonstrated that the privilege is not absolute. *Humphreys, Hutcheson & Moseley v. Donovan*, 568 F. Supp. 161, 175 (MD. Tenn. 1983) in construing the statute ruled that:

- (2) the asserted holder of the privilege is or sought to become a client;
- (2) the person to whom the communication was made
 - (a) is a member of the bar of a court, or his subordinate and
 - (b) in connection with this communication is acting as a lawyer,
- (3) the communication relates to a fact of which the attorney was informed
 - (a) by his client
 - (b) without the presence of strangers
 - (c) for the purpose of securing primarily either
 - (i) an opinion on law or
 - (ii) legal services or
 - (iii) assistance in some legal proceeding, and not
 - (d) for the purpose of committing a crime or tort and
- (4) the privilege has been
 - (a) claimed and
 - (b) *not waived by the client.*

Waiver of the privilege can be intentional (when a client signs a release of information) or unintentional. Unintentional waiving of a privilege includes communicating the substance of the privileged communication to a person with whom the confidential relationship does not exist. In email this can occur by forwarding the email to someone other than the client. Also, using an employer email system, where there is not an expectation of privacy, waives the privilege. A single waiver of the attorney-client privilege can have dramatic effects that must be considered before deciding whether to voluntarily waive the privilege. Clients should be made aware in the

Informed Consent they are provided, that their posting private information about therapy on a public forum can waive privilege on their part.

If a client posts negative information about a therapist on a social media site, how should a therapist respond? Some call this being “Yelped” from the website www.yelp.com where reviews can be posted about a professional. By fighting back, posting a response, the therapist would be acknowledging the therapeutic relationship. Any public response certainly risks breaching our primary responsibility of confidentiality. Just because the client breaches some of the confidential information, the therapist has not been given consent to do the same. Most therapists writing about this scenario suggest doing nothing in response. What a therapist can do is to avail themselves to publish positive online articles to combat any negative perceptions that may occur due to the negative post. Companies like www.reputation.com basically help you post sufficient articles so as to push down the negative information when doing internet searches. What you can’t do is log in and make a fake post (deceptive advertising), ask clients to sign a statement agreeing not to post negative reviews (not enforceable), or ask the website to remove the post (won’t do without a court order). Another legitimate approach is to contact the client privately and offer to resolve the conflict with them. Suing the client for slander is not only costly but not likely to succeed and more likely to involve breaching confidentiality.

The third issue asks how a therapist should handle having a social media presence. There two possible social media presences; the first is that the therapist has a professional page on social media, for example, a Facebook page for their practice, and second, to have a personal “social” page. For a professional page the site would be public and there would have to be settings so that posts could not be made to the site. Settings on Facebook that make it a professional site include strict filtering of messages to inbox, only friends of friends can send friend requests, No “friending” of any third parties. By having no friends and only allowing friends of friends sending you a friend request, then no client will be able to send you a friend request. Your posts would just be professional posts, psychoeducational in nature. The therapist having a social page is potentially problematic. By allowing a client to see your personal life via Facebook, can be construed as the therapist establishing a dual relationship (therapeutic and social). Certainly friending a client does create a social relationship. By the therapist limiting viewing to only friends, and accepting only friends of friends as “friend requests” you have limited clients from accessing your personal life and perhaps misconstruing this as an invitation for a dual relationship. Here the only problem you will have if a friend seeks out you as a therapist. This situation is not any different than when a non-Facebook friend seeks you out as a therapist. Also you may have at times a client who is a Facebook friend of one of your friends. You would have to decline/ignore their request to friend you via Facebook. I recommend you include in your informed consent the fact that you will not accept any social media requests for communication or friending by clients. This will ease the fact that you later refuse their friend request. Managing the social media site as a therapist with a social presence is very important in avoiding dual relationships.

Recording Conversations

It is legal to record [record, intercept??] a conversation between you and another party in a face-to-face conversation without gathering permission of the other party. Therapeutically most ethical guidelines state that the therapist must get the written consent of the client to record

sessions (APA Code 4.03 “Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all persons or their legal representatives”). Regarding telephone recording, Tennessee is a one-party consent state; this means that only one party must consent to recording a conversation on the phone. However, the followings states require both parties to consent to recording a conversation: California, Connecticut, Delaware, Florida, Illinois, Massachusetts, Maryland, Michigan, Montana, New Hampshire, Pennsylvania, and Washington. If you are calling someone who is located in one of those states, you must have both parties permission to record. If the party is a client, recording may be legal but would be a violation of the ethical code unless you had written permission.

At times a therapist is aware that their client is involved in recording a spouse. This occurs to attorneys also, especially in the practice of family law. It is wise to familiarize yourself with the law in this area. It is illegal to record third parties (i.e., you are not on the phone) on a phone conversation or to electronically intercept emails between two other parties without their knowledge and consent (Electronic Communications Privacy Act –ECPA; Tennessee Wiretapping and Electronic Surveillance Act, TCA §39-13-601). Criminal and civil penalties can ensue. There is a Tennessee statute (TCA § 39-13-606) that prohibits putting a tracking device on a motor vehicle without the permission of all the owners. Individuals have an expectation of privacy. Installing video surveillance in one’s home may or may not be legal, depending upon where it is placed (not in bedroom or bathroom... place where there is an expectation of privacy).

At times during couples treatment, a party will give consent to their spouse or significant other to see all emails, posts, or computer activity. I would suggest such agreements are made in writing so that there is no confusion later should one party blame the other for wiretapping. Also, realize that any consent may be limited in time or scope. Giving one permission to use your computer to access the internet is not giving permission to access email accounts or to install spyware. Consent, once given, can be revoked. It would be a violation of wiretapping laws to continue to access information that was once allowed but subsequently revoked. If a party has granted permission that they later revoke, they need to document the revocation and particularly that the other party was notified of the revocation. Sending certified mail can document the sending and receipt of a revocation of permission.

Statutes

Licensed Professional Counselors-TCA 63-22-101 to 63-22-207 is the statute that creates the Board of Examiners over the Licensed Professional Counselors. That Board enacted rules and regulations. The rules and regulations enacted by the Board governing LPCs states in 0450-1-.13 “In addition to the other requirements of this rule, all licensees and certificate holders who practice counseling electronically shall comply with the Ethical Standards for Internet Online Counseling adopted by the American Counseling Association, www.counseling.org, except to the extent that they conflict with the laws of the state of Tennessee or the rules of the Board. If the standards for the ethical practice of internet counseling conflict with state law or rules, the state law or rules govern the matter. Violation of the standards for the ethical practice of web counseling or state law or rules may subject a licensee or certificate holder to disciplinary action.” Per the documentation on ACA’s site, the Ethical Standards for Internet Counseling is no longer in force as section A.12 of the Code of Ethics was updated to address issues previously

listed outside of the Code of Ethics. This section addresses informed consent, accessibility, web-presence and providing assistance to those who require it in using technology. Standard A.12.e., “Laws and Statutes. Counselors ensure that the use of technology does not violate the laws of any local, state, national or international entity and observe all relevant statutes.” Technology-assisted counseling, whether conducted by telephone, Internet, e-mail or other application, often results in the crossing of jurisdictional lines. So laws which apply in Texas may not apply in New York. It is incumbent upon a counselor to know and be in compliance with all laws in both their state or jurisdiction and the state or jurisdiction of the client. Thus for LPCs, the Code is incorporated into the Rules and Regulations by reference.

Electronic Communications Privacy Act (ECPA) of 1986 (18 U.S.C. §§ 2510–2522)

TCA §39-13-601

(a)(1) Except as otherwise specifically provided in §§ 39-13-601

– 39-13-603 . . . a person commits an offense who:

(A) Intentionally intercepts, endeavors to intercept, or procures any other person to intercept or endeavor to intercept, any wire, oral, or electronic communication; (C) Intentionally discloses, or endeavors to disclose, to any other person the contents of any wire, oral or electronic communication, knowing or having reason to know that the information was obtained through the interception of a wire, oral, or electronic communication in violation of this subsection (2) A violation of subdivision (a)(1) shall be punished as provided in § 39-13-602 and shall be subject to suit as provided in § 39-13-603.

(5) *It is lawful* under §§ 39-13-601 – 39-13-603 and title 40, chapter 6, part 3 *for a person* not acting under color of law *to intercept a wire, oral, or electronic communication*, where the person is a party to the communication or *where one of the parties to the communication has given prior consent to the interception*, unless the communication is intercepted for the purpose of committing any criminal or tortious act in violation of the constitution or laws of the state of Tennessee.

The Tennessee Wiretapping and Electronic Surveillance Act, for example, makes it a Class D felony to intentionally intercept, access or procure another person to intercept or access unauthorized communications. Civil damages include:

The sum of the actual damages, including any damages to personal or business reputation or relationships, suffered by the individual and any profits made by the violator as a result of the violations; or 2) Statutory damages of one hundred dollars (\$100) per day for each day of violation or ten thousand dollars (\$10,000), whichever is greater; and 3) Punitive damages; and 4) Reasonable attorney’s fees and other litigation costs incurred.

TCA § 39-13-606—Electronic tracking of motor vehicles (as of 2012) reads, as follows:

(a) (1) Except as provided in subsection (b), it is an offense for a person to knowingly install, conceal or otherwise place an electronic tracking device in or on a motor vehicle without the consent of all owners of such vehicle for the purpose of monitoring or following an occupant or occupants of such vehicle. (2) As used in this section, “person” does not include the manufacturer of the motor vehicle.

(b) (1) It shall not be a violation if the installing, concealing or placing of an electronic tracking device in or on a motor vehicle is by, or at the direction of, a law enforcement officer in furtherance of a criminal investigation and is carried out in accordance with applicable state and federal law. (2) If the installing, concealing or placing of an electronic tracking device in or on a

motor vehicle is by, or at the direction of, a parent or legal guardian who owns or leases such vehicle, and if such device is used solely for the purpose of monitoring the minor child of such parent or legal guardian when such child is an occupant of such vehicle, then the installation, concealment or placement of such device in or on such vehicle without the consent of any or all occupants in such vehicle shall not be a violation. 3) It shall also not be a violation of this section if the installing, concealing or placing of an electronic tracking device in or on a motor vehicle is for the purpose of tracking the location of stolen goods being transported in such vehicle or for the purpose of tracking the location of such vehicle if it is stolen.

(c) The provisions of this section shall not apply to a tracking system installed by the manufacturer of a motor vehicle.

Case Law

Social media

McMillen v. Hummingbird Speedway, Inc., No. 113-2010, Pa. County Ct. Sept. 9, 2010 “When a user communicates over Facebook or MySpace, he or she understands and tacitly submits to the possibility that a third party recipient . . . will also be receiving his or her messages . . .” In a case addressing the confidentiality of social media, a Pennsylvania court ordered a personal injury plaintiff to allow opposing counsel access to his password-protected Facebook and MySpace accounts to investigate whether information on those sites contradicted his claims.

Recording

Lawrence v. Lawrence, Ct. Appeals November 2010

Leigh Ann Lawrence (“Mother”) secretly tape recorded her 2 1/2-year-old daughter’s telephone conversation with the child’s father, Chris Lawrence (“Father”), during the course of a divorce and custody dispute. After the divorce was concluded, Father filed a complaint against Mother seeking damages for, among other things, wiretapping in violation of Tenn. Code Ann. §39-13-601 (2006). Father filed a motion for partial summary judgment which the trial court denied upon finding that “[n]o set of facts would create liability under §39-13-601 et seq. for [Mother’s] interception of [Father’s] communication with his daughter.” The court then entered partial summary judgment in favor of Mother and certified the judgment as final. Father appeals. “Accordingly, we hold that, as a matter of law, Mother had the right to consent, as that term is used in Tenn. Code Ann. § 39-13-601, vicariously to intercepting, recording and disclosing the child’s conversation with Father.”

Robinson v. Fulliton, Court of Appeals May 2002

This is a wiretapping case. A husband and a wife were experiencing marital difficulties. During that time, the husband tape recorded a telephone conversation between his wife and her brother without the knowledge of either. When the brother found out, he filed a lawsuit against the husband, his brother-in-law, seeking damages under the civil damages provision of the Tennessee wiretapping statutes, Tenn. Code Ann. § 39-13-603. The trial court, sitting without a jury, held that the husband was liable to his brother-in-law, and awarded nominal compensatory damages, litigation expenses, and attorney’s fees. The husband and the brother-in-law both appeal that decision, arguing that the damage award was erroneous. We reverse the trial court’s award of damages, finding that the statute requires that, when a violation is established, the trial court must award either the actual damages or the statutory minimum penalty of \$10,000, whichever is greater.

Klumb v. Goan, 2-09-Cv-115 (E.D. Tenn.; July 19, 2012) Federal District Case
 Plaintiff Roy Klumb brought this action alleging defendant Crystal Goan, formerly is wife, violated the federal Wiretap Act, 18 U.S.C. 2510 et seq., and the Tennessee Wiretap Act, Tenn. Code Ann. 39-13-601et seq., by installing spyware on his computers without his consent to intercept his incoming email. A bench trial was held and, having heard all the evidence, the Court concludes that defendant Crystal Goan did violate the two wiretap statutes, that the plaintiff is entitled to the statutory damages of \$10,000, and that defendant's violation of the wiretap acts was part of a larger scheme to gain advantage of the plaintiff during their divorce thereby warranting punitive damages in the amount of \$10,000. The plaintiff is also entitled to reasonable attorney's fees and costs. An appropriate judgment shall be entered.

Waiving privilege

In re Columbia/HCA Healthcare Corporation Billing Practices Litigation, 293 F.3d 289 (2002), the District Court of Appeals held that a client cannot selectively waive the privilege. Columbia/HCA voluntarily waived the privilege by providing the Federal government with privileged communications in order to resolve charges of criminal and civil violations brought by the government. The Court held that the waiver of the privilege to the government waived the privilege in all other Columbia/HCA cases for which the same information was sought, e.g. lawsuits by insurance companies seeking reimbursement for improperly billed medical services. "The client cannot be permitted to pick and choose among his opponents, waiving the privilege for some and resurrecting the claim of confidentiality as to others, or to invoke the privilege as to communications whose confidentiality he has already compromised for his own benefit." *Permian*, 665 F.2d at 1221.

Rule 502 of the Federal Rules of Evidence provides that a party's intentional disclosure of a privileged communication or an attorney work product waives the privilege as to all other communications or work product regarding the same subject matter "if they ought in fairness to be considered together." Fed. R. Evid. 502(a). Courts will not allow a client to waive only those communications favorable to its cause. Rather, fairness requires that once a client voluntarily waives the privilege regarding a communication, all other communications relating to it must be disclosed, as well. Determining the scope of a subject matter waiver is a fact intensive inquiry: "There is no bright line test for determining what constitutes the subject matter of a waiver, rather, courts weigh the circumstances of the disclosure, the nature of the legal advice sought and the prejudice to the parties of permitting or prohibiting further disclosures." *Fort James Corp. v. Solo Cup Co.*, 412 F.3d 1340, 1349-50 (Fed. Cir. 2005).

Lenz v. Universal Music Corp., No. 5:07-03783, N.D. Cal. Nov. 17, 2011, a California court found that the plaintiff in a copyright infringement suit had **waived the attorney-client privilege by sending emails to third parties and creating blog posts** regarding conversations with counsel. The infringement dispute arose when plaintiff sued Universal Music Corporation, claiming that Universal knowingly misrepresented that a video plaintiff posted on YouTube infringed Universal's copyright in a song.

Professional Ethics

ACA: see section A.12.a-h

AMA Guidelines

New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.

Communication Guidelines

1. Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
2. Inform patient about privacy issues.
3. Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
4. Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mails communications with patients.
5. Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
6. Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
7. Request that patients put their name and patient identification number in the body of the message.
8. Configure automatic reply to acknowledge receipt of messages.
9. Send a new message to inform patient of completion of request.
10. Request that patients use auto reply feature to acknowledge reading clinicians message.
11. Develop archival and retrieval mechanisms.
12. Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
13. Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
14. Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
15. Explain to patients that their messages should be concise.
16. When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
17. Remind patients when they do not adhere to the guidelines.
18. For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Medicolegal and Administrative Guidelines

1. Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
2. Terms in communication guidelines (stated above).
3. Provide instructions for when and how to convert to phone calls and office visits.

4. Describe security mechanisms in place.
 5. Hold harmless the health care institution for information loss due to technical failures.
 6. Waive encryption requirement, if any, at patient's insistence.
 7. Describe security mechanisms in place including:
 8. Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
 9. Never forwarding patient-identifiable information to a third party without the patient's express permission.
 10. Never using patient's e-mail address in a marketing scheme.
 11. Not sharing professional e-mail accounts with family members.
 12. Not using unencrypted wireless communications with patient-identifiable information.
 13. Double-checking all "To" fields prior to sending messages.
 14. Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
 15. Commit policy decisions to writing and electronic form.
- (2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.
- (3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate. (BOT Rep. 2, A-00; Modified: CMS Rep. 4, A-01 and BOT Rep. 24, A-02)

AMA Ethics Policy

The following recommendations of the AMA Council on Ethical and Judicial Affairs were adopted as AMA Ethics Policy at the December 2002 Interim Meeting of the AMA House of Delegates.

Electronic mail (e-mail) can be a useful tool in the practice of medicine and can facilitate communication within a patient-physician relationship. When communicating with patients via e-mail, physicians should take the same precautions used when sending faxes to patients. These precautions are presented in the following considerations:

- E-mail correspondence should not be used to establish a patient-physician relationship. Rather, e-mail should supplement other, more personal, encounters.
- When using e-mail communication, physicians hold the same ethical responsibilities to their patients as they do during other encounters. Whenever communicating medical information, physicians must present the information in a manner that meets professional standards. To this end, specialty societies should provide specific guidance as the appropriateness of offering specialty care or advice through e-mail communication.
- Physicians should engage in e-mail communication with proper notification of e-mail's inherent limitations. Such notice should include information regarding potential breaches of privacy and confidentiality, difficulties in validating the identity of the parties, and delays in responses. Patients should have the opportunity to accept these limitations prior to the communication of privileged information. Disclaimers alone cannot absolve physicians of the ethical responsibility to protect patients' interests.

- Proper notification of e-mail's inherent limitations can be communicated during a prior patient encounter or in the initial e-mail communication with a patient. This is similar to checking with a patient about the privacy or security of a particular fax machine prior to faxing sensitive medical information. If a patient initiates e-mail communication, the physician's initial response should include information regarding the limitations of e-mail and ask for the patient's consent to continue the e-mail conversation. Medical advice or information specific to the patient's condition should not be transmitted prior to obtaining the patient's authorization.

Chapter Fifteen: Employer Considerations [TOC](#)

Respondeat Superior

Background checks required

29-26-206. Employer liability.

(a) An employer of a therapist may be liable under § 29-26-204 if sexual misconduct occurred as provided in § 29-26-204, and either of the following applies:

(1) The employer fails to take reasonable action when the employer knows or has reason to know that the therapist has engaged in sexual misconduct with any patient; or

(2) The employer fails to make inquiries of a former employer concerning past sexual misconduct of the therapist and the:

(A) Former employer's name and address has been disclosed to the employer;

(B) Therapist was employed by the former employer as a therapist within five (5) years of the date of employment as a therapist for the employer and during the period of prior employment the therapist engaged in sexual misconduct.

(b) An employer or former employer of a therapist may be liable under § 29-26-204 if:

(1) Sexual misconduct occurred as provided in § 29-26-204;

(2) The employer or former employer receives a written request from another employer or prospective employer concerning sexual misconduct by the therapist;

(3) The employer or prospective employer is considering the therapist for a therapist position; and

(4) The employer or former employer knows or has reason to know of the sexual misconduct and fails or refuses to disclose to the requesting employer the occurrence of sexual misconduct by the therapist.

(c) An employer or former employer who gives information concerning sexual misconduct by a therapist when presented with a request for such information by a prospective employer of the therapist is absolved from any legal liability due to the therapist's failure to find employment or damage to the therapist's reputation as a result of the information provided, unless the information is false and the reporting employer knew or should have known that the information was false.

(d) Nothing in this section is intended to affect in any way the application of employer liability if such liability rests upon negligence by the employer in supervising the therapist or where the scope of employment would encompass the sexual misconduct.

Chapter Sixteen: Documentation [TOC](#)

- a. Informed consent (policy statement re couples counseling, social media, online contact)
- b. Record keeping
 - Office policy statement regarding storage/destruction of records
 - HIPPA psychotherapy notes separate
 - Elements of medical records (TCA 63-2-101 (c) (2) and RR 1180-1-.06 (4)(c))
 - List of releases
 - Minimal disclosure
 - Destroying records
 - Couples/marital record keeping
- c. Test data and protecting intellectual property of test designers

Chapter Sixteen Documentation

From rules and regs

1180-1-.06 (4)(c) Content – All patient records, or summaries thereof, produced in the course of the practice of psychology for all patients shall include all information and documentation listed in T.C.A. § 63-2-101 (c) (2) and such additional information that is necessary to insure that a subsequent reviewing or treating psychologist, senior psychological examiner or psychological examiner can both ascertain the basis for the diagnosis, treatment plan and outcomes, and provide continuity of care for the patient.

1. Patient records include, but are not limited to:

- (i) modalities and frequencies of treatment furnished
- (ii) results of clinical tests
- (iii) counseling session start and stop times
- (iv) summaries of:
 - (I) diagnosis
 - (II) functional status
 - (III) treatment plan
 - (IV) symptoms
 - (V) prognosis
 - (VI) progress to date

2. Not included in patient records are:

- (i) test data – raw and scaled scores, client/patient responses to test questions or stimuli, and notes and recordings concerning client/patient statements and behavior during an examination.
- (ii) test materials – manuals, instruments, protocols, and test questions or stimuli.
- (iii) psychotherapy notes – notes recorded (in any medium) by a psychologist, senior psychological examiner or psychological examiner, who is designated as a health service provider as defined in Rule 1180-1-.01, that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's patient record.

Chapter 17 Other Statutory Provisions

Chapter Seventeen: Other Statutory Provisions [TOC](#)

- d. Mentally Ill and Mentally Retarded Persons TCA 33-1-101ff
- e.

Chapter 18 Selecting an Attorney

Chapter Eighteen: Selecting an Attorney [TOC](#)

Chapter 19 Selecting an Counselor

Chapter Nineteen: Selecting a Counselor [TOC](#)

Chapter Twenty: Competence [TOC](#)

Hungerford v Jones 1998

Recovered mem, client accused Fa of sexual abuse, after fa was tried and exonerated, he sued txpist; does therapist have a duty to parent? Court said yes, when dx made based upon a psychological phenomenon or technique not generally accepted

Custody cases

Appendices [TOC](#)**A. Therapist Sexual Misconduct Act****Appendix A: Therapist Sexual Misconduct Act****29-26-201. Short title.**

The title of this part is, and may be cited as, the "Therapist Sexual Misconduct Victims Compensation Act."

29-26-202. Intent.

It is the intention of the general assembly to provide victims of sexual misconduct by a therapist with a legal remedy, including significant compensatory damages and a more reasonable statute of limitations. It is intended to prevent sexual misconduct by a therapist by imposing significant liability upon any therapist who engages in this type of misconduct. This is necessary due to the inadequacy of the current system of malpractice where the statute of limitations fails to address the specific problems associated with sexual misconduct by a therapist. This part also clarifies the legal landscape and attempts to prevent most instances of sexual misconduct by making employers liable if they refuse to take simple and reasonable steps to avoid endangering their patients.

29-26-203. Definitions.

As used in this part, unless the context otherwise requires:

- (1) "Claimant" means any of the following:
 - (A) The victim;
 - (B) The parents of the victim where the victim is still a minor;
 - (C) The legal guardian of the victim if the victim is not competent to assert such victim's legal rights; or
 - (D) The spouse of the victim where the sexual misconduct occurred while the spouse and the victim were married;
- (2) "Deception" means the representation that sexual actions are part of or consistent with the patient's treatment by the therapist;
- (3) "Emotionally dependent" means that the patient's emotional condition is such that the therapist knows or has reason to know that the patient is not competent to give consent to sexual advances due to the relationship which the therapist and patient have developed in the course of treatment by the therapist;
- (4) "Employer" means any person or entity that employs any therapist for the purpose of providing therapy;
- (5) "Patient" means a person who has obtained therapy from a therapist. For purposes of this part, "patient" encompasses both current and former patients of a therapist;
- (6) "Sexual behavior" means sexual activity of the victim other than the sexual act or acts at

issue in the case;

(7) "Sexual misconduct" means any of the following, regardless of the consent of the patient:

(A)

(i) Any intrusion into an opening of the patient's body by any part of the therapist's body, or an object used by the therapist to effect an intrusion for the purpose of sexual arousal or gratification;

(ii) Any intrusion into an opening of the therapist's body by any part of the patient's body, or an object used by the patient to effect an intrusion for the purpose of sexual arousal or gratification where the therapist has consented to the conduct verbally or by acquiescence;

(iii) Touching of the patient's body by the therapist for the purpose of sexual arousal or gratification; or

(iv) Touching of the therapist's body by the patient for the purpose of sexual arousal or gratification where the therapist has consented to the conduct verbally or by acquiescence;

(B) Sexual misconduct includes attempts by the therapist to engage in the conduct described in (A)(i) through (iv), inclusive; and

(C) Conduct which is part of standard medical treatment shall not constitute sexual misconduct if the therapist is legally permitted and qualified to perform such medical treatment;

(8) "Therapist" means any person who performs therapy regardless of whether the person is licensed by the state; and

(9) "Therapy" means action by a person who represents that the person is and does practice the professional treatment, assessment, or counseling of a mental or emotional disorder, illness, condition or symptom. "Therapy" includes, but is not limited to, marital counseling, substance abuse treatment, and family counseling. Therapy begins the first time the patient seeks the therapist's assistance as a therapist. "Therapy" includes services provided without charge if they otherwise meet the definition.

29-26-204. Elements.

A cause of action for sexual misconduct exists for a claimant where the sexual misconduct occurred:

(1) During the time when the patient was receiving therapy from the therapist; or

(2) After the patient has stopped receiving therapy from the therapist if the patient is still emotionally dependent upon the therapist or the sexual misconduct was the result of deception; or

(3) Both (1) and (2).

29-26-205. Exceptions.

A therapist does not violate § 29-26-204 if the patient is:

- (1) The spouse of the therapist and was married to the therapist prior to the establishment of the therapist-patient relationship; or
- (2) The sexual relationship began prior to the establishment of the therapist-patient relationship.

29-26-206. Employer liability.

(a) An employer of a therapist may be liable under § 29-26-204 if sexual misconduct occurred as provided in § 29-26-204, and either of the following applies:

- (1) The employer fails to take reasonable action when the employer knows or has reason to know that the therapist has engaged in sexual misconduct with any patient; or
- (2) The employer fails to make inquiries of a former employer concerning past sexual misconduct of the therapist and the:

- (A) Former employer's name and address has been disclosed to the employer;

- (B) Therapist was employed by the former employer as a therapist within five (5) years of the date of employment as a therapist for the employer and during the period of prior employment the therapist engaged in sexual misconduct.

(b) An employer or former employer of a therapist may be liable under § 29-26-204 if:

- (1) Sexual misconduct occurred as provided in § 29-26-204;
- (2) The employer or former employer receives a written request from another employer or prospective employer concerning sexual misconduct by the therapist;
- (3) The employer or prospective employer is considering the therapist for a therapist position; and
- (4) The employer or former employer knows or has reason to know of the sexual misconduct and fails or refuses to disclose to the requesting employer the occurrence of sexual misconduct by the therapist.

(c) An employer or former employer who gives information concerning sexual misconduct by a therapist when presented with a request for such information by a prospective employer of the therapist is absolved from any legal liability due to the therapist's failure to find employment or damage to the therapist's reputation as a result of the information provided, unless the information is false and the reporting employer knew or should have known that the information was false.

(d) Nothing in this section is intended to affect in any way the application of employer liability if such liability rests upon negligence by the employer in supervising the therapist or where the scope of employment would encompass the sexual misconduct.

29-26-207. Evidence of sexual conduct.

In an action for sexual misconduct, the victim's sexual history is not admissible as evidence except to prove that the sexual behavior occurred with the therapist prior to the provision of

therapy to the patient by the therapist. During discovery, only evidence of the victim's sexual history which is relevant to a determination of the timing of the sexual relationship between the parties is discoverable.

29-26-208. Statute of limitations.

(a) The statute of limitations in sexual misconduct actions is two (2) years from the date the alleged injury occurred or is discovered, whichever is later. For purposes of this section, discovery of the alleged injury occurs after therapy ends, the victim is no longer emotionally dependent upon the therapist, and the patient knew or should have known that sexual misconduct by a therapist is unprofessional and harmful to the patient.

(b) Except as provided in subsection (c), no such action shall be brought more than three (3) years after the date of the last communication of any kind between the therapist and the patient.

(c) Where the sexual misconduct involves a minor, the statute of limitations shall be one (1) year after the minor's eighteenth birthday, except that where subsection (a) or (b) would provide for a longer time in which to bring a claim, the provision that provides the longest time in which to bring a claim applies.

29-26-209. Damages.

The claimant may recover for damages caused by the sexual misconduct. Such damages include, but are not limited to:

(1) Reasonable economic losses caused by the emotional, mental or physical effects of the sexual misconduct, including, but not limited to:

(A) The cost of counseling, hospitalization and any other expenses connected with treating the harm caused by the sexual misconduct;

(B) Any payments made to the therapist for treatment;

(C) The cost of counseling, hospitalization and any other expenses connected with treating the mental disorder, illness, condition, or symptom for which the patient had sought therapy from the therapist; and

(D) Loss of income caused by the sexual misconduct;

(2) Pain and suffering caused by the sexual misconduct, including, but not limited to, psychological and emotional anguish;

(3) If the victim is dead, the claimant may seek damages for wrongful death where the victim's death is the result of the physical or emotional harm inflicted upon the victim by the sexual misconduct of the therapist; and

(4) Punitive damages as otherwise provided by law.

29-26-210. Construction.

The provisions of this part are declared to be remedial in nature and the provisions of this part shall be liberally construed to effectuate its purposes.