

Title: Staying Within Your Scope of Practice: Understanding Professional Boundaries from a Risk Management Perspective
Date & Time: September 13, 2024 at 1pm ET

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As such, they both have a financial and intellectual interest in the webinar content. The purpose of this presentation is to provide a balanced view of defining professional boundaries and staying within your scope of practice. APA does not endorse any products or services. The content was created by the risk management experts at Allied World and does not reflect the views of APA or its editorial staff. Email advertising at apa.org to learn more. The information in this topical webinar will be from a risk management perspective and not from a clinical perspective.

This presentation does not constitute and should not be relied upon as legal or clinical advice, and should not be used as a substitute for obtaining personal legal or clinical advice and consultation prior to making decisions. Next, this program does not offer CE. However, we will email everyone watching live today a certificate of attendance. Certificates will only be issued to those who watch for a minimum of 45 minutes. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides.

During our time together, you will be on mute. You will communicate with us using the Q&A box located on your webinar screen. Have a question for our presenters? Type them in using the Q&A box located on your webinar screen. A link to the presentation slides will be posted in the chat box. If you miss it, don't worry. We will email the slides with the recording. Now let me introduce our presenters. First, Allison Funicelli. She is an Assistant Vice President of the Risk Management Group AWAC Services Company, a member company of Allied World. Cara H. Staus, also an Assistant Vice President of the Risk Management Group AWAC Services Company, a member company of Allied World. Welcome, Allison and Cara.

Allison Funicelli: Thank you, everybody, for having us today. I'm going to begin by talking about what are the objectives of this presentation? As just mentioned, Cara and I are certified professional healthcare risk managers. Our presentation is geared towards giving information based on that risk management perspective. It is not our goal or intent to tell you how to practice psychology. We just give you things of food for thought, so, especially with this topic on boundaries, when you're in an area where you feel like you're in a gray area and you're not sure what to do, just some things to think about that might help guide you as to the best direction to go.

Our objectives are understanding what constitutes a boundary crossing or a boundary violation. We're going to talk about identifying the ethical, legal, and risk

management issues related to boundary crossings and violations. We'll examine liability issues and identify risk reduction strategies by exploring best practices to minimize professional liability claims. We'll be discussing strategies to help psychologists avoid ethical and legal boundary crossings and remain within their scope of practice. The general definition of a boundary as it relates to psychologists.

In psychotherapy, an important part of psychotherapy and an important limit that is usually set by the therapist as part of the ground rules and treatment. We're going to get into more detail about what that means as we go through the presentation. Boundaries may involve areas of discussion or physical limits which are guided by the ethical codes or standards. We want to have respect for boundaries by both the therapist and the client because it's an important part of that therapeutic relationship. Boundary issues. Ethical issues relating to the proper limits of a professional relationship between a provider of services and their patient or client such that the trust and vulnerability of the latter are not abused. That's how we want to stay within our ethical guidelines.

Boundary issues may result in boundary crossings, which are generally defined as a deviation from classical therapeutic activity that is harmless, non-exploitive, and possibly supportive of the therapy itself versus a boundary violation. That's what therapists should be trying to avoid. Boundary violations can be deemed harmful or potentially harmful to the patient or others and the therapy provided. Those are the things that we want to be careful about, not crossing into that area because violating a boundary may result in a licensing board situation or a malpractice claim.

Cara Staus: Thanks, Allison. As we begin this presentation today, we'll be looking at the following areas which may, as Allison talked about, present challenges, and oftentimes you may experience the potential for a boundary issue. We're going to be discussing dual relationships, treating multiple family members, custody, divorced parent situations, social media, and the confidentiality and privacy associated with that, email and texting, and then lastly, intrusive patient behaviors. Next slide, please. Let's start off by looking at a dual relationship.

This list is not all-inclusive, but rather it takes into consideration the most common scenarios that you see in the practice of psychology. We want to be sure we address that dual relationships are not forbidden, and we'll discuss things to consider. Oftentimes we say, "Have you considered this as it relates to dual relationships and the best ways to mitigate the potential risk associated with that potential dual relationship?" A lot of times dual relationships exist within a small community, rural communities, and there may be opportunities or times where a therapist's paths cross in the community or in multiple settings.

We'll talk about this. It is without a doubt, one of the most important factors with dual relationships is really determining the appropriateness of the relationship, and what's the purpose of that relationship. Again, family, friends, social acquaintances, business personal relationship, and students are often where we would consider the possibility of a dual relationship which can exist. It's always important to really go through a thoughtful ethical decision-making process to determine whether or not this is a potential therapeutic relationship you should enter in.

Consider analyzing any and all implications and really ask yourself, "Am I meeting the patient's need?" Remember you're not your patient's friend or your student's friend. You would be acting in the role as therapist. Consider whose needs would the action for upward consideration be met. Does this action include a therapeutic value to the patient? Is it consistent with the ethical principles and code of conduct? Is there any potentially damaging action to your profession or to the patient? We want you to consider, can you be objective? For example, if you have a family member approach you, this is probably a really hard one, but they trust you.

They're a loved member of your family, and so they trust that you would give them the appropriate guidance. Again, would you be able to maintain your objectivity if you entered into that therapeutic relationship but also were family members? What would you do at family gatherings? How would you handle that situation? Where does that therapeutic family relationship start and end? The same thing goes for friends. Is there the ability for you to be put into a difficult situation where if you were treating a friend and then saw them in a social setting, how exactly would you handle that if they approach you and say, "Oh, coming up next Tuesday, I'm going to be seeing you."?

Again, we want you to consider it. It's not an absolute no. Think about a high school classmate. They might reach out to you because they know that you're an expert in your profession. What does that look like? Again, maintaining that objectivity. Do you feel comfortable? They want to feel comfortable with you. An example would be if one of your patients asks you to be in a running club with them. Is that appropriate? Consider those relationships. What about if you're teaching, you're a professor teaching a student and you have young children and that student may be looking to make some extra money, should you ask them to be your babysitter? Probably not a good deal because those lines could be blurred. That student may expect good grades. Again, you want to make sure that you are thinking through any of these situations in the event you are asked to become and enter into that therapeutic relationship. If you do consider dual relationships, always document the rationale behind your decision-making process so it's clearly documented in the patient's record. Next slide.

Allison: Sorry about that. I'm going to talk a little bit about treating multiple family members. Completely acceptable most of the time to treat more than one family member, especially if you see children, you might be treating more than one child. Maybe they're going through some stress because their parents are getting divorced. We have some scenarios here to think about. We have Dr. Smith was seeing 12-year-old Sally for treatment of anxiety and oppositional defiant disorder. Then a year later, the patient's mom began expressing marital issues and requested to be seen by Dr. Smith.

Now she wants treatment. Dr. Smith agrees to see her. During the course of mom's treatment, because he's treating both mom and the child, and he specializes in both treating children and adults, he realizes upon reflection, should he have taken on Mom? Because now Mom is discussing how the child's oppositional defiant disorder is impacting her marriage. Again, it doesn't mean that in this case, Dr. Smith couldn't treat Mom and child. We just say, before you enter into seeing another family member, just take a pause for a second and say, "Let me try to think of what are the potential conflicts that may occur down the road that may make it hard for me to treat

both of them, be impartial to both of them or in a situation where I have to maintain confidentiality between both of them."

Just think about that ahead of time. Then if you are going to treat multiple family members, just explain, especially if you have multiple children in the same family, explain to the adults that there could be a scenario in the future where you would have to refer one or all the children to a new therapist. We have another scenario here where Dr. Jones is treating John, who is a married adult male, for anxiety and depression. While treating John, John asks Dr. Jones, can she also treat his wife for anxiety and marital issues. Again, what are some of the issues that should be considered?

If they're having marital issues, maybe it should be a different provider because now there's going to be marital stuff that comes up. It's not just anxiety and depression, that maybe they need to have a separate counselor. Certainly, when there's marital issues, sometimes one person will have their therapist, the other one has another therapist, and then they have a marital therapist. Again, just think about, before you enter into these relationships, am I able to keep that wall up between the two? Because if John is talking to you about things, and his wife, Mary, is talking to you about things and making sure that you're not getting into a situation where you feel like you're in a conflict because you're trying to talk to each of them about stuff without necessarily breaching the confidentiality of the other one.

What do we want to think about? We want to think about, again, informed consent. Everybody understands upfront this is how it's going to work. Now, you might be in an area where it might be a rural area. It might be you have a particular area of expertise and you're the go-to person for that expertise. You might even be in a situation where you're treating multiple family members that they don't even know that the other family member is seeing you. Again, you have to be careful. Do you feel that you can keep that separate without blurring the lines between the patients and maintaining that confidentiality?

Again, where possible, setting clear expectations. Then you'll hear Cara and I often say throughout this presentation, talking about documentation. Documenting the rationale of what you're doing, why you're doing it, what was discussed, et cetera, because documentation is not only legally required, but it's also a key defense to you if you do have a licensing board complaint or a malpractice case. That documentation basically is the document that tells a jury, this is the care I was providing, and substantiating what you were doing. It's your best defense.

Custody. Sometimes we're treating children that their parents are divorced or in the midst of a high-conflict divorce situation. The very first thing you should do, preferably before you even see the child or children the first time, is to get a copy of the custody agreement. There was a court battle that took place and a judge took the time to render a custody agreement and put it in writing. You should follow what that says. We understand that some states say that even when parents have joint custody, you only need the permission from one parent to treat, but we don't want to alienate the other parent.

If a court says that the parents have dual decision-making and have the right to both consent to treatment for their child or seek therapy for their children, that we respect

both those parents because if one parent decides not to consent, we always say, stop, take a pause, and let those parents figure out what to do next. We don't want to have a parent calling up and yelling and screaming at the staff or screaming at you about why did you violate their rights by not getting their consent. If a parent represents that they're married, you can just assume that both parents are consenting unless it comes up.

If a parent represents that there is no custody agreement, maybe the other parent was never in the child's picture, took off, whatever, then you just document that. We're not going to make the parent go get a document that doesn't exist. We're going to document what that parent has represented and say, "Dad brought child in, says Mom is not in the picture, there's no custody agreement." We document that. If Mom, in that scenario, appears and then has some issues, then you would reach out to Mom and say, "Can you give me a copy of the custody agreement if it exists?"

We always want to stay neutral between the two parties. If your role is not as the court evaluator and determining custody, and your role is to treat the children for anxiety, depression, whatever the reason is they're there, then you have no dog in the fight of that custody. We want to be careful when we have one parent say, "I know my child talks badly about the other parent," and they try to get you on their side to try to change the custody agreement or get it to go their way. That's not for you to do. You respectfully say, "My client is the child, and so I can't be involved with that."

If they say, "Listen, my attorney wants to talk to you, my attorney wants your testimony," then say, "Listen, I would prefer to have a subpoena or a court order before I go any further as far as getting involved with that custody," because if you do that, most malpractice carriers will offer a service to you that once you get served with a subpoena or a court order, they can usually give you some legal advice as to how to handle that. Basically, your testimony, if you were forced to testify, is basically consistent with the medical records. Again, trying to stay neutral and not say which parent is better than the other.

Same thing if you're asked to write a support letter in that same vein or sign an affidavit. Anytime you're asked to do something that puts you in this non-neutral position or something that could get you involved in something that's litigated, you want to consult either your personal practice attorney or general counsel of the facility you work for if you're insured through a facility or you malpractice carrier. Just understand your role. What is your role and what's not your role? One thing I forgot to mention about the custody agreement is, another good thing to look at is even when parents have joint custody, sometimes the judge will order a tiebreaker, especially when the parents are not agreeing on what care their child is going to get.

It may say both parents have to consent, but in the event one is dissenting, it'll say who's the tiebreaker. Sometimes the tiebreaker is one of the parents. It could be the pediatrician or the PCP, or they defer to actually the therapist to decide does this child need therapy. Follow what that custody agreement says. If you're not sure and you don't understand it, ask your risk manager. If you have access to a risk manager through your malpractice carrier, a facility or a practice attorney, they should be able to guide you. Cara?

Cara: Thanks, Allison. Social media, technology has really transformed how we operate in our personal and professional lives. It really is important to take a look at this impact and be aware of the duty to maintain privacy and confidentiality with our patients. Some of the areas that we're looking at are the professional use, the personal use, patient friend requests, and online reviews to name a few. Social media is designed as that interaction. It's a communication tool so that individuals can interact, whether it's two individuals or in, let's say, group forums.

We talk about social networks. Some of the common social networks we have are Facebook, X, which is formerly known as Twitter, Instagram, and LinkedIn. LinkedIn can be both personal and professional. There's discussion forums that exist out there, whether it's Quora or Reddit. Then consumer reviews, Yelp and Google. Oftentimes, we will get calls and help our policyholders on, what do I do with an online review? Somebody posted a negative review. Then there's blogging. From the professional standpoint, you may engage in a professional blog to educate individuals, whether they're your current patients or just the general public, in general, about things that are happening in the area of psychology and mental health.

Really, it's focusing on the socialization. That was really what social media, as it's exploded, was designed as the ability to socially engage for multiple purposes. Next slide, please. We talked about social media. That personal use. Is maintaining that personal social media strictly for personal use, and engaging with your friends and family on your personal social media pages? Again, hobbies, school activities, and then professional, keeping the two, hopefully, as distant as possible. You might have a personal LinkedIn account where you're utilizing, or you might also create a professional link to your practice organization or your business.

A lot of individuals are doing podcasts or even social media. TikTok is one of the trends out there where individuals, healthcare professionals, are engaging and dipping their toes into the social media aspect. Again, is that professional or is that personal? I think we need to consider what we're doing, what advice we may or may not be giving, and is it within your ethical professional code. APA has a social media guideline, which is a great reference to make sure that if you are engaging and using social media that you have looked at this. What if you're mixing the personal and professional?

Obviously, sometimes you might have the opportunity to have a professional page, and there might be comments from personal friends on that professional page, or vice versa. On your professional page, there might be a patient that comments and talks about things that could lend itself to a potential privacy or confidentiality. We're going to get into that on the next few slides. Then obviously, what about that individual who wants to friend you after that therapeutic relationship has ended? Is that a consideration? Should you look at that?

What are the potential issues that may come out of that in the event you do friend on social media? Next slide, please. I mentioned privacy and confidentiality with social media. It is essential to consider HIPAA. The Health Insurance Affordability and Accountability Act is essential. There are privacy standards that our federal government has established to maintain the confidentiality of individuals. A lot of

times there's a question, what if someone does post an online review? They're the individual, the patient is initiating that online review.

Why can't I respond? Why can't I acknowledge that review? I want to set the record straight of what did and didn't happen. Again, it is not recommended because you would then be verifying that that relationship existed. It's best to stay away from acknowledging personal facts associated with any online review. The best thing if you want to acknowledge is to say that you take all complaints seriously, and, "We maintain our patient's privacy and confidentiality. Please contact the office, practice manager, or whoever to discuss this matter further."

That way you're acknowledging it, but you're not disclosing or violating any of the standards under HIPAA. You follow the APA code of ethics standards on confidentiality, along with advertising and then other public statements. I talked about consider not responding. You don't have to respond to reviews that are posted in a public forum. A lot of times that negative review, it doesn't feel so great if you're on the receiving end of that negative review, but think about all the positive reviews, and hopefully, those positive reviews will cancel out that one negative review.

We recommend having that neutral standard, I say canned response. You're acknowledging it, you're aware that that review exists, but you're redirecting the individual poster to contact you directly to resolve the matter and have a conversation. Especially if they're a current patient, you want to make sure that you're addressing that and maybe talk a little further about their concerns. It's important to note with privacy violations that there could be significant fines or penalties. The OCR, which is the Office of Civil Rights, which falls under the Department of Health and Human Services is the regulator behind complaints.

Individuals do have the right to file this complaint, and the OCR would then open up an investigation. Believe me, there are a lot of these violations that do happen. You can look at the Department of Health and Human Services website, they post press releases when there are violations of any social media privacy. Next slide, please. Looking at, how do we mitigate the risk associated with it, or boundaries with email and texting? It's not really just limited to email and texting. Our guidance is to set expectations, create a practice policy if you don't have one.

Have a policy that discusses the appropriate uses of whether it's social media, if you are using social media from a professional standpoint, that you want your patients to understand that it's limited to professional information. Whether it's education or resources or general tips, you're not going to be discussing or acknowledging anything personal on a social media site. Regarding email and texting, we, as I mentioned, are in an age of technology. Email and texting has made a lot of communication seamless and easy, but what it also has done is created an expectation for an immediate response.

We get a text, our phone beeps, what do we do? We look at it. I have to respond. Consider how that would impact your practice if you responded to every individual that sent you a text immediately. Establish the expectations, create that policy that says, this is what the appropriate use of email and texting is. You're limiting to the scheduling and canceling of appointments. You're not having protective health

information exchanged in that email and text. Also include, when are you going to respond? Are you responding during normal business hours?

What about evenings and weekends? You want it to be clear in your practice policy. We recommend having this really at the onset of that therapeutic relationship so that when you meet with this person and you decide that you're going to enter into that therapeutic relationship, you're going over these expectations. You don't want to be on call or on demand and have an individual take advantage of the immediate response that you may be providing from an email or a texting situation. Make sure that it's clear. The next is avoiding detailed discussions.

As I mentioned, you don't want protected health information or any therapy information to be exchanged in these forums because they're not HIPAA-protected. You may have a HIPAA-protected platform or email system, but you don't know where it's going when it enters the cloud and lands in the laps of your patient. Do they have a significant other who may have access to their phone? Again, that's why it's best to limit the use of social media and email, and texting. If you do have an electronic health system, record system, that has the ability to have an email, text feature in that secure portal, that's going to be recommended.

That's going to be safest. What it also does is if there is any exchange of protected health information or any type of information related to your therapy, that then is captured because remember, if you start to talk about therapy-related information in texting or email, that has to be transferred into the medical record. That is why we recommend it's best to avoid that when practicing psychology. Avoiding personal and social texts. It's all great when we have formed strong relationship with the individuals that we are providing therapy to, but you don't want that personal text to be misconstrued, and therefore, blur the lines for the person on the receiving end. It is best to limit or not engage in any type of social or personal texting with your patients. You don't want there to be confusion and then end up going down the slippery slope of that blurred line from a professional boundary standpoint. Allison, next slide.

Allison: Thank you, Cara. This is a topic we, unfortunately, have to talk about. Sadly, it's happening a little more frequently. We're getting more of these types of calls on our risk management helpline, which is what happens when you have a patient that's exhibiting intrusive behaviors towards you. We all know about the transference and that type of stuff, but nowadays we have more and more patients that are unhappy. They may become harassing, bullying, et cetera. Some medical providers think, "It just comes with the territory, especially if I'm providing mental health services."

The reality is, no. You have the right to safety and security, and you have the right to not be harassed or bullied, or your staff. You should be setting, certainly, the boundaries up front and discussing the patient's behavior. If they're acting in a way that is not appropriate, then talk to them about it. Say, "Listen, you're crossing a boundary. I can't have you yelling at staff. I can't have you harassing. I can't get 20 emails and texts a day," that kind of stuff. Try to redirect them to what your office policy is and what's appropriate behavior. Unfortunately, if that doesn't work, then you might have to go to the next step.

The next step might be, "Unfortunately, I'm going to have to terminate you from my practice. I'm going to have to discharge you," because you have the right to not be harassed, or your staff. Then you would go through the typical termination process of discharging them from the practice, which is giving them referrals. If appropriate, giving them 30 days that you're available for emergency care. If they are threatening or you have a safety concern, you have the right to immediately terminate. Then tell them you'll transfer a copy of their record to their new provider.

It's not your responsibility, by the way, when you discharge someone from the practice, to automatically find the new provider for them. Patients are allowed to go, let them go find their own provider. The other thing, too, is I know some providers, their policy is, I give them the names of three specific other people they could go see. Our general philosophy is, give them places to go to find a new provider, for several reasons. One, a lot of practices are full. If you give them the names of three specific people, and then they come back and they're ping-ponging back and forth, "That one can't take me. That one is not the right specialty. This one's practice is closed." We want to avoid that.

Giving them places to get lists of names, like their health insurer, if they want an in-network provider, Psychology Today, the County Mental Health Department, whatever it is you want to use. That's really the better way to go. The second thing, too, is if they're a problem for you, they're probably going to be a problem for somebody else. We want to be kind to our colleagues and try to avoid directly referring our problems to somebody else. They may find a colleague of yours through one of these ways, but again, you didn't directly send them that way.

You want to document all the details of the event that's going on. Certainly, if you are experiencing physical stalking or cyber-stalking by a patient, or continued harassment, like I said, bullying, they're calling constantly, they're threatening, you have the right to contact authorities. I know some folks are concerned about HIPAA, but if you look up the HHS regulations, there is a provision that talks about law enforcement and HIPAA. You could actually just Google law enforcement and HIPAA, and you'll find it. It's like a two-page document, and it talks about what information you can give to them.

We want to try to avoid giving copies of the medical records to the law enforcement, but we can give them the patient's name and their contact information, and what the issue is, so that they can hopefully go knock on their door and tell them to stop the behavior. Hopefully, it makes them go away. Certainly, if the behavior continues, you have the right to also get a restraining order, and then you would provide whatever documents the court needs to substantiate that you need that restraining order. Hopefully, it doesn't get to the point where you would need personal counsel or something, but again, you have the right to these different avenues to protect yourself and your staff, and your family.

We're going to transition a little bit to another part of boundaries where we're going to talk about scope of practice. The general definition of scope of practice, it refers to the range of the knowledge, skills, and experience of that provider that they possess, and the tasks and activities that they're going to engage in as part of their professional duties. Then the primary purpose of the professional practice guidelines is to educate, to facilitate competence, and to assist the practitioner in the provision

of high-quality psychological services by providing well-supported practical guidance and education in that particular area.

That's a lot of words I just said. What does that mean? We get lots of questions are, how do I know I'm practicing within my scope of practice? Is a person coming to you for care that you feel that you have the proper knowledge and skills to treat them for and provide that care for them? If they are coming because they have an eating disorder, or they're coming because they have gender identity issues, just think, do I feel I'm the right provider for them? If so, you move forward. If not, then you may want to refer them out to someone who specializes in that.

Just keep in mind, is this within my particular scope of practice? As well as if somebody, say, you're treating, and they're stable, and then all of a sudden they have a crisis situation, and they wind up in the hospital. Before they're discharged, are you the right person? Is it within your scope of practice to treat them when they come back? Do they need a different level of care, a higher level of outpatient care, a certain specialty? Just keep that in mind. Cara.

Cara: Thanks, Allison. Boundaries of competence. You provide many different services, teaching, conducting research in the following areas. Education, training, supervision, consultation, studying, and professional experience. It's important that we're looking at these boundaries of competence. They're guidelines, so they're meant to really give you a pathway. They're not codes. They're not laws or regulations. They're simply talking about the areas of which you can practice psychology. When we talk about competence, you might be asking a lot of the questions that came in as part of the pre-registration for this webinar.

There were specific questions about certain areas of practice. Always, from a risk mitigation standpoint, we'll talk about, do you have the necessary training and experience, and expertise, as a common theme when we talk about the next couple of slides. Next slide, Allison. Here are some of the areas we are going to touch upon. We're going to look at coaching versus therapy. That has been, I say, one of the hot topics that we will talk to policyholders for, especially following the COVID-19 pandemic and the releasing of the telehealth interstate licensure matters. Coaching versus therapy. We'll look at forensic expert versus that therapy treater. We're going to take a look and discuss supervision and writing letters, and then treating or providing therapy outside an area of competence or expertise. Allison is going to talk about coaching versus therapy.

Allison: To go a little quickly, because I don't want to run out of time for our presentation, basically, this is a hot topic now. Coaching versus therapy, and what's the difference, and what if I want to do both? The big difference is you are required to be licensed to go through that certain training we were just talking about in order to be a psychologist. Coaching is unregulated, basically, right now. There are certifications you can get in coaching, but it's a different thing. Coaching is not therapy. If you want to do both, we want you to make sure it's very clear. You have coaching clients, you have therapy patients, and they shouldn't be the same person.

We talked about dual relationships at the beginning of the presentation. This is one where, from a risk perspective, I would advise it's not a good idea. If you want to have a coaching client and you think that they would benefit from therapy, refer them

to some therapist. If you have a therapy patient and you think they have an interest in coaching, refer them to someone that's doing the coaching, even if they're a former patient or a former coaching client. It gets muddy. We've had situations that have come up, like I have a coaching client, they wind up in a mental health crisis. They're at the ED, the emergency physician says, "Who's your therapist so I can discharge you? I want to talk to them."

They give the coach's name because they know they're also a psychologist. Then the response back to the ED is, "They're not my patient. I don't do therapy with them." Make it very clear in your paperwork you don't keep a medical record for coaching clients. You do for therapy. You want to keep them as two separate things and try not to have the same person in both of those patient and client roles. The other thing, too, is we don't want to use coaching as a way to get around licensing. A lot of states now are participating in the PSYPACT program.

If you are in a PSYPACT state and you go through the credentialing, and you're able to practice under PSYPACT, you have an ability to practice legally in a lot of states with your psychology license. If we have a patient that moves, we're doing therapy, and we have a patient, say, I'm in New York and I'm not in a PSYPACT state, so if they want to move to Utah, and I'm saying, "I can't keep seeing you because I'm not licensed there because the licensing follows where the patient is physically located at the time of the visit, what if I call it coaching?"

We can't do that. That gets us into trouble because if the Utah licensing board finds out or the New York one, you may be slapped with a licensing situation that you don't want to be in. We can't call something different when it's not that thing. Just make sure you keep those two things separate. Expert versus treater. They are two different roles. If you're the treating provider and someone needs your testimony for some reason, tell that patient's attorney, "If you put me under a subpoena or a court order, I will do what I need to do legally."

Then you get legal advice through your carrier or whoever. Experts, they are not the treater. Experts are usually somebody that's an independent person, reviewing records from all different providers and rendering an opinion, or so the attorney hopes, in support of their client. That's a different role. They tend to charge differently. Experts, when they're acting in that role, are prepared that they may have a pretty brutal, at times, cross-examination by the attorney that's on the opposing side of that litigation or claim. They have to be prepared for that.

If you're a forensic expert, you're doing court evaluations and stuff, criminal evaluations, that's a part of your practice. If you're a treater and someone has a disability claim and they want you to come in and also be an expert and testify as to why they qualify for disability or a workers' comp situation or whatever, if that's not your area of expertise, that's not what you were signed up for, you're providing therapy, then just say respectfully, "I can't be an expert." You should never feel you're forced into doing something. If an attorney wants to talk to you about something, take a pause.

Say, "You know what? I'll get back to you." Talk to an attorney if you have a practice attorney. Talk to a risk management consultant if you have one available to you because we can all give you guidance before you respond, and take some of that

pressure off you so that you only stay within your lane, or stay with the hat that you're supposed to be wearing. Oop, it looks like Cara might be frozen. I'm just going to keep going. Supervision, we're going to talk about supervision next. When you're supervising someone, understand the state and federal laws, especially if you're supervising someone that is not a psychologist.

Maybe you're supervising a social worker, or an MFT, or an MHC, or whatever. They have requirements through their boards as well. You want to make sure, from a supervisory standpoint, you understand what your role is, and they also have the independent obligation of understanding what they need to do as it relates to the supervision that they require. You want to have, when you're asked to do supervision, especially if you're supervising somebody outside your own practice, a written agreement, spell out what your role is, what their role is, if you have a fee agreement, whatever that is.

Make sure it's in writing. Make sure you feel you have the competent skill and knowledge to supervise that type of person. Then, again, we want to avoid multiple relationships as well. Same thing. Am I their supervisor or am I something else, Just make it very clear. Cara I think actually recently fielded a question on our helpline where somebody thought they knew what they had to do for the number of supervised hours they had, and unfortunately, due to some misunderstanding of what the rules were because they changed, unfortunately, may be in a situation and they're in the midst of appealing it, that their supervisory hours might not count now. We want to avoid those types of situations. It looks like Cara is back.

Cara: I'm back. I lost connection there.

Allison: That's okay.

Cara: Sorry about that. Writing letters. This is something that did come up in the Q&A, and we talked about it briefly when Allison was touching upon custody. The considerations with writing letters, consider what the purpose of the letter is. Is it within your scope? Do you have consent to write the letter and release information and be objective? For example, a patient comes to you and is seeking an emotional support animal so that they can bring that animal with them to college. Sure, you probably have documentation in your therapy notes that indicates that this animal provides comfort and reduces the stress of the patient that you've been treating, but can you speak to the animal itself?

Is the animal vaccinated? Is the animal aggressive? Probably not as a therapy animal. Again, consider what you're writing in that letter, and is it appropriate for you to comment specifically. A lot of times there may be forms attached with these letter requests that are asking very pointed questions, whether it's for an emotional support animal, or let's say it's for a request for a disability benefit. There might be portions of that form or letter that you certainly can answer and be objective based on the treatment notes that you have in your medical record.

There may be portions of that form or letter, if it is for disability, that is better suited to be completed by a primary care physician from a medical standpoint. Does this situation or request for a letter require an independent psychological evaluation? Would that independent evaluator better serve the need for a letter? The other thing

is, again, we often have situations that come up out of our helpline. I had a call about a year ago that was regarding someone that the individual had had therapy with. This person took a therapy hiatus of about nine months to a year.

Now they're calling because they need a letter of accommodation for their work. Wanting to help is the profession that you're in. Of course, there was consideration. However, we need to think, what has changed during that past nine months? Am I the best person to write this letter? Always think that if the records, obviously with consent of the patient, were ever requested for further justification of any letter or form, would your documentation in that record reflect what you're writing about? You don't want the focus to then turn on you. Why did you write this letter, and have to deal with, any time, especially with disability benefits or letters of accommodation?

Again, we just want you to consider the ask. Is it appropriate and within your scope? Next slide, Allison. Areas outside of competence or expertise. These are not an all-inclusive list. There, I'm sure, are many, obviously, with what you treat. These are some of the common areas that we thought we'd point out. Treating eating disorders. While you may, in your general training, have the ability to provide therapy, does this individual have a more complex medical condition going on?

Allison: I'll pick up where Cara left off. Sorry about that, that we lost connection with her. As Cara was saying, are you the best person that should be treating this person? As she said, if they have a more complex eating disorder situation, do they need to be with a provider or maybe in a more inclusive program that has a psychiatrist, a psychologist, et cetera, all as part of the program for that eating disorder? Forensics. If somebody, is looking for a competency evaluation-- I'm sorry, capacity. Competency is awarded by courts. Capacity situation or, they say, "Hey, could you sign off a thing because my family's saying I shouldn't drive anymore? Can you just sign off and say I'm okay to drive?"

These kinds of things. Are you the best person to be doing that? Do they need a formal forensic evaluation that a forensic provider does? Medication advice. We do know that there are some prescribing psychologists out there, but in general, most psychologists are not doing that, so, are you the best person to be giving any advice related to if they should be taking supplements or anything like that? Because they may have a complex medical history and they may not be forthcoming with you that they have a heart condition or they have diabetes or something where some of the things might be outside your area of expertise in recommending or discussing, and it really would be more appropriate with a different type of medical provider. We're going to sum up. Here's our general risk tips after everything we've said today.

You need to make sure that you create and adhere to the various office policies that make it very clear, this is how my practice is run, this is the expectations. Then if a patient starts crossing that boundary or into something that potentially will violate your office policy, you can direct them right back there and say, "As we had agreed at the beginning, this is how my practice works." You need to abide by it by yourself as well. We want to avoid dual relationships or treating family members where we feel we're in a potential situation of a conflict.

Doesn't mean you can't have them, we just want to take a pause, think through what is the likelihood or what are the types of conflicts that may arise, and should I not

take this dual role or treat multiple family members from the beginning, or is everybody understand something may arise and they have to be referred out? Consider your level of competency and expertise, what are you comfortable treating, not treating, et cetera. You always want to make sure you follow all your state and federal laws. You want to make sure that you're complying with HIPAA.

You want to make sure that you consider patient termination, discharged from the practice if they are repeatedly or extremely crossing a boundary with you. We want to create clear boundaries. Again, avoid that dual relationship if it's not something we should be entering into. Documentation. Document, document, document, most important thing to defending you as well as substantiating your billing and your treatment plan, et cetera. It doesn't mean you have to write the next American greatest novel. That's the expression I always use. It doesn't need to be 15 pages long every time you see a patient, but a sentence or 2 might be too short.

When you look at your documentation at the end of the day for that note, say, "Does this capture appropriately? Would this help defend me in a situation if I was before the licensing board or in a malpractice situation? Would my attorney that I get assigned be able to use this documentation to help me or is it going to hurt me?" Understanding your professional guidelines and standards, clearly defining supervisory roles and expectations. Then again, consult an attorney or risk management professional. If you're in a solo practice by yourself, you don't need to feel like you're on an island by yourself.

There are many types of professionals out there that can help you. It's good to have an attorney that's familiar with healthcare law, licensed in your state if you have certain types of legal questions, and again, specializes in healthcare law, that can help you. If you have a malpractice insurance, most malpractice carriers have a risk management department that you can get guidance from and help from. We have resources in the slides, just some of the resources where some of the information came from that might be able to help you and guide you.

We have three slides for those. Thank you. We only have a minute or two to take some questions. I was monitoring the questions in the Q&A. Some of the things I think we've already hit on, and I think we've hit on some of the ones that were sent in advance. We tried to weave a lot of those questions and answers into the presentation. I did see one that popped up and said, "What about clients asking for a billing statement via email?" If you have a HIPAA-compliant way to communicate with a patient, that's the best way to use email, like through a secure patient portal.

If you have a patient that wants to, and understands, and accepts the risks of accepting information in a non-HIPAA-compliant manner or understands you're sending it HIPAA-compliant, but they may not receive it that way based on the system that they're using, if they write permission, "Yes, I give you permission to communicate with me that way," then you can do so. I'm just going to do one more quick question that we had come up about cultural issues and cultural differences and maintaining that balance. We fall back into, do you feel you have the cultural competence to take care of somebody if they have a cultural difference from you?

That's true for all of healthcare. We talk about, there are different cultural differences amongst people, especially at mental health. Some people come from a culture

where it is shameful to admit you have a mental health issue. Is there a language barrier? These are all the things that you need to think about. Am I the right fit? With that said, just one little quick caveat before we end is, it is up to the provider at their cost to provide a medical interpreter if a person falls into a protected class. If English is not their native language, if they are deaf, the provider is required to pay for an interpreter.

We can't be discriminatory. It's very clear in the ADA laws. Just make sure you're following that. We want to try to avoid using family members of the patients to interpret for them because we don't want to put the patient or that family member into a situation where they feel uncomfortable relaying information of a sensitive nature. With that, I want to say thank you, and I'll turn it back over to the APA folks.

Moderator: Thank you so much, Allison and Cara, and thank you so much for all of you for joining us. Thank you to all listeners for your participation. We would like to thank the American Professional Agency for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. As soon as the webinar has ended, a short survey will appear on your screen. Please take the survey and give us your feedback. We thank you for your attention and hope you all have a great day.

[00:56:27] [END OF AUDIO]