

Common Legal Issues

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"Knowing the risks that confront today's counselors represents the critical first step in the process of enhancing quality of care, serving clients appropriately and reducing liability exposure."

(CNA, 2014, p. 77)

INTRODUCTION

The clinical practice of counseling can present many complex legal matters. Counselors must have access to others who can provide guidance and advice on navigating some of the legal issues that can arise within the course of a counselor/patient relationship. Consultation with supervisors, organizational committees, employer policies, or legal counsel can reduce liability exposure for the counselor when faced with challenging situations.

COMMON LEGAL ISSUES

Involuntary treatment

Although the most effective treatment for mental illness involves voluntary participation, there are instances in which counselors' clients pose a serious risk of harm to themselves or others. Involuntary treatment, as a last resort, might be necessary in these cases. This can take the form of involuntary medication or other treatments, emergency hospitalization for evaluation, commitment to an inpatient facility, mandated outpatient therapy, or a combination of all. It is essential that counselors know the laws in the states they practice so patient rights are not violated in the process of implementing any of these measures. State laws vary and court orders may be necessary.

The decision to compromise a person's autonomy should be made only after careful analysis of state laws and ethical considerations in a particular case. The World Health Organization recommends that, "[P]ersons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation (World Health Organization, 2013).

Similarly, Mental Health America (MHA) expresses concern about involuntary treatment:

Today we know ... persons with mental health conditions are not only capable of making their own decisions regarding their care, but that mental health treatment and services can only be effective when the consumer embraces it, not when it is coercive and involuntary. Involuntary mental health treatment is a serious curtailment of liberty. ...

Most dangerously, coercive outpatient treatment may drive people away from long-term treatment. Unless there is a full array of community mental health services, mandatory outpatient treatment has not been shown to add to the effectiveness of community mental health services and, indeed, may interfere with recovery by compromising personal responsibility and lowering self-esteem (Health Management Associates, 2015).

MHA suggests the following principles for circumstances in which involuntary outpatient commitment is instituted:

1. **Presumption of competency:** adults are presumed to be competent and capable of making their own mental health care decisions;
2. **Declaration of incompetency:** individual state procedures for determining when a person is incompetent vary and mental health providers understand that even the most serious mental illness does not render a person incompetent most of the time;
3. **Informed consent:** the patient's informed consent is required for mental health treatment until a person has been declared incompetent;
4. **Standard.** Serious risk of physical harm to themselves or others in the near future: involuntary commitment is reserved for those persons who pose serious imminent risk of physical harm to themselves or others and is not used in cases of risk to property or other non-physical harm;
5. **Least restrictive alternative:** dignity and autonomy are best preserved when persons with mental health conditions are treated in the least restrictive environment;
6. **Procedural protections:** due process must be preserved through notice, the right to be heard, attorney representation, independent

mental health evaluation, appeals, limited time limits with reviews for continuation of involuntary commitment, and adherence to required standards of evidence;

7. Qualified right to refuse treatment: persons who have been convicted of crimes and are serving prison sentences maintain their right to refuse medication and the imposition of involuntary medication should be reserved for those inmates who meet rigorous standards and procedures;
8. Opposition to outpatient commitment: non-coercive measures are instituted prior to compelling treatment;
9. Voluntary treatment should be truly voluntary: people should not be coerced into admissions and those who are voluntarily committed should be free to leave when they choose; and
10. Advanced directives: persons with mental illness should be able to direct their treatment wishes in advance (Mental Health America, 2015).

The Treatment Advocacy Center (TAC) presents a different point of view regarding involuntary hospitalization or assisted outpatient treatment (AOT), “[T]he deplorable conditions under which more than one million men and women with the most severe mental illness live in America will not end until states universally recognize and implement involuntary commitment as an indispensable tool in promoting recovery among individuals too ill to seek treatment (Treatment Advocacy Center, 2015, p. 4). The TAC recommends universal adoption of emergency hospitalization and need for treatment standards, enactment of AOT laws by the five states that have not passed them, and the provision of sufficient inpatient beds.

An example of an AOT statute is “Kendra’s Law” in New York. On January 3, 1999, Andrew Goldstein pushed Kendra Webdale to her death in front of a subway train. Goldstein was a paranoid and delusional man with a history of multiple hospitalizations for schizophrenia, multiple emergency department encounters, and a long history of violence, having attacked 13 women. He was not receiving treatment for mental illness at the time he pushed Webdale to her death and had previously received sporadic and uncoordinated care. The hospital characterized him as “extremely dangerous and potentially violent” yet he

was completely on his own at home and with no follow up supervision, and had stopped taking his medication (Magnus, 2007).

The Webdale family lobbied for legislation to compel persons like Goldstein to take medication and for the state to monitor and hospitalize them when they were non-compliant. The New York State Legislature enacted Mental Health Hygiene Law § 9.60 (Kendra’s Law) in 1999 and renewed the law in 2005 (New York Codes, 1999). Kendra’s law allows courts to order treatment for certain people with serious mental illness. Courts can order people with a history of violence or multiple hospitalizations to stay in outpatient treatment while living in the community. Under the law, AOT can be ordered “for certain people¹ with mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision” (New York State Office of Mental Health, 2006). Most states have passed similar laws, referring to AOT programs with different names, such as involuntary outpatient commitment (IOC) or mandatory outpatient treatment (MOT). Studies indicate that such laws are effective in reducing homelessness, psychiatric hospitalizations, arrest and incarceration, and harmful behavior, as well as decreasing costs and improving outcomes (Treatment Advocacy Center, 2009; National Alliance for the Mentally Ill, ND; Health Management Associates, 2015) but they vary considerably and suffer from many obstacles (Treatment Advocacy Center, 2014a).

Relapse is associated with medication non-compliance and persons with mental illness can be non-compliant with medications for many reasons. They might be unaware or not believe that they are sick. Alcoholism/drug abuse or poor relationships with mental health providers can interfere with compliance. Side-effects might be too disturbing. The medications might be too expensive or unavailable (Treatment Advocacy Center, 2014b). Medications can be administered against a person’s will under certain circumstances as well. As with any other form of involuntary treatment, each state balances an individual’s rights with public safety and it is critical to understand the laws in which a counselor practices.

Washington v. Harper is a United States Supreme Court case that addresses involuntary medication for inmates. Walter Harper served a prison sentence after being convicted of robbery. During his incarceration and while on parole, he received psychiatric treatment which included the consensual administration of medications.

When he was not taking antipsychotic medications, his condition deteriorated and he became violent. He was transferred to the Special Offender Center (SOC) a state facility for convicted felons with serious mental illness. The SOC diagnosed Harper with what was then called manic-depression and required him to take medications against his will. The SOC policy stated that an inmate with a mental disorder who posed a threat to himself or others could be treated involuntarily if a psychiatrist ordered medication. Certain conditions, among others, had to be met such as the right to notice and an opportunity to be heard at a hearing. These conditions were met and Harper was compelled to take medication against his will.

Harper filed a lawsuit in state court, claiming that his constitutional rights were violated. The trial court rejected his claim and he appealed. The state's supreme court reversed the trial court and sent the case back because it found that the SOC could compel Harper to take medications against his will only if the state could prove that the medication was necessary and effective by clear, cogent, and convincing evidence. The United States Supreme Court agreed to hear the case. The Court analyzed the SOC policy and found that it met constitutional requirements. It found that there was a legitimate government interest in decreasing the danger posed by dangerous persons and that the hearing procedures at the SOC comported with procedural due process:

...[W]e hold that the regulation before us is permissible under the Constitution. It is an accommodation between an inmate's liberty interest in avoiding the forced administration of antipsychotic drugs and the State's interests in providing appropriate medical treatment to reduce the danger that an inmate suffering from a serious mental disorder represents to himself or others (*Washington v. Harper*, 1990, p. 236).

Termination vs. abandonment

Counselor/client relationships come to an end for a number of reasons. Counselors and clients can mutually decide to end the relationship when treatment goals have been met or when a previously specified time for working together has been reached. The relationship can end prior to that point whenever the client disengages and when clients stop attending sessions or communicating with the counselor. Counselors should document in the health care record the attempts they made to follow up with a client that has ceased treatment. When terminating a relationship, the counselor should make the client aware of the termination and retain all communications.

Counselors who terminate the relationship when the client continues to require counselor services should do so with the understanding that legal and ethical issues can arise. Some situations in which counselors might terminate the relationship include:

- when the client has needs that exceed the counselor's competency or scope of practice;
- upon determining that a conflict of interest has arisen;
- when the client is noncompliant with therapy;
- when the client fails to make progress;
- when the counselor is unable to continue; or
- when the client has failed to participate or communicate with the counselor.

Termination of the relationship should only occur after a final session with the client in which attained progress and continuing treatment requirements have been assessed and the counselor and client have discussed any future needs. Documentation should reflect discussions about termination with the client and indicate that the client was not in crisis at the time of the termination. A best practice is to prepare for termination at the beginning of the counselor/client relationship (Felton, 2015).

Premature termination can lead to legal allegations of abandonment in a malpractice lawsuit or licensing board investigation. Additionally, professional associations consider abandonment to be unethical conduct, as exemplified by the American Counseling Association's Code of Conduct:

A.12. Abandonment and Client Neglect

Counselors do not abandon or neglect clients in counseling. Counselors assist in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacation, illness, and following termination (American Counseling Association, 2014).

Abandonment occurs when a counselor unilaterally discontinues services to a client who still requires counseling services without making adequate arrangements for another qualified counselor to continue services to the client. Confidential termination letters that clarify the end of the relationship and referrals if necessary can provide defense evidence in the event of such allegations. Counselors should provide written notification to a client indicating the date of termination and providing adequate time for the notice. If services will still be required, the termination notice should include a list of alternative providers.

Duty to protect

In their practice, counselors may become aware that their clients pose a potential threat to a specific individual or to the public at large. Conflict can arise when sharing such information would require disclosing private communications, thus violating client confidentiality. Both federal and state privacy laws can govern a counselor's practice. Generally, federal law prevails if there is a conflict between the federal and the state law. An exception to this exists, however, when state law is more stringent. With privacy, confidentiality, and privilege issues, state law(s) will prevail if its protections are stronger than the federal law(s).



Counselors should know if they are “covered entities” as defined by the Health Insurance Portability and Accountability Act (HIPAA) – the federal law. A confidentiality exception is made for covered entities under HIPAA's Privacy Rule:

§ 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required.

(j) Standard: Uses and disclosures to avert a serious threat to health or safety -

(1) Permitted disclosures. A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure:

(i)

(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of

a person or the public; and

(B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or

(ii) Is necessary for law enforcement authorities to identify or apprehend an individual:

(A) Because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim; or

(B) Where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody ...

(United States Government Printing Office, 1996).

Counselors who are not “covered entities” under HIPAA are subject to state law(s). Privacy laws and exceptions vary by state so it is essential for the counselor to know what the law says in the state in which the counselor practices. Some states impose a “duty to warn” which obligates a counselor to advise individuals at risk, or those who can prevent the danger. Other states do not impose a duty to warn, but do create a “right to warn” others of dangerous situations imposed by their clients. The state law is determined both by written statutes and by court decisions. Additionally, some states provide immunity for counselors whose patients harm third parties, but impose requirements for the immunity to apply. The conflict between patient confidentiality and the duty to protect clients and others can be complicated. The following cases illustrate the need for counselors to know the law in their own states and to seek legal counsel when in question.

The landmark case addressing the issue is *Tarasoff v. Regents of the University of California*. Although the decision in the case is only binding in the state of California, the court's analysis of a therapist's duty has been influential throughout the country. In this case, University of California (UC) graduate student, Prosenjit Poddar, had been stalking another UC student after a failed relationship with her. He confided to a UC psychologist, Dr. Lawrence Moore, that he intended to kill her. Neither that student, Tatiana Tarasoff, nor her parents, were warned about the threat. Two months later, Poddar stabbed Tarasoff seventeen times and shot her with a pellet gun, killing her (Rothstein, 2014).

Tatiana's parents brought a wrongful death lawsuit in Alameda County Circuit Court against UC and some of its employees, including Dr. Moore. The court dismissed the case, finding that the defendants did not

owe a duty to Tatiana or her parents. The parents appealed the dismissal and the California Court of Appeals affirmed the dismissal. The parents escalated the appeal to the California Supreme Court. They argued that the defendants failed to exercise reasonable care to protect Tatiana and were therefore liable for failure to warn them of the danger, and for failure to confine Poddar. The court found that the relationship between a therapist and patient is a special relationship that creates a duty of care, "...[o]nce a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger" (Tarasoff v. Regents of University of California, 1976, p. 439).

The court further found that the revelation of a communication such as Poddar's to Moore would not be a violation of privilege or a breach of professional ethics, "[t]he public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins" (Tarasoff v. Regents of University of California, 1976, p. 442). The Court reversed the dismissal as to Dr. Moore.

Mark Rothstein characterized the consequence of this case:

Although Tarasoff is often regarded as establishing a duty to warn the intended victim of a violent threat, the duty recognized by the court is broader. It requires a mental health professional to take reasonable and necessary action to protect the threatened individual, which could include having the patient confined, notifying law enforcement, warning the intended victim, or other measures to protect the intended victim (Rothstein, 2014, p. 3).

The duty to protect is also demonstrated in a 2006 Vermont case. In Kuligoski v. Brattleboro Retreat and Northeast Kingdom Human Services, Evan Rapoza was admitted to the psychiatric unit of Central Vermont Medical Center (CVMC) after threatening children. He was diagnosed with schizophreniform disorder and determined to pose a danger to himself and others. CVMC retrained Rapoza and transferred him to Vermont State Hospital (VSH) where he was also deemed to be a danger to others and where a physician determined that, if released, he would pose a danger to his family. During his stay at VSH, he repeatedly asked to leave, made an escape attempt, threatened to punch out a window, and appeared to be

hallucinating. After he told a social worker that he felt unsafe, a referral was made for a transfer to another psychiatric hospital called the Retreat.

A Retreat physician confirmed the diagnosis of schizophreniform disorder and reported that Rapoza verbalized homicidal ideation toward the staff. Rapoza demonstrated menacing conduct, homicidal and suicidal ideations, auditory and visual hallucinations, and floridly psychotic behavior. An assessment indicated that if discharged, he would be noncompliant with medication and aftercare treatment, and likely to decompensate. While still at the Retreat, Rapoza stopped taking his medication and heard voices telling him to kill himself. Despite this assessment, he was discharged to the care of his parents in November of 2010. The aftercare plan involved regular visits to Northeast Kingdom Human Services (NKHS).

In December, 2010, Rapoza told his mother that he had stopped taking his medication. His mother spoke with a physician at NKHS who told her that it was worrisome, but that Rapoza had to decide he could take care of himself. Rapoza did not continue visits to NKHS and NKHS did not reach out to him or take action with regard to his medication noncompliance.

In February, 2011, Rapoza went with his father to an apartment building his family owned. Michael Kuligoski, a propane delivery man, was working on the furnace in the basement at the time. Rapoza attacked him, striking him in the head with a pipe wrench, strangling him by dragging him across the floor with a belt wrapped around his neck, and forcibly submerging his head in a bucket of water. (Faher, 2016). Kuligoski was severely and permanently injured, suffering brain damage and partial paralysis that required ongoing medical attention and supportive assistance for the rest of his life.

Kuligoski's family filed a complaint alleging, among other things, that the Retreat was negligent in discharging Rapoza knowing he was dangerous and in not warning his parents or training them in how to supervise and manage him. The allegations were based upon the Retreat's duty of reasonable care to avoid risk to third parties because of the special relationship that existed between the Retreat and Rapoza. The court dismissed the claims, concluding that the Retreat did not owe a duty to the plaintiffs because Kuligoski was not an identifiable victim, and because the Retreat had no duty to control Rapoza.

The Kuligoskis appealed and on appeal, the Supreme Court of Vermont reversed the dismissal, finding that the Retreat did owe a duty to foreseeable victims, "...[w]e hold that both the Retreat and NKHS had a

duty to provide information to E.R.'s parents, both to warn them of E.R.'s risk of violence to themselves and others and to advise them as caretakers of E.R. on how to manage E.R.'s conduct (*Kuligowski v. Brattleboro Retreat and Northeast Kingdom Human Services*, 2016, p. 30).

In addition to the duty to protect third parties who can be harmed by patients, counselors can also be accused of failure to prevent a patient's self-harm. In *Lee v. Corregedore*, Manuel Corregedore was a Veteran's Service Counselor IV with the State of Hawai'i's Office of Veteran Services. Although Corregedore did have some training in mental health and suicide prevention, he was not trained or licensed in psychiatry or psychology. He regularly helped a disabled Vietnam veteran, Anthony Wayne Perreira, who was being treated by a psychiatrist and a social worker for neurological and psychological problems. In 1990, in front of Corregedore, Perreira threatened to commit suicide. In 1991 he threatened to commit suicide again. Later in 1991, Perreira, accompanied by his father, came to Corregedore's office and told his secretary that he was going to, "jump Hanapepe Bay Valley, if not I'm going to Kokee" (*Lee v. Corregedore*, 1996, p. 327). He then asked the secretary to write down instructions for what to do after his death.

Upon seeing Corregedore, Perreira again told him he was going to commit suicide. Corregedore advised Perreira that he was going to call his social worker but Perreira left the office with his father. Corregedore's secretary showed him the instructions Perreira had given for after his death. Corregedore did call Perreira's social worker and told him about the suicide threat. The social worker tried to follow up, but Perreira had already jumped to his death at the Hanapepe Bay Lookout. The administrator of Perreira's estate brought a lawsuit against Corregedore and the State of Hawai'i. The complaint alleged that Corregedore's professional relationship with Perreira and his knowledge that Perreira had stated that he intended to take his own life created a duty to prevent foreseeable injury. The complaint further claimed that Corregedore breached that duty to Perreira when he failed to warn Perreira's father that he was suicidal.

The defendants made a motion for summary judgment, claiming that Corregedore had no duty to prevent Perreira's suicide. (A motion for summary judgment is a request that the court not let the case proceed. It is an argument that the plaintiff does not have a case, and that there are no facts at issue for a jury to consider.) The motion was granted and the plaintiffs appealed. On appeal, Perreira's estate argued that Corregedore did owe Perreira a duty because

the counselors at the Veteran's Service had a "special relationship" with the veterans they counseled. They argued that Perreira's suicide was foreseeable, requiring Corregedore to prevent it. The Supreme Court of Hawaii reasoned that Corregedore did not have custody of Perreira and only in custodial relationships did counselors have a special relationship that imposed a duty to prevent suicide. It further held that *Tarasoff* responsibilities to disclose confidential communications only applied when the risk to be prevented was the danger of violent assault to a third party, not when the risk was self-inflicted harm or property damage. It held that Corregedore and Hawai'i did not have such a relationship or duty and affirmed the summary judgment (*Lee v. Corregedore*, 1996).

A different outcome occurred in a Maryland Case. Nicole Eisel was a thirteen-year-old student at Sligo Middle School. She had become involved in Satanism and told friends that she intended to kill herself. Her friends reported that to their school counselors and they, in turn, reported it to Nicole's counselor. None of the counselors notified the school administration or Nicole's parents of her suicide threat. A week later, Nicole went to a park with a friend. They were armed with a .32 caliber semiautomatic pistol. The friend shot Nicole in the head, then shot herself in a murder-suicide pact (McCord & Arundel, 1991).

Nicole's father filed a lawsuit against the board of education alleging negligence on the part of the counselors. The defendants filed a Motion to Dismiss and/or a Motion for Summary Judgment. They asserted that they did not owe a duty to Nicole or her father. The circuit court granted the motion, ruling against Mr. Eisel. He appealed and the case was heard by the Court of Appeals. Eisel argued that the school's own policy required counselors to notify the parents of a student with suicidal thoughts. He wasn't arguing that the school or its counselors should have prevented the suicide, but that they should have communicated her suicidal thoughts to him. Their failure to do so prevented him from exercising the custody and control over her as a parent to avert it.

The court noted that, "...[T]he relationship of school counselor and pupil is not devoid of therapeutic overtones" (*Eisel v. Board of Education of Montgomery County*, 1990, p. 385). It noted that Nicole's suicide was foreseeable and that counselors should know the warning signs and what to do when adolescents are thinking of suicide. It also noted that Maryland law (the Youth Suicide Prevention Programs Act) required schools to be at the forefront of prevention efforts and that Sligo Middle School had a suicide prevention program in place which specifically told the staff to

notify parents and not to worry about confidentiality in those circumstances. The court stated, "...[H]olding counselors to a common law duty of reasonable care to prevent suicides when they have evidence of a suicidal intent comports with the policy underlying this Act" (*Eisel v. Board of Education of Montgomery County*, 1990, p. 389.)

The court further stated, "[T]he youth suicide prevention programs provided for by the Act call for awareness of, and response to, emotional warning signs, thus evidencing a community sense that there should be intervention based on emotional indicia of suicide" (*Eisel v. Board of Education of Montgomery County*, 1990, p. 391). The court described the harm that could occur when a counselor failed to intervene as "total and irreversible" and the consequence of the risk was so great that, "even a relatively remote possibility of a suicide may be enough to establish duty." The situation placed a small burden on the counselors – merely to communicate the information to Nicole's father. Confidentiality did not relieve counselors of this duty, especially when the school policy itself clearly stated that confidentiality was to be disregarded when the concern involved suicide. The court reversed the dismissal of the case and sent it back to the circuit court for trial:

...[W]e hold that school counselors have a duty to use reasonable means to attempt to prevent a suicide when they are on notice of a child or adolescent student's suicidal intent. On the facts of this case as developed to date, a trier of fact could conclude that that duty included warning Eisel of the danger (*Eisel v. Board of Education of Montgomery County*, 1990, p. 393).

Lay counselors who do not have professional training or hold a license can also be held responsible for failure to protect, as exemplified in Nally v. Grace Community Church of the Valley. Kenneth Nally was a parishioner in a church which operated an active counseling program. He became good friends with one of the pastors, Lynn Cory. Cory knew Nally was depressed and did not refer him to a psychologist or psychiatrist, but did recommend that Nally seek counseling with church counselors Duane Rea and Richard Thomson. Nally was counseled by both Rea and Thomson. Rea had no training in mental health and counseled people with severe emotional problems that the Bible held answers to emotional problems. Thomson also believed that the Bible provided answers for emotional and psychiatric problems and counseled people with suicidal ideation or severe problems. He provided biblical counseling and also did not share with Nally's family that he was contemplating suicide.

Nally was hospitalized after a suicide attempt. A church pastor, John MacArthur, visited him in the hospital. Nally told MacArthur that he regretted not being "successful" in his suicide attempt. This was overheard by Cory. Neither MacArthur nor Cory shared this information with Nally's family or any of his doctors. Nally also told Rea that he would attempt suicide again if he were released. Like MacArthur and Cory, Rea also did not share this information with Nally's family or any of his doctors. Nally's mental illness worsened, and at age 24, he killed himself with a shotgun.

Nally's parents brought a \$1 million-dollar lawsuit against the church, alleging that their son's suicide was a result of incompetent counseling at the church. The trial court dismissed the case and the parents appealed. On appeal, the Court of Appeal held that, "[T]he non-therapist counselor who has held himself out as competent to treat serious emotional problems and voluntarily established a counseling relationship with an emotionally disturbed person has a duty to take appropriate precautions should that person exhibit suicidal tendencies" (*Nally v. Grace Community Church of the Valley*, 1988, p.226). The court stated that non-therapist counselors have less education and experience, so are held to a different standard of care. That standard of care requires the non-therapist counselor to take steps to get the suicidal person into the hands of someone who does have the education and experience to prevent the suicide, "[W]e recognize the responsibility to refer in appropriate cases extends not only to religious counselors but also to other counselors who are not licensed psychotherapists (*Nally v. Grace Community Church of the Valley*, 1988, p. 237). In so holding, it reinstated the lawsuit.

Release of treatment records

Mental health records are subject to privacy laws and organizational policies. Psychotherapy health records, in particular, are subject to rigorous protection under federal law (United States Department of Health & Human Services, 2014). Counselors should not release their notes, health records or materials without seeking legal advice. The release of health records can be complicated when the records are requested during the course of litigation demands, or when a minor's records are at issue. A 2014 case illustrates some of the analysis in determining whether or not the records can be released.

Randall Eric Culbertson and Hannah Ann Culbertson were married in 2004 and had two children. In 2010 they separated and Hannah filed for divorce. Her divorce complaint alleged physical and emotional abuse both toward her and toward the children. The trial

court granted an order of protection which prohibited Randall from being around Hannah or the children. Randall denied the allegations of abuse and filed a counter-complaint. He requested sole custody and decision-making authority regarding the children. An agreement was reached after mediation in which Randall was ordered to continue counseling with Dr. Deason until he began therapy with Dr. Crouse. Hannah was ordered to start therapy with Dr. Clark. Additionally, Dr. Clement was to evaluate Randall, Hannah, and the children to make a parenting recommendation. Randall and Hannah agreed that Dr. Clement could speak with both of their counselors.



In February, 2011, Hannah subpoenaed the notes and treatment records of three of Randall's psychologists. Randall argued that the records were not discoverable because they were protected by psychologist-client privilege. Dr. Clement filed her report, making the recommendation that Randall be given unsupervised and uninterrupted visitation with the children. Hannah argued that Randall had waived the privilege when he agreed that Dr. Clement could speak with his counselors. She also argued that Randall put his mental health records at issue when he denied her allegations of abuse. The court ruled in Hannah's favor and ordered Randall to produce his mental health records. Randall appealed and the appellate court placed the trial court's order on hold.

In July, 2011, bystanders called 911 to report that Randall was walking aimlessly along a highway. He had called a neighbor to say goodbye and there was

a question as to whether or not he had been drinking alcohol. Randall was picked up but not arrested or charged. Hannah filed a petition to remove his visitation rights until he had been evaluated again. In her petition, she claimed that he had had previous suicidal tendencies and that he might harm the children or himself in their presence. The trial court granted her request and ordered Randall to undergo an examination. Dr. Ciocca performed the evaluation and submitted a report in March of 2012. Dr. Ciocca's report stated that Randall had agreed to release his records from the other providers. It was Dr. Ciocca's opinion that Randall suffered from Bipolar disorder which was now stabilized with medication.

At the divorce trial, Randall introduced the opinions of both Dr. Ciocca and Dr. Clement. Hannah argued that in doing so, Randall had waived the psychologist-client privilege and the court agreed. Randall filed an appeal. The Court of Appeals noted that privilege belongs to the client and can only be waived by the client but that this dispute was within the context of a child custody determination. It noted that some jurisdictions hold that when a person seeks custody of a child or claims to be mentally stable in response to the other parent's claim that he is not, he automatically waives his psychologist-client privilege by putting his mental health at issue. Some jurisdictions require that those records be reviewed *in camera* (in the judge's chambers, as opposed to in open court). Some states are more protective of the privilege and hold that protecting that privilege is more beneficial to the children than compelling disclosure.

The court reasoned that Randall did not waive privilege with regard to his *treating* psychologists by relying on the reports of the *evaluating* experts, Dr. Clement and Dr. Ciocca. It held that Randall had waived the privilege with regard to Dr. Clement and Dr. Ciocca only (*Culbertson v. Culbertson*, 2014).

There are many circumstances where a counselor may or must breach confidentiality. Examples include when a client poses a danger to himself or others as discussed above, when reporting is mandatory, when clients must be treated on an involuntary basis, when clients are going to engage in criminal activity, or when the counselor must respond to legal proceedings. Signed authorizations to release records or share information might be required and limited in time. The patient's right to confidentiality remains in place after the patient's death. Because disclosure or failure to disclose can cause legal problems for a counselor, it is essential to get legal advice in these situations. It can be a complex matter to determine who has the authority to release the information in some cases.

Minors

A minor's privacy and confidentiality rights are determined by both federal and state laws. Federal laws, such as the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) specify protections and exceptions as a minimum standard. State laws can be more stringent than HIPAA or FERPA. As stated earlier, when there is conflict between federal and state law, the more stringent protection will apply. Parental access to a minor's records or treatment information varies considerably from state to state. Some states require counselors to deny such requests, particularly if compromising the minor's confidentiality could cause harm to the minor. Some states consider minors to be emancipated (deemed to be adults) with regard to specific information such as pregnancy, contraception, drug or alcohol management, and mental health treatment.

State laws also specify exceptions to confidentiality protection, such as mandatory child abuse reporting or disclosure of impending crimes. The counselor-client privilege can belong to the minor being treated, to the parent/guardian, or to the minor's attorney. It is important to know which it is when obtaining waivers or before releasing information.

State laws also vary regarding a counselor's obligation to assist in an investigation by a regulatory agency, such as protective services. Some states require written permission to communicate with the investigator. When it is left to the counselor's discretion, the counselor must know the state law and make a determination based upon what is in the minor's best interests. This can require consultation or supervision, but the best practice is to obtain permission in writing from the holder of the privilege.

Custody and divorce actions

Counselors who treat couples should clarify privacy and confidentiality practices at the beginning of the counseling relationship. The identified patient should be clearly defined. The couple should be told at the outset the counselor's policy regarding individual vs. conjoint sessions and the disclosure of any communications from individual sessions. The couple should understand that one-on-one sessions do not signify that the individual is the client, but are conducted within the context of treating the couple. If one of the parties does require individual therapy, the counselor can make a referral, but cannot provide that service. This information should be provided in writing and the counselor should maintain documentation, including signatures of both parties that it was reviewed prior to beginning treatment.

Counselors might have a legal obligation to report domestic violence, child abuse, elder abuse or dependent adult abuse depending upon state laws. Such mandatory reporting laws supersede patient confidentiality. If the couple becomes involved in divorce litigation, the counselor can be asked to provide information, records, or testimony. Organizational policies should address the response to requests, subpoenas, or court orders as determined by state law. Because it is the couple who is the client, treatment records should not be released to one party without written authorization from the other.

When collateral sessions are held with another family member, it should be clear that the reason for such a visit is to obtain information for the purpose of treating the couple, not for treatment of the collateral party. The counselor must document a discussion that clarifies that the collateral party is not a client and that the counselor is not providing services to the collateral party, so the confidentiality provisions of a counselor-client relationship do not apply. The couple being treated might have access to the treatment records, which can include the collateral party's session(s).

CONCLUSION

Many complex legal situations can arise in the course of a counselor-client relationship. In addition to seeking legal counsel, a counselor can reduce the risk of liability exposure by engaging in current, evidence-based practice that is consistent with organizational policies and both federal and state laws. The following actions are also recommended:

- Maintain a professional liability insurance policy that provides adequate coverage not only for malpractice lawsuits, but also for licensure defense;
- Be familiar with the state's practice act and scope of practice limitations;
- Obtain written authorizations for the sharing of information or releasing of records;
- Document discussions with clients about your practices, the client's goals, termination, referrals, and confidentiality expectations; and
- Maintain clinical practice skills and participate in supervision.

¹New York State Office of Mental Health explains the AOT requirements as follows:

No person may be placed under an AOT order unless the court finds by clear and convincing evidence that the subject of the petition meets all of the following criteria:

- Is at least 18 years old; and
- Is suffering from a mental illness; and
- Is unlikely to survive safely in the community without supervision, based on a clinical determination; and
- Has a history of lack of compliance with treatment for mental illness that has:
 - i. prior to the filing of the petition, at least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any current period, or period ending within the last six months, during which the person was or is hospitalized or incarcerated; or
 - ii. prior to the filing of the petition, resulted in one of more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated; and
- is, as a result of his or her mental illness, unlikely to voluntarily participate in the outpatient treatment that would enable him or her to live safely in the community; and
- in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others as defined in §9.01 of this article; and
- is likely to benefit from assisted outpatient treatment.

A court may not issue an AOT order unless it finds that assisted outpatient treatment is the least restrictive alternative available for the person (New York State Office of Mental Health, 2006).

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