Risk Management for Mental Health Professionals Working With Maltreated Children and Adult Survivors

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Twenty years ago, mental health professionals seldom worried about lawsuits or ethics complaints, but not so today. This article outlines what professionals should consider to lower their risk of these situations. Following is a much abbreviated version of the risk management chapter from the recent second edition of *The APSAC Handbook on Child Maltreatment* (Myers, 2002).

Malpractice and Negligence

Malpractice (literally, bad practice) covers a wide range of wrongdoing, from *in*tentional acts such as sexual relations with clients to *un*intentional acts that injure clients. Most malpractice is based on a claim of negligence. Negligence occurs when a professional fails to live up to the *standard of care* required of competent professionals in that discipline, and when the failure injures someone. The standard of care is shaped by general principles of the law of torts and by the ethics codes of the National Association of Social Workers, the American Psychological Association, and the American Medical Association. That is, failure to abide by applicable ethics codes can be evidence of malpractice.

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Clearly, psychotherapists owe a legal duty of care to their clients, and failure to fulfill the duty can be negligence. Are there situations where psychotherapists owe a duty to care to people who are *not* clients? The courts, for example, are in disagreement about this issue. Consider an adult who enters psychotherapy for treatment of depression. During therapy, the client recovers memories of child sexual abuse by her father. The client confronts the father, who denies the allegation and sues the *therapist* for "manufacturing false memories." In such lawsuits, a critical question is whether the psychotherapist owed a duty of care to the nonclient father. If the answer is no, then the father's lawsuit dies without reaching the issue of the therapist's alleged negligent treatment. If the answer is yes, the father's lawsuit proceeds. This is not to say that the father will win. The point is that if the therapist owed a duty of care to the nonclient father, then the father is allowed to press the lawsuit forward (see Appelbaum & Zoltek-Jick, 1996; Bowman & Mertz, 1996). The courts are still sorting out such litigation (see case discussion in Myers, 2002).

Direct contact with a *non*client can transform the nonclient into a *client* even though the nonclient does not formally enter treatment. Written, telephonic, and person-to-person communication with a nonclient may, depending on what is said, create a therapist-client relationship. The line can be crossed when a therapist offers professional advice to a nonclient. On the other hand, a therapist is probably safe saying, "Because you are not my client, I cannot give you advice, treatment, or counseling on how to proceed apart from advising you that you may wish to consult a professional on your own." Such statements should be carefully documented.

Professionals who work with survivors of abuse often see themselves as advocates for their clients, and many forms of client advocacy are entirely proper. But when might this advocacy for a client create a legal duty to a *non*client? There is no simple answer, but certain activities stand out, such as advising clients to take steps that *directly* and *adversely* affect nonclients. Examples include advising a client to sue a suspected perpetrator. The possibility of a legal duty to a nonclient increases when a therapist causes suspicions about the nonclient to come to public attention. In *Hungerford v. Jones* (1998), the New Hampshire Supreme Court concluded that a therapist owed a duty of care to the nonclient father of the therapist's client. The court emphasized the harm caused by false accusations of sexual abuse.

The court wrote:

The likelihood of harm to an accused parent is exponentially compounded when treating threapists take public action based on false accusations of sexual abuse or encourage their patients to do so. Public action encompasses any effort to make the allegations common knowledge in the community. In this situation, the foreseeability of harm is so great that public policy weighs in favor of imposing on therapists a duty of care to the accused parent throughout the therapeutic process. (p. 481)

Therapist involvement in a client's memory for abuse has been a subject of considerable attention in legal and therapeutic settings. Knapp and VandeCreek (1996) point out the dangers of "questionable techniques used to retrieve lost memories," such as "age regression, body memory interpretation, suggestive questioning, guided visualization, sexualized dream interpretation, high-pressure survivor groups, aggressive sodium amytal interviews, and misleading bibliotherapy" (p. 456).

Knapp and VandeCreek note that many experienced clinicians believe that it is therapeutically indicated, under certain circumstances, to seek to retrieve (or "de-repress") memories of abuse through hypnotherapy or sodium amytal interviews. According to Gold, Hughs, and Hohnecker (1994); Terr (1994); and Herman (1992), these techniques may be justified when hidden trauma is strongly suspected on basis objective criteria and the patient's suffering is severe. We would add that they are justified only when more prosaic techniques of memory recovery (e.g., talking) have failed and the patient has been informed of the limitations of these techniques and the potential for creating false memories.

To minimize the possibility that therapist bias could influence the content of the memory, contextual cues should be kept as neutral as possible. Psychologists should record in detail the patient's statements about possible past abuse ahead of time and should video- or audio-tape the sessions to protect against possible allegations that they, the psychologists, implanted false memories (p. 456).

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Hypnosis has important legal implications. In some states, individuals who have been hypnotized are not allowed to testify about events remembered during or after hypnosis. "Many courts have held or recognized that testimony concerning matters consciously recalled for the first time through pretrial hypnosis is inadmissable" (Fleming, 1990, p. 934). Therefore, a professional whose client may someday serve as a witness should seek legal advice before using hypnosis, sodium amytal, or similar methods.

Child Abuse Reporting Laws

The law requires professionals to report suspected child abuse and neglect. Reporting is required when a professional has evidence that would lead a competent professional to believe abuse or neglect is reasonably likely. The decision to report depends on the facts of each case, interpreted through experience and judgment. The duty to report does not require the professional to "know" abuse or neglect occurred. All that is required is reasonable suspicion of maltreatment. The law requires reporting of suspicion, not certainty. A professional who delays reporting until all doubt is eliminated probably violates the reporting law. The law deliberately leaves the ultimate decision about maltreatment to investigating officials, not professionals. Thus, Kalichman (1999) advises that professionals "should avoid acting as investigators and restrict their actions within proper roles" (p. 117). This is not to say that professionals ask no questions and consider no alternatives to maltreatment. The point is that in-depth investigation is the domain of law enforcement and child protective services, not professionals who diagnose and treat maltreatment.

If a professional fails to report suspected abuse and a child is abused or killed as a result, the professional can be sued for malpractice. On the other side of the coin, when a professional reports suspected maltreatment, an angry parent may sue. Reporting laws provide professionals with some form of immunity from liability. Immunity clearly covers the act of reporting. In many states, immunity extends beyond the report to include acts leading up to the report and, after the report is filed, to communication with investigators and to testifying in court.

Informed Consent

Informed consent is a legal requirement for most medical and mental health treatment, and failure to obtain informed consent can be malpractice (American Psychological Association, 1992). Client consent should be in writing and should be included in the client's record. The information required for informed consent is described in the *Code of Ethics* of the National Association of Social Workers (1997):

Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions. (Standard 1.03(a))

Explaining the meaning of confidentiality and its limits is an important part of informed consent (Deed, 1993; Ebert, 1993). The American Psychological Association's (1992) *Code of Ethics* states that "[u]nless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant" (1992, Standard 5.01(b)). The duty to report suspected child abuse limits confidentiality, and "[i]t is advisable at the outset of treatment to inform your clients that the usual rule concerning confidentiality does not apply when the duty to report child abuse arises" (Committee on Professional Practice, 1995, p. 378).

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Is informed consent required for purely forensic evaluation, where treatment is not provided? Because informed consent is based on respect for autonomy, the answer should normally be yes. In certain court-ordered evaluations, however, informed consent may not be necessary. Even in court-ordered cases, however, professionals are encouraged to inform clients of the nature of services to be provided, and, where possible, to obtain informed consent. For example, the National Association of Social Workers' (1999) *Code of Ethics* provides that "[i]n instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse services" (Standard 1.03(d)). The American Academy of Psychiatry and the Law's (1995) *Ethical Guidelines for the Practice of Forensic Psychiatry* provide that "[t]he informed consent of the subject of a forensic evaluation is obtained when possible. Where consent is not required, notice is given to the evaluee of the nature of the evaluation. If the evaluee is not competent to give consent, substituted consent is obtained in accordance with the laws of the jurisdiction" (Guideline III). Along similar lines, the American Psychological Association's *Speciality Guidelines for Forensic Psychologists* provides that "[f]orensic psychologists have an obligation to ensure that prospective clients are informed of their rights with respect to the anticipated forensic service, of the purposes of any evaluation, of the nature of procedures to be employed, of the intended uses of any product of their services, and of the party who has employed the forensic psychologist. Unless court ordered, forensic psychologists obtain informed consent of the client or party, or their legal representative, before proceeding with such evaluations and procedures" (Committee on Ethical Guidelines for Forensic Psychologists, 1991, Guideline IV. E). Finally, the American Psychological Association's (1994) *Guidelines for Child Custody Evaluations in Divorce Proceedings* states that "[t]he psychologist obtains informed consent from all adult participants and, as appropriate, informs child participants" (Guideline III, paragraph 8).

Professionals can reduce the likelihood of being sued. The best way to avoid a lawsuit is to practice competently and compassionately.

Children are legally incapable of consenting to most forms of medical and mental health treatment. Thus, informed consent is obtained from parents or caretakers (American Psychological Association, 1992). It should be noted, however, that children above specified ages (e.g., 12) are allowed to consent to certain types of treatment including, in many states, testing for venereal disease or pregnancy, abortion, and some kinds of mental health care (for California law, see Myers, 2001).

Consultation and Peer Review

Regular consultation and peer review decrease the likelihood of being sued (Harris, 1995). If a lawsuit or ethics complaint is filed, a written record of consultation and peer review constitutes powerful evidence of proper care. Knapp and VandeCreek (1996) write that "[a]t times, it may be desirable to seek consultation with an expert who has a different perspective. . . . The consultation should be documented and include responses to specific questions, including, but not limited to, the diagnosis or presenting problem, specific treatment plans, and alternative treatment strategies" (p. 458).

Documentation

Documentation is critical to risk management (Moline, Williams, & Austin, 1998). "An axiom among malpractice defense attorneys is 'If it isn't written down, it didn't occur'" (Knapp & VandeCreek, 1996, p. 458). Rivas-Vazquez and his colleagues write that "deficient documentation can draw attention away from the appropriateness of an intervention" (2001, p. 194). Thorough, accurate, ongoing documentation is convincing evidence of proper practice (Harris, 1995). Avoid "humorous" remarks in client records. What seemed funny at the time may appear callous and unprofessional when an attorney reads the professional's notes aloud in court. Never alter records. "This is particularly true once litigation involving the records is anticipated" (Smith, 1996, p. 92). Of course, records can be corrected. Corrections, however, should be noted as such.

How long should records be retained? The American Psychological Association's Committee on Professional Practice and Standards (1993) states that

The psychologist is aware of relevant federal, state, and local laws and regulations governing record retention. Such laws and regulations supersede the requirements of these guidelines. In the absence of such laws and regulations, complete records are maintained for a minimum of 3 years after the last contact with the client. Records, or a summary, are then maintained for an additional 12 years before disposal. If the client is a minor, the record period is extended until 3 years after the ageof majority (p. 985).

Conclusion

Professionals can reduce the likelihood of being sued. The best way to avoid a lawsuit is to practice competently and compassionately. Smith (1996) suggests that professionals "promote an atmosphere of concern for patients and respect for their legal rights" (p. 91). Reaves (1998), an expert on risk management for mental health professionals, provides sound advice: (1) Be as open and honest as possible with patients regarding the parameters of the provider/patient relationship; (2) Set out your qualifications, area of practice, and expectations, including limitations on confidentiality and the fee for service arrangement, in writing and have patients sign the document; (3) Practice within areas of competence for which you can demonstrate you are competent; (4) Maintain competence in your areas of practice; (5) Maintain complete records; (6) Treat your patients with respect, the way you would expect your therapist to treat you; (7) Terminate treatment properly and in writing; (8) Know the laws that impact your practice; (9) Maintain an ongoing consultative relationship with other respected colleagues; and (10) When in doubt, seek competent advice (pp. 62-63).

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