

Wisconsin Public Psychiatry Network Teleconference (WPPNT)

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Documentation, Ethics, and Boundaries

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Disclosure

- Dr. Mays is not on any drug advisory boards, paid for doing drug research, or otherwise employed, funded, or consciously influenced by the pharmaceutical industry or any other corporate entity.
- No off label uses of medications will be discussed unless mentioned in the handout and by the presenter.
- No funny business.

3

Agenda

- Why document?
- The electronic medical record
- Confidentiality review
- Boundaries, ethics, and cyberspace

4

Why Document?

- To remember what's going on with our client
- To communicate with other caregivers
- To justify billing
- To defend your treatment in court
- For quality assurance review
- Establish a history for future treatment purposes

5

Documentation is not for:

- Therapy, which happens in person, during the sessions, using client friendly language, while you are focusing on how the client is responding what is happening, not typing on your computer.
- Communicating to the administration about systems issues that are making you unhappy.
- Communicating to other staff about things they should do or be aware of, instead of calling them. (This is usually true. There are exceptions.)
- Passing judgment on someone else's treatment decisions or performance

6

Documenting is not for:

- Saying everything you know
- Meeting your personal needs: venting, being clever, performing for an audience

7

The Electronic Health Record

- The electronic health record is a lifelong client record for current and future healthcare providers.
- It requires succinct, clear, jargon-free writing in order to facilitate communication with non-mental health providers.
- The EHR is less secure and more easily available to a range of people, including your client, than the old paper chart locked in your office.

8

The Electronic Health Record: 10 min. is the new 20 min. appt.

- A recent study of 100 visits by Northwestern and UW, looking at eye-gaze patterns
 - EHR visits, clinicians spent 31% of their time looking at the computer screen
 - Non-EHR, clinicians spent 9% of time looking at the chart
 - Patients always look where the clinician is looking
 - Especially in mental health contexts, clinicians may miss non-verbal communications.

9

Confidentiality in Wisconsin Law

- 51:30 is the section of Wisconsin's mental health law that assures confidentiality of providers of mental health care. (DHS 92 is Wisconsin's Administrative Code that operationalizes confidentiality.)
- This statute has been seen as providing an obstacle to integration of behavioral health with other health care specialties in various clinics. This becomes particularly evident with the electronic health record. Primary care providers in integrated health care clinics have lobbied strongly to change this law. The result is the HIPAA Harmonization Act.

10

Wisconsin Mental Health Coordination Bill (HIPAA Harmonization)

- Wisconsin Statute 146.816 provides that certain restrictions in 51.30 do not apply to use or disclosure of protected health information if the use or disclosure is in compliance with HIPAA and is for the purpose of treatment.
- (Federal law still prohibits sharing AODA information without a consent.)

11

HIPAA

- The Health Insurance Portability and Accountability Act was written in 1996 to apply to doctors, agencies, psychologists, nursing homes, etc. if they transmit any information in electronic form, like health insurance or billing information.
- It was an act designed to bring primary care into compliance with “privacy” standards – to keep non-healthcare professionals from getting access to private health care information, and to make it easier for healthcare workers to communicate.

12

HIPAA vs. Confidentiality

- “Confidentiality” standards (e.g. 51.30) allow clients to choose which health care provider gets to see their information. HIPAA says that any health care provider can share information for treatment purposes without a signed consent. You do not need to eliminate all risk of incidental disclosures.

13

HIPAA

- HIPAA does place limits on disclosure of sensitive information, including HIV status, genetic information, alcohol and substance use, psychotherapy notes, domestic violence, and sexual assault.
- There is a movement to change the federal rules requiring confidentiality of AODA treatment.

14

Psychotherapy Notes

- Psychotherapy notes are notes recorded by the health care provider that are separate from the medical record that are solely concerned with the therapy. “Psychotherapy Notes” do not include diagnosis, functional status, treatment plan, medications, prognosis, or other information contained in the medical record.
- Psychotherapy notes always require a release of information before they are shared.

15

Family Members

- A provider can discuss a client’s mental health condition with family members, if the client does not object. If the client objects, this information cannot be discussed. If the client is incapacitated, then the health care provider can act in the client’s best interest.
- Of course, in emergencies, providers can contact whomever they need to in order to assure safety.

16

Further...

- Nothing prohibits a family member from speaking with the provider, or the provider from listening
- It is believed by many experts in mental health law and communication that there is a general unwillingness to communicate, a “culture of silence” that is prevalent, even when a person with a mental health condition has signed an authorization to release information.

17

Law Enforcement

- HIPAA permits disclosure of certain health information (time of admission and discharge, e.g.) to law enforcement for the purposes of locating or identifying an individual for the police, or to avert a particular threat. The information needs to be relevant and specific.

18

The Electronic Health Record

- “In the old days” it was not unusual for medical professionals to use code words to denote sensitive information they might need to recall later (an patient’s affair, hx of STD), or for therapists to keep a “shadow chart” that would not be available for insurance review, or that might contain viewpoints that would interfere with the therapeutic alliance (“oedipal issues”).

19

The Bifurcated Chart

- Clinicians should think about having two records: the treatment record that will be shared in the electronic health record (demographics, assessment, diagnosis, treatment, treatment plan), and psychotherapy notes that will be private and can only be shared by consent of he client (what goes on in the session.)
- No electronic record seems to allow this.

20

Social Media Informed Consent

(Kolmes 2014, Zur 2014)

- At times, your provider(s) may seek information on the Internet about you for risk management or other clinical purposes. If this happens, you will be told about any Internet searches and have an opportunity to correct any incorrect information.
- We don't accept Facebook requests from clients. Please don't contact us via any social network sites.
- Please don't text or take messages during our sessions.
- We can use e-mail/texting to communicate with you about administrative details, such as prescription refills, appointment times, and cancellations, but we cannot do therapy. E-mail is not secure or confidential.

21

What About E-mail or Texting?

- What is your clinic policy?
- All policies should require that clients be informed of the risks involved in Internet communication. HIPAA requires that you take reasonable precautions to keep information confidential.
- E-mail, of course, is not to be used for emergencies.

22

E-mail Policies

- E-mails should be answered within 2-3 days.
- Auto-reply should be used when the clinician is unavailable for longer than that.
- E-mails shouldn't be forwarded to third parties without consent.

23

What is the Purpose of E-mail?

- It is best used for administrative concerns: prescription refills, appointment changes, etc.
- These types of e-mails don't need to be saved, just as we don't save phone messages about appointments, etc.
- If you are doing "therapy" via e-mail, that is a different story. Here the lack of confidentiality and lack of "in person" observation of the client create serious concerns.

24

When is E-mail Therapy?

- Clients writing asking for advice in an unfolding social situation.
- Clients “journaling” about feelings.
- Suicide threats
- Provider sending behavioral prompts, or coaching in “real time”
- Clients reflecting about insights of behavior. Provider offering suggestions.

25

Boundary Issue

- If you give a client your e-mail address, there is an assumption that this address is available for use, 24 hours a day. Is this what you want? Is this good for client autonomy? Do you really want to *read* all this?
- Many therapists have been surprised by the anger in their clients when the therapist has not answered their e-mail immediately.

26

E-mail

- If e-mail is being used for treatment, then the following must be dealt with administratively:
 - How will you be billing for the time?
 - Expectation for your response time
 - Permanent storage of all e-mails is required
 - Higher degree of confidentiality
 - Limitations on what can be written about and in what kind of language. This is a permanent electronic health record, accessible to others.
 - Boundary issues – what is therapy and what is not

27

E-mail Consultation: Cut and Paste

- Frequently, consultation about therapy happens informally (common clients in families, clients well-known in different departments, catching the psychiatrist in the hall, etc.) These informal consults are rarely documented and often involve “thinking out loud.” Now we often use e-mail for the same purposes.
- If it is your intention to cut and paste the answers to these consultations in the client’s chart, the person being consulted needs to know this. This is not “thinking out loud.”

28

Cut and Paste

- Like verbal communication, e-mails are usually a combination of administrative details, feelings, and clutter. Cutting and pasting e-mails means that you will be including a lot of superfluous information. Do you want that in the chart?
- Be thinking about the difference between medical record information, psychotherapy notes, and chit-chat.

29

E-mail: Summary

- Clearly define whether e-mail is for administrative purposes or for therapy.
- Follow appropriate security and storage guidelines depending on the purpose of the e-mail.
- Consider how having 24 hour/day e-mail contact might affect how the client views you.
- Don't "think out loud" via e-mail.

30

Duty to Protect - Background

- Tarasoff I (1974)
 - “In this risk infested society, we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal...”
- Tarasoff II (1976)
 - “When a therapist determines that his patient presents a serious danger to another, he incurs an obligation to use reasonable care and protect the intended victim...”

31

Wisconsin Case Law

- Schuster v. Altenberg (1990)
 - Edith Schuster, bipolar, killed herself and paralyzed her daughter in an auto accident after leaving her appointment with Dr. Altenberg.
 - The Supreme Court of Wisconsin found that if the therapist anticipated, or should have anticipated that the client could harm a third party, known or unknown, the therapist can be held liable for damages if his care was negligent.
 - This is the broadest Tarasoff interpretation possible, and probably includes suicide as well.

32

Wisconsin Case Law

- Schuster v. Altenberg (1990)
 - It is the responsibility of the therapist to weigh the competing interests of confidentiality and protection of the public.
- State of Wisconsin v. Curtis Agacki (1999)
 - Therapist David Baldrige of Milwaukee was found to have acted properly in turning in his client for carrying a gun, upholding the Wisconsin “Tarasoff” duty.

33

Duty to CCAP?

- We assume that a careful risk assessment involves doing a skillful interview with the client, reviewing old records, interviewing significant others if applicable.
- In the future, courts may expect that you have done a Google search or checked Wisconsin Circuit Court Access (CCAP).

34

Boundaries

- All of our relationships have boundaries: work, family, friendships, healthcare, etc.
- The boundary is the frame that defines the nature of the relationship and what is expected and appropriate.
- Learning our cultural boundaries is an important part of growing up, and these boundaries have changed enormously in the last 25 years: Dr. Phil, Oprah, Facebook, etc.

35

Today

- The therapist/patient boundary has also changed enormously in the last 100 years. For various reasons, therapists have evolved into providers and patients have evolved into consumers. As consumers, people in mental health treatment are more likely to feel entitled to know personal details about their provider than “patients” used to.

36

The Therapeutic Frame

- Traditionally, therapy took place in a setting where the therapist was “impenetrable” to the patient. All the drama that took place in the room was caused by the patient’s “transference.” The transference was the substance of the therapy.
- Therefore, the boundary of treatment (the therapeutic frame) meant no physical contact, no contact outside of the office, no self-disclosure, no personal communications – anything that would contaminate the transference.

37

Changing Therapies

- As new psychotherapies evolved; the therapeutic frame was modified. Humanistic therapies valued therapist self-disclosure as a way of supporting people in emotional pain. Group therapies required group leaders to be participants. Cognitive behavioral therapists took clients into the community for exposure therapy. Assertive community programs expected case workers to assist clients with grocery shopping and other activities of daily living.

38

Today

- All professional ethics codes recognize that appropriate professional boundaries depend on the context of the therapy (ACT, office-based, prison), the type of therapy (faith-based, primal, CBT), the characteristics of the client (e.g. age, sexual abuse survivor, grieving), the quality of the therapeutic relationship (duration, intensity, dual relationship.)

39

A New Sense of Privacy

- The Internet has totally changed our personal sense of privacy, entitlement to information about people we know, and probably the very boundaries of what we think of as our “self.”
- For “digital natives”, there has been no transition. For “digital immigrants”, there is usually considerable difficulty grasping what has happened.
- Digital natives may also have a different view of “need to know” related to HIPAA.

40

What's OK?

- The following used to not be OK:
 - Looking through records to find out how much money your supervisor makes
 - Following your old girlfriend to see who she's dating now
 - Telling 50 friends and acquaintances all about your colonoscopy
 - Publicly showing a picture of your passed-out roommate after the party Saturday night

41

The Internet

- All these things that would have seemed creepy in person a few years ago, now seem OK on the Internet.
- Our stalking laws would have prohibited following an old lover around town. On the Internet, "stalking" can be done anonymously. There is no victim.
- Also, there is a feeling that if you are "connected" you are fair game.

42

Our New Sense of Privacy

- Since we now expect, and accept, that we will be searched for online by prospective employers, loan officers, old lovers, former classmates, clinical supervisors and residency programs, and criminals trying to exploit us, is there a new boundary for therapy: a new therapeutic frame?

43

Consumers

- We should expect that all of our clients will “google” us if they have the capability. Many will go beyond that to looking through social networking sites, use various search engines, pay for online firms to conduct both legal and illegal searches. Clients will know where we live, who our family members are, and if we have ever had any legal difficulties.
- You need to be aware of what you are putting online, and what others may be saying about you online. Everything will be online forever.

44

Should We Google Our Clients?

- Internet searches for forensic evaluations have become common practice.
- A recent survey (Kolmes 2014) of 227 mental health professionals found:
 - 48% intentionally found information online about current clients in a noncrisis situation. 81% of these were seeking general information.
 - 28% found information unintentionally
 - 8% searched for information about client safety in a crisis. 53% of these said the search was helpful.

45

Trust Your Feelings?

- In the same study:
 - 90% believed that discovering client information had no significant effect on their role as a provider
 - 22% did not consider it a boundary crossing at all
 - 61% considered it a “slight” boundary crossing
 - 17% considered it a significant boundary crossing
 - Slightly less than half (48%) told their clients what they had done

46

Remember Our Guiding Principles

- Beneficence
- Nonmaleficence
- Autonomy
- Justice
- Trust
- Confidentiality
- Right to privacy
- Informed consent
- The duty to protect

47

Gathering Data: Emergencies

- There are different norms about privacy depending on whether or not there is an emergency.
- In emergencies, the courts have not placed any limits on how information can be gathered. You may call significant others, roommates, search online, call the police, visit a residence. In fact, it is possible that the court may ask why you didn't do such a search if the emergency called for it.
- However, keep in mind that the data found may be inaccurate.

48

Non-Emergencies

- It is reasonable to suppose that most clients would feel surprised and frightened if they discovered their therapist was following them around spying on them. They might not feel that way about being searched for online, depending on their sense of privacy. But they might.
- The best approach in the context of therapy would be to either ask consent or simply inform clients that you may search out information about them.

49

Informed Consent

- Validates client autonomy: clients can consent or not consent, or decline treatment with a therapist that searches for online information
- Establishes trust: there is no hidden activity
- Respects the right to privacy
- If the cybercontact is accidental, the clinician can consider whether or not to disclose the encounter, depending on the circumstances (as in real life.)

50

Clinically Justified?

- Client asks you to see her website.
- You hear about a self-destructive Facebook posting.
- You need to get in touch with the client and do not have an address.
- Your client's story of accomplishments seem delusional.
- You wonder if your client is litigious.

51

Clinically Justified?

- Your client says her partner has full custody of the children, but is very vague when you ask why.
- You need more information about a custody battle that your client is engaged in and that you may need to testify in.
- Curious about what their house looks like, or boyfriend, or workplace, or parents, etc...

52

Where Are You?

- It would matter to me if my therapist was searching the Internet at work with my chart, versus at home, lounging in the living room in front of the TV.
- Stay professional. Restrict your Internet searches for work to the workplace.

53

Summary

- The purpose of documentation is to provide a record of treatment for the provider, the client, all other professionals who have a need for the information, billing services, quality assurance, and the court, if necessary.
- The Electronic Health Record assures that records will be easily accessed by a number of users, and that the record will be permanent.

54

Summary

- The EHR requires that notes be succinct and jargon free so that other professionals can easily access the information.
- Accessing the EHR during sessions generally reduces face-to-face communication with clients.
- With the EHR shared record, it is even more important that the clinician use the chart only for professional commentary, not other purposes.

55

Summary

- Informed consent during the intake process is a good time to clarify issues around e-mail and Internet searching and contact.
- E-mail that is used for therapy requires greater precautions for confidentiality and more permanent storage than e-mail for administrative purposes.

56

Summary

- Although searching for someone online feels different than following someone in person, some ethical restraints are analogous.
- Much of this boundary uncertainty is resolved by having an informed consent discussion with the client.

57

If it's not true, don't say it.
If it's not right, don't do it,

Marcus Aurelius
121-180 AD

58