Developing autonomy and individuation from one's parents is particularly critical in adolescence (Erikson 1968). Confidentiality brings these tensions to the forefront: Tebb (2011) notes the important role that clinicians can play both in helping young people in the transition to adulthood, encouraging them to take greater responsibility for making decisions about their own health, and in supporting parents accept the increasing independence of their children. Applewhite & Joseph (1994) observe that maintaining confidentiality indicates to both the young person and their parents that the child has a right to privacy and is capable of independent thought: 'this value fosters the development of the separation and individuation needed for growth and development'.

Not all societies share autonomy as a fundamental right. Some cultures have a more collectivist orientation, where family elders bear more influence on an individual's decision-making (G Durà-Vilà, personal communication, 2015). Applewhite & Joseph meanwhile argue for a hierarchy of principles: safety and security, then autonomy, then parental autonomy and privacy (Applewhite 1994).

Finally, clinicians must always be mindful of their own ethical values, built up from their experiences and their cultural background (Applewhite 1994). Ethical judgements are significantly subjective processes, and such biases could influence us. We must reflect on our own ethical stance when making decisions that impact so heavily on others.

Legal and regulatory frameworks

Various legal frameworks attempt to apply such ethical principles. The United Nations Convention on the Rights of the Child (UNCRC) states that children have the right to express their views freely in all matters affecting them, in accordance with their age and maturity (Article 12). The UNCRC stipulates that, for any action relating to a child, their best interests must be considered. However, who decides what is in their best interests – the child, their parents or the State – is perhaps ambiguous, as is what happens when rights to autonomy conflict with rights to protection (Iltis 2010).

In England and Wales, the Human Rights Act 1998 incorporates the European Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, ECHR), Article 8(1) of which specifies that everyone has the right to a private and family life. Preserving confidentiality respects the young person's right to a private life. In contrast, sharing information with parents respects the parental right to a family life, so that they can fulfil their responsibilities as parents. Article 8(1) could therefore be applied either way in a confidentiality dilemma, although many would generally prioritise a child's right to privacy over parental rights to know information about their child (Applewhite 1994). However, Article 8(2) defines situations which may supersede Article 8(1), such as to prevent crime or protect a person's health and welfare.

Most legislation relating to confidentiality arises from common law (i.e. case law that becomes accepted as legal). The common law duty of confidentiality mandates that information shared between a client and a professional (such as in the patient–doctor relationship) is generally confidential. However, both common law and Article 8(2) of the ECHR indicate that this duty is not absolute and disclosure can be justified when there is overriding 'public interest' (Robshaw 2004).

When it comes to children who do not have the maturity or understanding to make a decision, confidentiality can be breached if this is deemed to be in their best interests, reflecting the UNCRC. Meanwhile the Family Law Reform Act 1969 mandates that 16- to 17-year-olds can consent to medical treatment. For under-16-year-olds, case law on consent generally derives from *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] (subsequently referred to as *Gillick*), where the House of Lords judged that children could consent so long as they had sufficient 'competency' (Table 1). These legal frameworks,

TABLE 1 Key examples of case law relating to children's rights to confidentiality

Case	Claim	Outcome
Gillick[a]	A mother requested that her local health authority not provide family planning services to her daughters, who were under 16 years old, without her consent.	The mother's claim was rejected. The House of Lords determined that the health authority could give treatment to under-16-year-olds if they were deemed competent to make the treatment decision. Competence is deemed if the child has 'sufficient understanding and intelligence to enable him or her to understand fully what is proposed', which encompasses the ability to weigh the benefits and risks of medical treatment, and to manage any family and peer pressure. It is generally assumed that an obligation of confidence is owed to competent children.
Axon[b]	A mother claimed that it would not be in the bests interests of an under-16-year-old to receive an abortion without a parent's knowledge, as this would deprive the girl of the essential support and aftercare that a parent would provide.	The mother's claim was rejected. This confirms that an obligation of confidence is owed to competent children, as underpinned by Article 8 of the European Convention on Human Rights.

a. *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.
b. *R (Axon) v Secretary of State for Health* [2006] EWCA 37.

ever, constitutes one of the most common breaches of the law and ethical standards. This may be because reporting abuse can disrupt not only the therapeutic relationship but also disrupt and irrevocably destabilize the family in which the abuse occurs. In cases of child abuse, counselors may be called on to make ethical decisions that may once again put them at odds with the law. When dealing with such difficult decisions, it is important to confer with professional colleagues and to gain expert legal advice.

PROTECTION FOR COUNSELORS WORKING WITH MINORS

Working with minors can present a field of legal and "ethical landmines" that can, with a careless step in any direction, result in legal and professional problems. Legal action may be taken against the counselor by the parent or guardian for withholding information or by the minor for disclosing information. Careful counselors will step cautiously and judiciously when traversing this terrain. The following suggestions may be helpful to those who work with minors and their families.

1. Practice within the limits of your abilities as defined by education, training, and supervised practice.
2. Be thoroughly familiar with state statutes regarding privilege. Privileged communication (a legal form of confidentiality) cannot be assumed unless the state specifically allows for it (Hendrix, 1991).
3. Clarify your policies concerning confidentiality with both the child and parents at the initiation of the therapeutic relationship and ask for their cooperation. Provide a written statement of these policies that everyone signs.
4. If you choose to work with a minor without the parent's informed consent, minimally ask the minor to provide informed assent in writing (Hendrix, 1991). In addition, be aware of the potential legal risks of doing this.
5. Keep accurate and objective records of all interactions and counseling sessions.
6. Maintain adequate professional liability coverage. Keep in mind that "adequate" should not be equated with "minimum" coverage.
7. When in need of help or when uncertain how to proceed, confer with colleagues and have professional legal help available (Koocher & Keith-Spiegel, 1990).

Even doing all of the above cannot eliminate the risks involved in working with minors, but it can reduce them considerably.

SUMMARY

In reviewing the legal and ethical issues related to treating children, it might prove helpful to view the area of children's rights as an unfolding drama. As children and their advocates struggle to procure legislation and rulings to ensure protection and dignity for this vulnerable population, counselors can have an important impact. Counselors and other mental health practitioners have a responsibility to serve the best interests of their clients. How can we best do this? Is it by lobbying to set children free from parental constraints, thus granting them equal rights with adults (Jost, 1993)? Or is the goal to judiciously allocate enough legal power to minors to enable them to protect themselves from adult abuse while withholding enough legal power so that they are protected from themselves?

Whatever the goal, achieving it will be neither easy nor simple. The goal will be reached only if counselors and other mental health practitioners (the fairy godmothers to these potential Cinderellas) work together to assess children's needs, implement programs, and support the passage of legislation that fulfills the needs of all—society, parents, and children.

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"Replacing 'Who is the Client?' With a Different Ethical Question"

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Abstract

The familiar question, "Who is the client?" has become a distraction from more important ethical questions. By requiring a singular answer, the question obscures the fact that psychologists have ethical obligations toward every party in a case, no matter how many, or how named. Making the question plural is not a sufficient solution, because identifying the "client(s)" should not be treated as an end in itself; it is simply a means toward clarifying the nature of the relationship(s) and understanding the accompanying ethical obligations. After exploring the underlying implications for informed consent, confidentiality, and other ethical duties, the author suggests that psychologists adopt an alternative ethical question, "What are my ethical responsibilities to each of the parties in this case?" Finally, a case example illustrates the fact that the old question has several different meanings (and therefore different answers), depending upon whether it is asked as an ethical, clinical, legal, or reimbursement question. The proposed new question avoids such confusion because it is easily identifiable as an ethical question, and its meaning is clear.

KEYWORDS: ethics; informed consent; clients; obligations; ethical decision making

Text of Article

"Who is the client?" The question invites a singular answer. Yet in the very circumstances when the question is most relevant, the need for clarification arises precisely because there may be more than one client.

The question actually appears in this form only once in the American Psychological Association (APA) Ethics Code (2002) : Ethical Standard 3.07 (Third Party Requests for Services) poses the question in the singular. Two other Ethical Standards (3.11, Psychological Services Delivered To or Through Organizations; and 10.02, Therapy Involving Couples or Families) imply a plural answer. But the question, "Who is the client?" has become so familiar that psychologists tend to ask it across a range of cases.

The problem is that the question, "Who is the client?" encourages psychologists to name one person or entity as *the* client, even though they may have relationships with several different clients, perhaps several different types of clients, in a single case.

> "The notion of a singular client has gotten us into a real bind. It has become an impediment to thinking in a careful and nuanced manner about our ethical obligations, which even in our binary approach extend beyond 'the' client" (S. Behnke, personal communication, August 3, 2007).

In other words, the question obscures the fact that psychologists have ethical obligations to all parties in every case, regardless of the number or the nature of the relationships.

Nevertheless, some casebooks that explicate the APA Ethics Code recommend that psychologists identify a single person or entity as *the* client. For example, regarding Ethical Standard 3.07, Nagy (2005) phrases the question as "Who, exactly, will be the client or recipient of your services?" (p. 84), suggesting that there is only one. C. B. Fisher (2003) similarly states that this Ethical Standard requires "identifying

whether the third party or the individual receiving the services is the client" (p. 73), again suggesting that psychologists should specify only one individual or entity as *the* client.

This single-client recommendation sometimes appears even when the Ethical Standard itself implies the plural. For example, in therapy cases involving multiple clients who are related to each other, Ethical Standard 10.02 requires psychologists to ask : "Which of the individuals are patients or clients?" Nagy (2005) nevertheless suggests that psychologists must make clear "which person is actually your client or patient" (p. 297), implying a single answer. C. B. Fisher (2003) first uses a plural subject with a singular verb : "[P]sychologists must identify and explain which members of the couple or family is (sic) the primary client/patient" (p. 219). But the singular is emphasized by the suggestion that psychologists may identify as the client or patient either the multiperson unit or a single individual; and there is no mention of the possibility that several individuals might be considered clients.

In contrast, Knapp and VandeCreek (2003), when discussing therapy with couples and families, do not mention identifying the client(s). Instead, their first recommendation is that psychologists "clarify their roles and their relationships with all parties" (p. 148). Similarly, Pope and Vasquez (2007) focus not on client identification, but on ensuring that "informed consent and informed refusal is provided for each person" (p. 146). When Koocher and Keith-Spiegel (2008) discuss the question, "Who is the client?" in the context of challenging work settings, they provide a broad answer : "[T]he professional has an obligation to clarify the nature of the ethical duties due each party, to inform all concerned about the ethical constraints, if any, and to take any steps necessary to ensure appropriate respect for the rights of the person at the bottom of the client hierarchy" (p. 486).

Such clarification is considered so ethically important that the APA Ethics Code (2002) references the initial informed consent conversation in a dozen separate Ethical Standards (M. A. Fisher, 2007). The content of this conversation will necessarily vary, depending on the context and the nature of the prospective relationship; but it would be a mistake to presume that the psychologist needed to provide clarifying information to (or obtain consent from) only one party (i.e., a single "client") whether about the limits of confidentiality, or about other important aspects of the psychologist's policies. (See Table 1.)

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Table 1

Ethical Responsibilities in Clarifying Client Relationships During Initial Informed Consent Interview

Ethical standard	Ethical mandate: Identify client(s) implies		Ethical mandate: Clarify nature of relationships; nature of services, role(s); fees; third party involvement; intended recipients of services; probable uses of information; limits of confidentiality, etc.
	Singular Answer	Plural Answer	
3.07 (Third party requests for services)	x		x
3.11 (Services to/through organizations)		x	x
9.03 (Informed consent to assessments)			x
10.01 (Informed consent to therapy)			x
10.02 (Therapy with couples or families)		x	x

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Third Party Requests

In cases involving third party requests for services, it can be very misleading to name only one party as *the* client. These cases often have at least two different types of client : the individual or entity contracting for services, and the individual receiving the services. For example, a forensic psychologist may have both a contracted relationship with a court to provide a court-ordered assessment, and a clinical relationship with one or more individuals who receive the contracted services. Haas and Malouf (2005), in discussing the potential loyalty conflict in such cases, suggest that, "it might reasonably be argued that the 'patient' is the court, at least as much as is the individual sitting in the consulting room" (p. 64). Describing the court as the "patient" in a forensic case seems very awkward; but it would certainly be appropriate to describe the court as a "client" – in this case, the "contracted client."

In such a case, however, forensic psychologists are being trained to identify the court as *the* client. This has not always been the case. In the current forensic guidelines (APA Division 41, 1991), the word "client" is used only to refer to the examinee. However, in t he proposed new Guidelines for Forensic Psychologists (APA Division 41, 2008), the definition of "client" is limited to mean only "the attorney, law firm, court, agency, entity, party, or other person *who has retained, and who has a contractual relationship with* , the forensic practitioner to provide services" (p. 20) [*emphasis added*]. Throughout the document, the word "client" carries only this meaning, with the person receiving the assessment services described instead as the "examinee" (p. 20).

But ethically speaking, the person receiving the contracted services is certainly *also* a "client" in such cases, holding the rights (and deserving the protections) of any client receiving assessment services. Thus, although the confidentiality of the information obtained from forensic examinees may be limited (or even removed) by the third party contract or court order, this does not mean they have no rights at all about confidentiality. On the contrary, they have the right to be informed in advance about the potential limits (or complete absence) of confidentiality, about the foreseeable uses of the information that will be obtained from the assessment, and about their right to consent or refuse to participate. The ethical obligation to conduct this conversation with all assessment clients arises from Ethical Standards 3.10c, Informed Consent; 4.02, Discussing the Limits of Confidentiality; and 9.03, Informed Consent to Assessments. In the context of forensic cases, this ethical duty becomes doubly important, because the examinee's legal and civil rights can be left unprotected if this information is not provided.

It thus seems most accurate to think of these two entities – the court and the examinee – as two different types or levels of "client." All clients have rights. In this example, the court may have established (through its contract or in its order) the right to receive the results of a timely evaluation in the form of accurate report (or, for court-ordered therapy, a description of services rendered, a treatment summary or compliance report, etc.). The person receiving the contracted assessment services has the right to receive a competent evaluation, as well as the right to be informed in advance about the psychologist's prior relationship with the court and any limits of confidentiality that will be imposed by that contract. Regardless of whether a court or some other third party contracts for the services, naming only one entity as *the* client obscures the fact that the psychologist has important ethical obligations to both.

Koocher (2007) concurs that "(b)oth the entity requesting the service and the person undergoing evaluation hold a kind of client status in such cases" (p. 380). He includes such client-identification issues among the ethical challenges facing twenty-first century psychologists; but that does not mean this issue is new. It was addressed as long ago as 1980, when Monahan made "Who Is The Client?" the title of a classic monograph about dilemmas faced by psychologists in the criminal justice system. " What psychology appears to lack at the present time is an effective way to differentiate obligations owed to organizational as opposed to individual clients . . . " (Monahan, 1980, p. 2). Noting the potential conflict between the interests of the referring entity and the interests of the individual receiving services, this report's first recommendation was that psychologists inform *all* parties of the circumstances that might affect confidentiality. The implications of this recommendation would apply in any third party referral, whether the third party is a court, an agency or organization, an attorney, or another individual. (See also Services To or Through Organizations, below.)

Cases Involving Family Members

Matters become more complicated if the third party requesting the services is a family member of the person receiving the services. For example, psychologists who provide individual therapy to children usually do so at the request of some third party, most often the child's parents. If we think of this only as a third-party request, the "single client" rule in Ethical Standard 3.07 would seem to apply. But although it is appropriate to identify the child as the *therapy client* , it is important to remember that the psychologist incurs ethical responsibilities toward the parents as well. When he meets with them, they are not therapy clients; so what are they? The APA Insurance Trust (APAIT, 2006) suggests that they be considered *collaterals* to the child's therapy. If parents are seen separately, they might be called *parent consultation*

clients , in addition to being considered third party referral agents and/or collaterals. But what if child and parents are sometimes seen together? If this makes everyone *family therapy clients,* will Ethical Standard 10.02 apply? If so, that Standard suggests the possibility of plural clients. But a family – systems therapist may argue that often the family unit should be considered *the* client even if the family members are seen separately. What is obscured by this confusing client-identification process is the fact that psychologists have ethical responsibilities to all these family members, regardless of what they are called or how the case is structured.

Cases involving related individuals are also complicated when clinical services to the family are requested by an agency or ordered by a court. As in the third party referrals described above, what is ethically important is that *each party* has a right to receive, in advance, an explanation of the psychologist's role, a clarification of the nature of the relationship; an explanation of rights; a discussion of probable uses of the services provided and the information obtained, and an explanation of limits of confidentiality, including how each party's confidentiality may be affected by the third party's involvement. (See Ethical Standards 3.07 and 10.02.)

In all cases involving family members, Pope and Vasquez (2007) stress the importance of providing everyone with clear answers to such clinically important questions as, "Will the therapist hold confidential from one family member material disclosed by another family member?" (p. 146). Knapp and Vandecreek (2006) similarly note the importance of discussing with everyone "the role of secrets" and the "rules for confidentiality with minors" (p. 105). Therapists disagree about such matters, so their confidentiality rules in couple and family cases can vary greatly; and this means that each psychologist is the only source of accurate information about exactly what the policies will be. This poses no ethical problem as long as psychologists "clarify their policy at the outset of therapy" (Knapp & Vandecreek, 2006, p. 117). However, failure to provide adequate explanations to all parties in advance is one of the common confidentiality pitfalls in therapies with couples and families (Weeks, Odell, & Methven, 2005).

This initial clarification is especially important in cases where the relationship will not be the same with all parties. Clinically speaking, all the members of the family may be therapy clients; but ethically speaking, this does not necessarily mean that they all have exactly the same rights. For example, a minor's confidentiality rights are not usually the same as those of the parent(s). Some difference in rights will likely arise voluntarily (as when psychologists have differential disclosure policies in order to protect the safety of minors or impaired family members); but other differences in rights can be imposed by law.

Legally speaking, minors' rights vary from state to state. Some states allow minors to seek outpatient mental health treatment without parental consent, many states legally allow parents to have access to the treatment records of their minor child, and some states allow both. This means that the psychologist must be very familiar not only with the minor's legal rights, but also with the parents' legal rights, whether or not the parents are to be considered therapy clients. Further complicating matters is the fact that the federal HIPAA regulations interact in complicated ways with these state laws, leading to differing privacy rights for minors across state jurisdictions. The APA Legal and Regulatory Affairs Staff (2005) has provided a helpful discussion of these legal complications.

Regardless of the legal specifics, the initial informed consent discussion can require significant preparation in any case involving minors. In advance, psychologists must determine their own preferences about what information they will voluntarily disclose to parents, and when; must learn how their policies will be affected by state laws, including abuse reporting laws; must clarify the HIPAA implications (if applicable); then must develop very clear policies consistent with those legal constraints. Only with such planning will the psychologist be prepared to fulfill the ethical obligation to describe, *in advance* , to both the parent(s) and the minor(s), exactly when confidentiality will apply and when information will be disclosed (M. A. Fisher, 2002).

For documenting this conversation in adolescent therapy cases, Kraft (2005) has provided a sample informed consent form to be signed by both the adolescent and the parents. As with all such forms, however, it must be adapted to match the policies in the setting; details will differ from therapist to therapist, depending on the combination of legally-imposed and voluntarily-imposed exceptions to confidentiality. With younger minors, or with other family members legally incapable of giving informed consent, psychologists are ethically responsible for providing an age-appropriate explanation, seeking their assent to participate, considering their preferences and best interests, and obtaining formal consent from the parent(s) or guardian(s). (See Ethical Standard 3.10, Informed Consent.)

Clearly, settling for a single answer to "Who is the client?" in such cases would not only have ethical and legal ramifications, but could create unnecessary clinical complications. Family members who were not adequately informed in advance will have every reason to feel betrayed if information about them is later disclosed unexpectedly to other family members, or to third parties. Failing to address the important issues with *all* parties; making incompatible promises to different family members; and/or failing to encourage questions and provide honest answers — such ethical mis-steps at the beginning can deprive everyone of the opportunity to make an informed decision about whether to participate.

Services To or Through Organizations.

In cases involving organizations, the Ethics Code suggests a plural answer to the "Who is the client?" question. But Ethical Standard 3.11 (Psychological Services Delivered To or Through Organizations) is somewhat confusing in two respects. First, it applies to two very different types of circumstances (e.g., a psychologist providing consultation services *to* an organization, and a psychologist providing services *through* an organization that employs or contracts with him/her). Second, the wording makes it difficult to be sure who is considered "client" in either of these circumstances : "Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about . . . which of the individuals are clients" (APA, 2002, p. 1066). This Standard leaves some important questions unanswered : First, are the clients of the first phrase the same as those of the second? If not, what is the relationship between the two? Second, are "those directly affected by the services" not also considered "clients"? If not, what are they? Will the answers vary depending on the circumstance, or the psychologist's role?

Psychologists who provide services *to* organizations may encounter complications similar to those in third party referral cases. For example, a psychologist might have a contract with a corporation, specifying a plan for providing leadership consultation to the CEO, in addition to case consultation to several of his managers who have problematic relationships with their supervisees. The psychologist might meet with the CEO, with the managers, with their supervisees, and perhaps with other employees. Asking "Who is the client?" may lead to the simple answer : "The corporation is my client, because it issued the contract and pays my fee." But this answer provides the psychologist with no guidance about specific ethical responsibilities in the complex relationships that will be developed with individuals within this corporate system. What are their individual rights? How do they differ? What will happen to the information confided to the psychologist by the CEO? by the managers? by their supervised employees? It will probably not be appropriate for the psychologist to promise the same level of confidentiality in each of these relationships; so the limits of the confidentiality will need to be defined in advance, explained at the initial informed – consent interview with the CEO, and made clear to each individual at each level of the consultation process. None of this will be adequately clarified in the mind of the consulting psychologist who relies on the "Who is the client?" question and settles for its single answer.

In organizational consulting relationships, a singular answer is usually presumed (Kramer, Kleindorfer, & Colarelli, 1992), even though "there are no specific guidelines for determining who the client is or should be in complex consulting situations" (Kramer, Kleindorfer, & Colarelli-Beatty, 1994, p. 12). As a result, psychologists who consult to organizations or agencies give very differing answers to the "Who is the client?" question when faced with sample case scenarios. The wide-ranging rationales for their choice of "most important client" include "who holds organizational authority, who is responsible to solve the problem, who will be impacted by the solution, and who is the initial contact person" (p. 11).

Psychologists who provide services *through* organizations may encounter conflicting loyalties when the interests of their employing (or contracting) organization conflict with the interests of the party receiving the services. In this regard, no circumstances are more complex than those faced by psychologists who work within the school setting, with differing ethical responsibilities to their employer, to the students who receive their services, to the teachers who elicit their consultation, and to staff colleagues who are members of their team. No single-answer question would adequately clarify the potential conflicts of interest or the complicated confidentiality rules that must be established and explained among those relationships.

Less discussed are the potentially conflicting loyalties psychologists face when they sign legally-binding managed care contracts or other reimbursement agreements, under which they become contracted providers for third party payer organizations. Legally speaking, this may not be considered the same as providing services *through* those organizations; but ethically speaking, similar issues are involved. Such contracts bind the psychologist to operate within the organization's guidelines, thus creating the ethical requirement that they inform persons receiving services about the implications of the prior organizational relationship. For providers of clinical services, this ethical duty might arise from several different APA Ethical Standards. Under Ethical Standard 3.06 (Conflict of Interest), psychologists must consider whether their contract with the reimbursement organization would create a potential conflict of interest (e.g., if it offers an incentive for the psychologist to limit services). Under Ethical Standard 3.11 (Psychological Services Delivered to or Through Organizations), therapy clients have the right to be informed about "the relationship the psychologist will have with each person and the organization" (APA, 2002, p. 1066). And under Standard 4.05 (Disclosures), clients have the right to give (or to refuse to give) consent for information to be disclosed to the contracted third party for obtaining reimbursement.

When asked as a reimbursement question, "Who is the client?" ordinarily requires a singular answer, to meet third party payer requirements; and that answer may be different from the answer obtained when the question is asked from a clinical, legal, or ethical perspective. (See case example, below.) Ethically, what is important to remember is that, for the person who is to be billed as "the client," the psychologist is the only

possible source of information about what will be sent to the third party payer. For disclosures to reimbursement organizations, the informed consent process therefore requires (a) designating the person under whose name the services will be billed; (b) informing that person about the nature of the information to be disclosed and the potential implications of disclosing it, and then (c) seeking explicit consent to make the disclosure. Once fully informed, the person can make a voluntary decision about whether to give consent for the planned disclosure, or whether instead to give informed refusal. It is impossible at intake to predict the content of future disclosures, but the client's rights can be protected by renewing the informed consent discussion at the time of the disclosure (M. A. Fisher, 2008). In fact, Acuff, Bennett, Bricklin et al. (1999) suggested that it should be the "usual rule of thumb" to discuss each treatment plan at the time of transmission with the client in whose name it is being sent (p. 570).

New Ethical Question?

Obviously, to ask, "Who is the client?" is not helpful enough in these case examples. In fact, seeking a singular answer can create more problems than it solves. But making the question plural does not solve the problem. Whether singular or plural, the question obscures the fact that *identifying* the client(s) is only a beginning, not an end in itself. It is simply a means to the important end of clarifying the psychologist's ethical responsibilities.

If we stopped asking "Who is the client?" what should we ask instead? Regardless of the type of case or the number of relationships it involves, the question psychologists should ask might be " *Exactly what are my ethical responsibilities to each of the parties in this case?"*

This new question reminds psychologists that they are responsible for protecting the rights of everyone involved – those who request services; those who receive services; those who participate as collaterals in the services provided to others; "outsiders" who provide information; others to whom information is disclosed, etc. This is consistent with the ethical duty to clarify the *nature* of relationships, regardless of what they are called; to conduct an informed consent conversation that describes the psychologist's role; and to explain the resulting limitations on confidentiality as they will apply to each party (see Table 1).

This new question is consistent with the fact that psychologists have an ethical obligation to clarify such things with *all* involved parties, not just with the party requesting or receiving the psychological services. With third party referrals, it is a reminder that psychologists have an ethical obligation to provide, *in advance* (preferably in a written contract), clarification of the nature of all the proposed relationships, as well as a description of what (if any) information will be provided to the referring third party about the services received. Similarly, in cases involving "collaterals" (whether family members or others), it is a reminder of the obligation to inform them that their relationship (and their rights) will not be the same as those of the person(s) receiving the therapy or assessment (APAIT, n.d.). In any type of case, this new question would help psychologists prepare to discuss with each party exactly how confidentiality will apply (or not apply) in the relationship, making it possible to obtain truly informed consent for their participation (M. A. Fisher, 2008).

This new question does not imply that psychologists should abandon the term "client" altogether. It does require, however, that psychologists identify the *type* of client, as a means toward understanding their differential ethical responsibilities. This becomes especially important for psychologists who provide therapy services. In its section on therapy relationships, the APA Ethics Code (2002) uses the terms "client" and "patient" interchangeably; but regardless of what they are to be called, persons in therapy relationships are deemed more vulnerable, and are therefore given special rights and safeguards. Thus, psychologists in therapy relationships have ethical duties beyond those described above, including responsibility for explaining potential risks (Ethical Standard 10.01, Informed Consent in Therapy) and for dealing ethically with issues of interruption or termination of the relationship (Ethical Standards 10.09, Interruption of Therapy; and 10.10, Terminating Therapy). Furthermore, beyond the broadly-applicable ethical requirement to avoid multiple relationships that might lead to exploitation or harm (Ethical Standard 3.05, Multiple Relationships), in therapy relationships psychologists have four additional Ethical Standards that bar sexual relationships (Ethical Standards 10.05, Sexual Intimacies With Current Therapy Clients/Patients; 10.06, Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy With Former Sexual Partners; and 10.08, Sexual Intimacies With Former Therapy Clients/Patients). These ethical duties make it important for psychologists to clarify for themselves the nature of their relationships and the type of services to be provided, in order to differentiate therapy clients/patients from other types of "clients."

"*What are my ethical responsibilities to each of the parties involved?"* The answer will differ depending on whether the relationship is with a therapy client/patient, an assessment client, a collateral participant, a supervisee, a consultee, a contracted party, a research subject, or some other type of "client." Whereas the old question does not help psychologists make ethical distinctions among these potentially overlapping types of relationships, the new question requires them to define the nature of each relationship in order to know which ethical duties will apply.

"What are my ethical responsibilities to each of the parties involved?" This new question is longer. It's not as catchy. It has no single-word answer. It requires us to consider the full range of our ethical obligations toward everyone involved. But isn't that exactly the point? As suggested years ago,

> "When psychologists do try seriously to articulate who their client is – where their loyalties are to be given – . . . they sometimes appear to be under the impression that they are constrained to a multiple-choice answer. . . It appears to us that there is no need for psychologists to impale themselves on the horns of this dilemma, since "Who is the client?" is not a multiple-choice question. It requires an essay answer" (Monahan, 1980, p. 5).

Clarification :
Ethical Question, Clinical Question, Reimbursement Question, or Legal Question?

So far, we have addressed the question, "Who is the client?" only from an ethical perspective. But the very same question is often asked from other perspectives – clinical, reimbursement, legal – and this creates confusion about its meaning and about how it should be answered.

As illustrated in the following case example, the meaning of the question can be understood only if one clarifies the perspective from which the question is being asked.

> *Mrs. Smith, a prospective therapy patient, is so severely depressed that she can make it to the intake session only with Mr. Smith's help. The therapist is not sure Mrs. Smith can provide adequate information for making decisions about dangerousness or for planning treatment. Mr. Smith is therefore invited to join her in the intake session and to attend some of the early therapy sessions. Mrs. Smith meets the criteria for a mental health diagnosis, but the third party policy provided by her employer does not cover outpatient therapy, so she will pay for each session herself. Mr. Smith does not meet the criteria for a mental health diagnosis. He remains involved, as needed, in joint sessions that focus on Mrs. Smith's current status and future needs.*

"Who is the client?" If this is a *clinical* question, the therapist's answer might be simply that Mrs. Smith is the therapy client (or patient). However, the proposed new *ethical* question requires that the therapist determine the rights of all parties and clarify the therapist's ethical obligations in behalf of those rights. So the ethical answer in this case might therefore be, "Mrs. Smith, as the individual receiving therapy services, will have all the rights afforded to therapy clients by the APA Ethics Code. Mr. Smith, whose participation is collateral to her treatment, has the right to an informed consent conversation in which the psychologist defines his role and clarifies the nature of Mr. Smith's involvement, including the important fact that Mr. Smith does not have all the same rights (e.g., he may not be promised the same level of confidentiality) as the therapy patient."

> *Mrs. Smith's condition improves, and she begins making new decisions for her own life. This complicates her relationship with Mr. Smith. Her therapist refers them to a marital therapist.*

The marital therapist might say : " *Clinically* , I consider Mr. and Mrs. Smith to be equally my clients" (or perhaps, from a systems perspective, "*Clinically*, I consider the couple to be my client"). The answer to the new *ethical* question might be, " *Ethically* , they each have all the rights afforded to therapy clients by the APA Ethics Code, including the right to know whether or not I promise to maintain the confidentiality of communications made to me by one person when the other is not present."

Mr. Smith requests that the marital therapist submit a reimbursement claim to his managed care organization, which provides coverage for outpatient therapy, including family therapy.

The couple's therapist now asks, "Who is the client?" as a *reimbursement* question. In that context, the question will require a singular answer, because third party payers require that claims be filed in the name of one covered individual, even if the services are provided to more than one person (as in couples or family therapy). In this case, the therapist must determine whether Mr. Smith's policy covers marital therapy, decide whether it is appropriate to file a claim under Mr. Smith's name, and if so, under what diagnosis. Depending upon who has coverage and who qualifies for a mental health diagnosis, the answer to the reimbursement question may be completely different from the clinical and/or ethical answers, which will remain the same regardless of how the reimbursement question is answered. In this case, the answer to the reimbursement question may be either "Mr. Smith," or "No one;" but that answer will vary, case by case. If the couple's therapist does decide to submit a claim for reimbursement under Mr. Smith's name, the new *ethical question* serves as a reminder to protect Mr. Smith's right to be informed about what will be disclosed and the implications of disclosing it, and (once so informed), his right to give (or to refuse to give) consent.

Mr. and Mrs. Smith decide to separate. Mr. Smith files for divorce and for custody of their two minor children. He alleges that he has suffered great emotional distress as a result of Mrs. Smith's depression, and that she is still not emotionally able to provide good parenting. To produce evidence of this in his custody case, he wants both therapists to testify at the custody hearing. His attorney suggests that, before making that decision, he should invoke his legal right, under HIPAA, to obtain copies of the records.

For both therapists, "Who is the client?" now becomes a *legal* question that may take numerous forms : "Who has a legal right to obtain a copy of mental health treatment records?" or "Whose consent is legally required for voluntarily releasing records in a multi-client case?" Further legal questions will need to be answered in the context of the court case if a subpoena or court order creates a legal demand for "involuntary" disclosure of records, but one party contests the disclosure. "If one client receiving couple therapy waives privilege, does the privilege still apply to the other member of the couple?" (Pope & Vasquez, 2007, p. 146). The legal answers will differ from state to state.

Note, however, that each of these legal questions may also be asked as an ethical question, clarifying each therapist's ethical responsibilities about the confidentiality and disclosure of records. In such cases, it is easy for psychologists to become so focused on one meaning of the question that they forget to ask and to answer the others. F ocusing on the reimbursement question can distract from the clinical question, or can lead to the mistaken assumption that both answers must always be the same. Similarly, when confused about the legal question or intimidated by legal demands for information, psychologists may have difficulty separating this from the clinical and reimbursement questions. But it is even more problematic, and potentially more harmful to clients, if psychologists are confused about the *ethical* question, or forget to ask it at all. In that event, the rights of all parties can be placed at risk.

Throughout this case example, the ethical question has remained the same : *"What are my ethical responsibilities to each of the parties in this case?"* The two therapists needed to give different answers. But for both, one part of the answer was that they had an ethical responsibility to protect the right of both parties to receive, *in advance* , information that might affect their decision to participate. This required both therapists to be prepared to communicate a great deal of information before the relationships ever began. Such planning could have helped them anticipate the potential ethical/legal dilemma about confidentiality, giving them the opportunity to consider, *in advance*, their ethical options for responding to it. " Virtuous psychologists who demonstrate practical wisdom will cultivate a habit of deliberating about the salient ethical issues that they are likely to encounter, anticipate them, and develop policies to proactively address them" (Knapp, Gottlieb, Berman, & Handelsman, 2007, p. 58). .

Unlike "Who is the client?" the proposed new question is easily identifiable as an *ethical* question. Its meaning is so clear that it would never be mistaken for a legal, clinical, or reimbursement question. It encourages psychologists to clarify all their relationships, exercise forethought, and become more ethically planful. These would be important advantages of making the change.

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'Shhh! Please don't tell...' Confidentiality in child and adolescent mental health

ARTICLE

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SUMMARY

Confidentiality in child and adolescent mental health is a complex and often challenging matter. Not only do young people frequently present to services in situations of risk, they often prefer to keep information confidential from parents and/or other professionals. This article explores confidentiality in the context of child and adolescent mental health services (CAMHS), particularly when the clinician is having to make decisions on whether to maintain or to breach it. Ethical principles (both deontological and consequentialist) and legal and regulatory frameworks (relating to human rights, case law and General Medical Council guidance) are outlined. Four hypothetical case scenarios are used to illustrate how to apply such principles: when a young person seeks confidential access to treatment, and when he or she discloses information that could signify a risk to self, to others or from others. Finally, practical suggestions on how to share information are explored.

LEARNING OBJECTIVES

- Outline some relevant ethical principles and legal/regulatory frameworks, and apply them when weighing up the pros and cons of maintaining or breaching confidentiality
- Apply strategies for breaching confidentiality that balance the need to share information appropriately against the need to preserve therapeutic rapport and engagement
- Judge how one's own ethical perspectives might influence decision-making in confidentiality dilemmas

DECLARATION OF INTEREST

None

Confidentiality involves keeping private the information disclosed by someone using services. They may well consent to the sharing of information, for example with their family and/or other professionals. However, dilemmas arise when they refuse the sharing of information, even though breaching confidentiality could potentially protect or benefit that person or others.

Confidentiality is a complex matter in clinical practice, and particularly so in child mental healthcare. First, young people frequently present to child and adolescent mental health services (CAMHS) with sensitive and risk-related situations, including self-harm, suicidality, sexual behaviour, and alcohol and substance use. Second, young people often prefer such information not to be shared with parents and/or other professionals. Third, the child's level of competency may need to be taken into consideration.

Confidentiality represents an opportunity to engage a young person in developing a trustful engagement with services, with long-term positive consequences for their mental health. The development of autonomy is also an important task of adolescent maturity, and the opportunity to engage with services in a confidential, supportive manner can be an empowering experience in its own right. However, the need to decide whether to maintain or breach a young person's confidentiality can face clinicians without warning and immerse them in a quicksand of legal, ethical and clinical dilemmas.

This article explores various ethical, legal, regulatory and practical issues regarding confidentiality that can present in CAMHS, using four case scenarios (Box 1) to illustrate the application of principles in practice.

Ethics

Ultimately, clinicians want to do the right thing. The challenge of confidentiality is that it can frequently tear them in different directions when deciding what the right thing actually is. On one hand, it can feel right to respect a young person's confidentiality in order to maintain trust. On the other hand, it feels important to protect a young person from harm, and if breaching confidentiality is necessary for protection, then so be it. But what if the process of breaching confidentiality could exacerbate the risk? And what about parents' rights – should they not be given information to enable them to protect their child? Dilemmas arise when such ethical values conflict. For any

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BOX 1 Four hypothetical case scenarios involving a decision on whether or not to breach confidentiality

Ahmed

Ahmed is a 15-year-old boy who presents with anxiety disorder. His school counsellor remains concerned despite a package of cognitive–behavioural therapy; Ahmed's anxiety is significantly affecting his work. He arrives in the clinic by himself. Ahmed has read information online about medication with selective serotonin reuptake inhibitors and wants to give it a go. However, he is clear that he does not wish his family to know anything: they have other stresses and he does not wish to worry them further.

Adele

Adele is a 15-year-old girl attending CAMHS with depressive disorder. In an individual session, she reports self-harming by cutting regularly for several weeks. She also has occasional suicidal ideation, although has never had any firm intent or plan. She begs her doctor not to tell her family. She is concerned that if they found out, they would just get angry.

Frank

Frank is a 16-year-old boy recently diagnosed with autism spectrum disorder. During the assessment, he reports that for several months he has had repeated thoughts of killing people. There is no forensic history or history of aggression. He is not overly distressed by these thoughts, but recognises that others might be concerned if they knew about them. The potential targets change frequently; they tend to be peers at college whom he perceives as bullies. There is currently no specific target in mind, but Frank thinks it is possible he might do something sometime in the future.

Katie

Katie is a 14-year-old girl attending CAMHS with an eating disorder. In an individual session, she discloses that she was drunk at a party and a 19-year-old man had sex with her. She remembers little, although reports that the man, who was vaguely connected to her wider peer group, had been sending her sexually related messages online. She feels distressed at what happened and blames herself. She does not wish anyone to know; she feels embarrassed and does not want to cause trouble.

given situation, some sort of ethical calculation is needed to determine the most appropriate course of action.

The deontological and consequentialist positions

Two distinct strains of moral philosophy have historically dominated the ethical landscape. Deontological ethics, such as that proposed by Kant, argues that the morality of an action is to be judged by whether the action is in itself right or wrong, based on a wider system of rules, rights or doing one's duty (Kant 1964). In contrast, consequentialist or teleological ethics, such as utilitarianism proposed by Bentham and Mill, argues that the morality of an action is based solely on all the good and all the harm that consequentially arises (Mill 1863). Although these arguments have further evolved in contemporary moral philosophy, both perspectives still remain relevant when considering confidentiality issues.

Medical ethics: beneficence, non-maleficence and autonomy

Specific ethical principles have also been proposed for medical practice (Beauchamp 2001). Beneficence involves acting so as to improve the patient's health or welfare, whereas conversely non-maleficence involves acting so as to avoid harm. Autonomy involves respecting and supporting the right of patients to make their own healthcare choices. These principles can also be viewed from both deontological and consequentialist positions. The intrinsic duty of a clinician acting out of good will, striving to do good and avoid harm for the patient, could be seen deontologically as a good in itself, represented archetypically by the Hippocratic Oath. A consequentialist position would instead place the ethical onus on the specific situation, calculating a 'harm/benefit ratio' of consequences.

When beneficence and non-maleficence are applied to confidentiality issues, preserving confidentiality may benefit the young person by encouraging disclosure of all relevant clinical information, enabling the clinician to act effectively (Ford 2004). Furthermore, protecting confidentiality may enhance both the therapeutic relationship and service engagement, with potentially long-term benefits to health and risk (Guedj 2009). In contrast, when the clinician learns of a significant risk, breaching confidentiality and sharing information with parents or other authorities may help them minimise the risk of harm.

One may need to think beyond the individual situation and consider principles more universally. For example, if young people have little faith in the confidentiality of health services, this may lead them to keep sensitive but important information hidden or may even prevent them from attending at all. Guidance from the General Medical Council (GMC 2007) specifically requests clinicians to value the wider principle of 'society's interest in maintaining trust between doctors and patients' (p. 20) whenever a clinician deliberates on an individual case. In contrast, another universal principle could be applied to supporting the need to breach confidentiality: societies where information is freely shared within families and between services may help deter those who might otherwise abuse.

Autonomy is arguably more deontological in character. A young person's right to confidentiality lies in their right to autonomy; the freedom to make meaningful choices about one's own welfare is an important aspect of being human. With this argument, whether the choices ultimately prove good or bad is less important than the intrinsic freedom to make one's own choices. In fact, it is often through seemingly adverse outcomes that individuals learn from their mistakes and develop as human beings.

however, more explicitly focus on children's rights to consent to treatment as opposed to their rights to confidentiality (Cave 2009). However, in *Gillick*, Lord Scarman's statements indicate that such rights could be viewed equivalently. For example, he states that once a child is 'competent', then 'parental rights yield to the child's right', and this has since been interpreted to encompass rights to confidentiality.

The case law that most explicitly relates to children's rights to confidentiality is *R (Axon) v Secretary of State for Health* [2006] (subsequently referred to as *Axon*) (Table 1). Justice Silber's High Court judgment noted that the ECHR and the UNCRC:

> 'show why the duty of confidence owed by a medical professional to a competent young person is a high one and which therefore should not be overridden except for a very powerful reason. In my view, although family factors are significant and cogent, they should not override the duty of confidentiality owed to the child.'

However, it does beg the question as to what constitutes a 'very powerful reason' to override a competent young person's right to confidentiality. In *Axon*, the children were appropriately seeking beneficent access to healthcare. What if a child instead wanted to keep confidential information that would indicate that they, or others, were in danger: would it still be in the public interest to keep this type of information confidential?

The GMC defines 'public interest' as when:

> 'the benefits which are likely to arise from the release of information outweigh both the child or young person's interest in keeping the information confidential and society's interest in maintaining trust between doctors and patients. You must make this judgement case by case, by weighing up the various interests involved [...] You should consider the benefits and possible harms that may arise from disclosure [...] You should disclose information [...] to protect the child, or someone else, from risk of death or serious harm' (GMC 2007: pp. 20 & 21).

Example situations cited include a child at risk of abuse or involved in behaviour that might put them or others at risk of serious harm (for example, serious addiction, self-harm or joyriding) or where the information would help in the prevention, detection or prosecution of serious crime (GMC 2007: p. 21). There are also situations where confidentiality needs to be breached in accordance with legal or regulatory statutes (Box 2).

The GMC's position here is considerably consequentialist: decisions involve calculating the consequent harms and benefits of disclosure versus non-disclosure. The position allows the clinician significant leeway. First, the guidance invites clinicians themselves to weigh up the benefits and risks. Different clinicians may well prioritise different factors, on the basis of their own wider ethical perspectives. Second, clinicians may vary in how they judge 'risk' and what harm they count as 'serious'. As Jellinek (2010) notes, 'where judgment must play a role [...] is in dissecting different degrees of danger. You may want to hold in confidence the idea that a teen has contemplated initiating a sexual relationship, while never hesitating to consult with parents about real and present dangers, such as the news that a child is planning to run away [or] is suicidal'.

Ultimately, there are various reasons why a child may wish for information to be kept confidential. They may feel that the information itself is too sensitive and personal, particularly if it would cause them embarrassment. They may worry about how their parents will react, particularly if they are already worried about their parents' mental health or that disclosure would lead to family conflict. They may worry parents will intervene in a seemingly unhelpful way. Disclosure may therefore result in distress or other negative feelings that actually lead to an exacerbation of risk. The GMC guidance specifically notes that clinicians should consider the 'possible harms that may arise from disclosure' (GMC 2007).

Likewise, there are a good reasons why the sharing of information with parents can help a young person. Parents are well placed to support their children, and the Children Act 2004 endows them with an important role in both safeguarding and providing guidance to their children. The sensitive sharing of information could represent an opportunity to help support and develop

BOX 2 When confidentiality can be breached

In the following examples confidentiality can be breached in order for authorities to receive notification, in accordance with legal or regulatory statutes

Health and Social Care Act 2008

Death of a person who has been receiving a health or social care service

Death or unauthorised absence of someone detained (or liable to be detained) under the Mental Health Act 1983

Application to deprive a person of their liberty (under the Mental Capacity Act 2005)

Placement of a child on an adult psychiatric ward

Other frameworks

Security of medical records (Data Protection Act 1998)

Aiding police in matters relating to terrorism (Terrorism Act 2006)

Aiding regulatory bodies as part of their duties to investigate complaints, accidents or health professionals' fitness to practise (GMC 2007)

When ordered by a judge or presiding officer of a court, as long as the information is relevant (GMC 2009)

Victims of mentally disordered offenders detained in hospital have a right to receive information regarding the patient's discharge (Domestic Violence, Crime and Victims Act 2004)

Disclosure of information (e.g. to mental health review tribunals) for statutory purposes under the Mental Health Act 1983

The balance of clinical, legal and regulatory principles summarised in Table 2 is applicable in each of the case scenarios presented earlier (Box 1) depicting a young person wanting to keep information confidential. Deontological arguments generally support the young person's right to confidentiality in terms of their rights to autonomy and privacy, and this is further supported by case law such as *Gillick* and *Axon*. Parents also have rights to fulfil their parental responsibilities under the same Article 8(1) of the ECHR and under the Children Act 2004. Furthermore, Article 8(2) of ECHR can supersede Article 8(1) in order to protect someone's health or welfare. A balancing act in relation to the specific context needs to be considered, since consequentialist and legal arguments may vary depending on the case.

Access to treatment

The first scenario involves Ahmed, the 15-year-old with anxiety disorder who wants medication, but does not want his parents to know. This situation The treatment would need to be warranted in terms of its potential effectiveness ('beneficence') significantly outweighing its potential for side-effects ('non-maleficence'). Furthermore, Ahmed needs the required maturity and intelligence not just to understand the treatment (as per Gillick-competency), but to manage the practical aspects of attending appointments, picking up prescriptions, and storing and administering the medicine safely. What is the risk of him potentially misusing the medicine, even using it to self-harm or in a suicide attempt? All these judgements need to be made in terms of calculating beneficence and non-maleficence.

If it is felt that legally Ahmed is competent, that clinically the benefits outweigh the risks, and that practically access is feasible, then the treatment should arguably proceed in confidence. However, the GMC would generally advise the clinician still to encourage Ahmed to involve his parents, even if ultimately his confidentiality is respected (GMC 2007).

TABLE 2 **A summary of principles to consider when deciding whether to maintain or breach confidentiality of a competent young person**

	Principles in favour of maintaining confidentiality	**Principles in favour of breaching confidentiality**
Deontological or rights-based	A competent young person's right to confidentiality lies in their right to autonomy, and the developing of autonomy is an important part of adolescence Individuals have a right to a private life (Article 8(1) of ECHR) Legal rights enshrined in case law (*Gillick* and *Axon*)	Parents have rights in order to fulfil their responsibilities as parents (Children Act 2004) Parents have a right to a family life (Article 8(1) of ECHR)
Consequentialist relating to the individual attendee	Encourages the young person attending the service to disclose relevant clinical information to enable the clinician to act in the most clinically effective way: 'Without the trust that confidentiality brings, children and young people might not seek medical care and advice, or they might not tell you all the facts needed to provide good care' (GMC 2007: p. 18) Protects/enhances the therapeutic relationship and the attendee's engagement, with potentially long-term health benefits Disclosure by the attendee might cause stress or conflict in the family, which might exacerbate risk	Enlists help of parents or authorities to help safeguard the young person, thereby minimising the risk of harm 'You should disclose information if this is necessary to protect the child or young person [...] from risk of death or serious harm' (GMC 2007: p. 20) Represents an opportunity to help support and develop family communication
Consequentialist relating to the wider society	If young people in society do not in general trust in the confidentiality of health services, they might keep important information hidden or might not attend at all 'A disclosure is in the public interest if the [likely] benefits [...] outweigh both the child or young person's interest in keeping the information confidential and society's interest in maintaining trust between doctors and patients' (GMC 2007: p. 20) 'Confidential medical care is recognised in law as being in the public interest' (GMC 2009: p. 16)	Societies where information is freely shared within families and between services may help deter those who might otherwise abuse 'You should disclose information [...] when there is an overriding public interest in the disclosure' (GMC 2007: p. 19)

When considering Ahmed, we must also bear in mind the wider importance of trust between clinician and patient in society. In *Axon*, Justice Silber noted that between the decision of the Court of Appeal in *Gillick* (which originally upheld the mother's claim) and that of the House of Lords (which ultimately rescinded it), the number of under-16-year-olds who sought contraception fell by almost one-third.

In fact, research has convincingly shown that protecting confidentiality can improve, and restricting confidentiality can diminish, the likelihood that adolescents access healthcare (Cheng 1993; Ford 1997, 1999; Klein 1999; Carlisle 2006). In one survey of adolescent girls attending family planning clinics, 60% said that they would stop using sexual health services if parents were notified of contraceptive prescribing (Reddy 2002). In two large surveys, approximately one-quarter of adolescents reported not attending needed health services, 35% of them because they did not wish their parents to know (Kaplan 1998; Logan 2002). Lehrer *et al*'s survey found that 10.5% of boys and 14.3% of girls who reported not accessing healthcare services gave concern about confidentiality as their reason, particularly if they had high depressive symptoms and suicidal ideation (Lehrer 2007).

Parents meanwhile vary in their attitudes towards adolescent rights to confidential consultations. Magnusson *et al* (2007) showed that, although 92% of parents agreed that 16-year-olds should always have access to confidential appointments, this figure dropped to 52% when they considered under-16-year-olds. Ethnic and religious factors may also influence parental attitudes (G Durà-Vilà, personal communication, 2015).

Risk to self

Now let us turn to Adele, the 15-year-old with depression, self-harm and suicidal ideation, but no firm suicidal intent or plan, who does not wish her parents to know. This is a common scenario presenting to CAMHS services, and the principles illustrated in Table 2 apply.

GMC guidance advises that information can be disclosed if there is an overriding public interest in the disclosure in order to protect the child from risk of death or serious harm, including through self-harm (GMC 2007). A risk–benefit analysis is needed: 'look to the consequences and determine which action produces the greatest proportionate good' (Applewhite 1994). One needs to decide whether Adele's cutting and suicidal ideation, without suicidal intent, would constitute a risk of serious harm. On one hand, superficial cutting may arguably constitute a low risk of serious harm. Furthermore, given the lack of suicidal intent, and considering that about 30% of adolescents report having had suicidal ideation (the overwhelming majority of whom do not attempt suicide) (Evans 2005), again the risk of serious harm here does not appear high. Yet, research also indicates that self-harm is a risk factor for more significant suicide attempts, albeit in the longer term, so this would also need to be factored in. In addition, many other static and dynamic factors may influence risk, for example history of suicide attempts, mental disorder, adverse childhood events, interpersonal difficulties, low educational achievement, and drug and alcohol use (Hawton 2012).

The clinician needs to evaluate whether breaching confidentiality would ultimately reduce or increase risk. Although its aim would be to involve parents to help protect their child and thus reduce risk, the potential for risk exacerbation also needs consideration. Breaching confidentiality could lead to: increased stress for Adele, real or perceived stress for her parents, increased family conflict, damage to therapeutic rapport/effectiveness and disengagement from services.

The risk of such negative consequences is implicated in research. The risk that young people will not disclose sensitive issues such as substance use, mental illness and sexual behaviours (Carlisle 2006) and that they might disengage from services altogether (Ford 1997; Thrall 2000) is significant if they feel that their confidentiality may be breached. This in turn could have a negative impact on the adolescent's longer-term health and overall risk.

In contrast, research shows that parents value being told important information about their child. In one study, 87% of parents interviewed wished for issues concerning their adolescent children's mental health to be disclosed to them (Duncan 2011). However, 77% of the parents also acknowledged the value of adolescent confidentiality, which, as Tebb (2011) notes, reflects some discordance in attitudes. Another study (Carlisle 2006) reported that parents unanimously wished to be informed about their adolescent children's health and risky behaviour, often citing their 'right to know'.

Various studies have surveyed clinicians' attitudes on what influences them to breach confidentiality when a child expresses risk to self. Clinical child psychologists (Sullivan 2002) and school counsellors (Sullivan 2008) generally place much weight on the immediacy, seriousness, frequency, intensity and duration of the risky behaviour, and the need to protect the child. More moderate importance was attached to the negative effects of breaching on the family and

on service attendance. A survey of clinical child psychologists found a significant lack of consensus in attitudes but the authors reflected that 'ethical codes and guidelines allow for (and result in) individual differences in decision making' (Rae 2002). Anecdotal experience of CAMHS services suggests that clinicians do hold disparate views on confidentiality, despite a general appreciation of its underlying principles, ethics and regulations.

If Adele's clinician decides to breach confidentiality, they would need to explain to her why they think it necessary, as well as monitoring her for any negative consequences and supporting her and her family so as to minimise any exacerbation of risk. If the clinician decides to maintain confidentiality, they could still encourage and work with Adele to help her to continue reflecting on the sharing of information with her parents (GMC 2007).

Risk to others

Let us now consider Frank, the 16-year-old with autism spectrum disorder and repetitive thoughts of killing people, but no specific intent or target. In contrast to the two previous scenarios, the potential risk is to others and so sharing information with other authorities (e.g. the police and/or children's services) may need consideration.

The GMC guidance states that 'disclosure without consent may be justified in the public interest if failure to disclose may expose others to a risk of death or serious harm' (GMC 2009: p. 21). It refers to the NHS code of practice on confidentiality in clarifying which serious crimes this may encompass:

> 'Murder, manslaughter, rape, treason, kidnapping, child abuse or other cases where individuals have suffered serious harm may all warrant breaching confidentiality. [...] In contrast, theft, fraud or damage to property where loss or damage is less substantial would generally not warrant breach of confidence' (Department of Health 2003a: p. 35).

Had Frank actually made specific threats against a person, with some intent to kill, then confidentiality should be breached, and police and children's services informed, in accordance with GMC guidelines and ethical principles (since safety and protection would generally supersede rights to autonomy). However, the scenario is less clear-cut since Frank is currently not making any specific threats nor is there intent. One could argue that the potential outcome is so serious, one should have a low threshold, so that confidentiality should be breached even if the likelihood of him acting on his thoughts is low. Police and children's services might even offer support, which could attenuate risk. On the other hand, it could be argued that the short-term risk is low, and that breaching confidentiality might have a negative impact on his rights, his healthcare engagement and perhaps his social situation, any of which could exacerbate risk.

The specificity of intent and threat is legally important. In *Palmer v Tees Health Authority* [1999] a mother claimed that the health authority had been negligent by discharging a man with personality disorder who subsequently killed her child. However, the Court of Appeal dismissed the case as the man had not specifically threatened that particular child (Agyapong 2009).

Frank's clinician should make a risk assessment, since other factors are also involved. An evidence-based tool such as the Structured Assessment of Violence Risk in Youth (SAVRY) could be particularly useful. The presence of autism spectrum disorder could work either way. The murderous thoughts may represent a concrete 'black or white' internal response to peer problems and consequent difficulty in emotional regulation, but little actual risk of carrying out violent acts. On the other hand, the lack of empathy associated with autism spectrum disorder may increase risk.

Ultimately, the lack of any history of aggression or forensic history (a significant risk factor for violence), as well as lack of current intent or threat, may tip the balance towards not sharing the information with authorities. However, the clinician should remain vigilant in case the level of intent or threat changes. Furthermore, it would still be useful to encourage Frank to have information shared with his parents, who may be well positioned to more closely monitor and support him.

Risk from others

Finally, let us consider Katie, the 14-year-old who discloses that a 19-year-old man had sent her sexually related messages and then had sex with her while she was drunk. Various factors would indicate abuse (Box 3): the significant age difference, the use of alcohol, and Katie being an age where her maturity to consent is questionable. This, and that Katie is under 16, indicates that the abuse is also criminal, while the sending of sexually elated messages suggests child exploitation and grooming.

Although the argument to breach confidentiality is particularly strong here to ensure appropriate safeguarding, it is worth reflecting on the various principles listed in Table 2 in order to appreciate the process. On one hand, there is the consideration of preserving engagement and therapeutic rapport, particularly important given Katie's eating disorder and the associated risks. Even in cases

BOX 3 GMC guidelines on the need for reporting

The following factors concerning possible sexual abuse would indicate the need for reporting:

- the young person is too immature to understand or consent
- children under 13 years old are legally considered to be unable to consent to sexual activity
- significant differences in age, maturity or power between the young person and the sexual partner
- the young person's sexual partner having a position of trust or having a history of abusive relationships with children
- the use of force or the threat of force, pressure, bribery or payment
- the use of drugs or alcohol to influence a young person

(GMC 2007)

of potential child abuse, the GMC still notes the relative value of confidentiality: 'although it may seem that parents would be the obvious people to disclose to in these circumstances, doctors should consider the potential adverse consequences. Doctors must also consider the impact that such a disclosure and its consequences could have on other young people and their trust in doctors' (GMC 2015). This consequentialist position is shared by Gillon (Williams 1987), whereas Roche argues more deontologically that 'information-sharing [...] carries the risk of overwhelming any concern for children's rights and family privacy [...] in a way that so clearly ignores the complex reality of children's lives and their voices' (Roche 2008).

On the other hand, breaching confidentiality would allow services (e.g. police and children's services) to intervene and thus hopefully reduce the risk to both Katie and, potentially, others now and in the future. In situations of child abuse, particularly given the difference in the power dynamic, the child may not be in a position to adequately protect themselves from the risk of further abuse by a coercive perpetrator. Furthermore, there are also the rights of others to consider: first, those of her parents, who have an important role in safeguarding; second, there is the issue of public interest, i.e. other people's rights to be protected from the 19-year-old man, either victims currently being abused, or potential victims at risk in the future.

Overall, GMC guidance is clear:

> 'Your first concern must be the safety of children and young people. You must inform an appropriate person or authority promptly of any reasonable concern that children or young people are at risk of abuse' (GMC 2007: p. 25);
>
> 'if a child or young person is involved in abusive or seriously harmful sexual activity, you must protect them by sharing relevant information with appropriate people or agencies, such as the police or social services' (GMC 2007: p. 27).

The guidance *Working Together to Safeguard Children* explicitly states that:

> 'fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children [...] If a professional has concerns about a child's welfare and believes they are suffering or likely to suffer harm, then they should share the information with local authority children's social care' (Department for Education 2015: p. 17).

The need to ensure appropriate information-sharing between agencies involved in child protection has been highlighted by several high-profile cases and reports on child abuse. For example, the Laming inquiry which followed the Climbié case noted that more effective communication, interagency working and information management would eventually lead to better outcomes for children (Department of Health 2003b).

Interestingly, there is some discrepancy between the GMC guidance relating to competent children as opposed to competent adults. The guidance for adults advises that, although doctors should encourage patients to consent to disclosures necessary for their protection, they should 'usually abide by a competent adult patient's refusal to consent to disclosure, even if their decision leaves them, but nobody else, at risk of serious harm' (GMC 2009: p. 21). The greater onus on reporting child abuse may reflect significantly greater public interest in reporting it than in keeping it confidential. This would reflect the risks to the child in question, the potential or actual risks to other children and the overall vulnerability of children, even if they happen to be competent. Therefore, in Katie's case, where child abuse and criminal behaviour are implicated, GMC guidance would advise breaching confidentiality to children's services, and ultimately the police, to help ensure protection for her and, potentially, others.

Practical aspects

Confidentiality should be one of the first issues raised when initially meeting a young person and their parents; this helps them understand the principles from the start (Lehrer 2007; Tebb 2011). Such transparency makes it easier if

confidentiality has to be breached in the future and may help protect longer-term therapeutic rapport and engagement (Ford 2004). Despite this, only 3% of parents said their general practitioner (GP) had discussed with them confidentiality in relation to their adolescent children (Magnusson 2007).

Structuring sessions

Confidentiality concerns should influence how clinicians structure their sessions with young people if parents or carers are also involved. One model consists of breaking the session into distinct components: time with the young person alone, time with parents (or carers) alone and time with the family together.

Protected individual time with the young person maximises their opportunity to confide important but sensitive issues that could help determine the support and treatment offered. However, Kapphahn *et al* (1999) found that 34% of boys and 43% of girls with high depressive symptom scores, and 25–41% of youth reporting substance use, high stress levels, physical abuse or sexual abuse, were not given an opportunity to speak privately with their doctor. The risks of future non-attending due to concerns over confidentiality have been previously discussed.

Protected time just for parents gives them the opportunity to share information or raise concerns that it would be inappropriate or distressing for their child to hear.

Time with the young person and their parents together allows information to be shared both ways, as well as enabling psychoeducation and discussions about the care plan. It also gives an opportunity to create a safe, supported space to encourage communication between the young person and the parents (Ford 2007). This is particularly important given the evidence that many girls who cite concerns about confidentiality as a reason for future non-attendance reported unsatisfactory communication with their parents (Lehrer 2007).

Evidence supports such a model. Roughly half of the adolescents in one online survey believed a parent's presence (or absence) had an effect on clinical conversations about their health (Gilbert 2014). Furthermore, the mean number of topics discussed was significantly higher when a young person was seen both individually and with family (4.11 topics), as opposed to only being seen with family (2.76 topics). The mean number of topics for individual-only sessions was 3.16, which, although not significantly different, implies that the split-session approach results in the best coverage of topics. The researchers also found that the topics most likely to be raised in individual time included mental health, stress, drugs and alcohol, and difficulties at school, problems frequently encountered in CAMHS.

Accidental disclosure

One occasion on which information is sometimes unwittingly shared is when letters to GPs are copied to parents. To avoid this pitfall, check with the competent young person each time whether they want any information to be excluded. They may actually consent for information to be conveyed to the GP, but not to their parents. If parents do not need to know, but the GP does, consider writing the GP a separate letter or contacting them by phone.

Weighing the decision and making the disclosure

When initially considering whether to breach confidentiality, negotiation could be used. For example, a teenager whose weight is dropping and who confides early signs of an eating disorder may agree to gain weight on a prescribed schedule and attend regular visits until you are assured that he or she has the problem under control. Sometimes it is useful to set up an agreed 'if, then' scenario. For example, 'If your weight drops below the *x*th percentile or I feel you are in danger, I will need to raise the issue with your parents' (Jellinek 2010).

Finally, the clinician has weighed up the pros and cons, the rights and the consequences, and has determined that on balance, confidentiality should be breached to parents and/or other authorities. Now what? Box 4 lists various practical aspects of disclosure. One qualitative survey found that adolescents generally wanted their doctor to ask them before telling a parent and to give them the opportunity to tell the parent themselves (Carlisle 2006).

Conclusions

We have explored how ethical, legal and regulatory principles can be applied to dilemmas relating to confidentiality that present to CAMHS services. It is useful to bear in mind deontological positions and individuals' rights, as well as analysing the consequential benefits and harms of disclosure versus maintaining confidentiality. Research has usefully shown the importance of confidentiality in helping young people access and engage with services. However, decisions are often complex, and colleagues may well vary in their viewpoints. Ultimately, in negotiating the minefield of confidentiality clinicians are significantly helped by reflecting thoughtfully on the various issues presented by a case and carefully documenting the reasons for their actions.

BOX 4 Some principles and practical aspects of disclosure

General principles

- Tell the young person and/or family what you propose to disclose and why, unless that would significantly undermine the purpose or increase the risk of harm
- Help them to understand the importance and benefits of sharing information, and reflect on the potential costs, so that ways to minimise them can be considered
- Consider any views given by them on why you should not disclose the information
- Appreciate that young people and families may understandably worry, particularly if they think they will be denied help, blamed or made to feel ashamed, or have had bad experiences or fear contact with the police or Social Services
- Ask the young person for consent to the disclosure, if you judge them to be competent; even if not competent, ascertain their views on what information should be disclosed to whom, and how, and try to accommodate these views
- Do not delay information-sharing if delay would increase the risk to the child or other children
- Disclose the minimum information necessary to protect or benefit the child: information-sharing should be proportionate to the risk of harm
- Disclose only to those who need to know
- If in doubt whether to share information against the child's or family's wishes, seek advice from a senior colleague, a named doctor for child protection, or your organisation's Caldicott guardian; you could also discuss the case anonymously with children's services to get their initial opinion; bear in mind that a risk might become apparent only when a number of people with niggling concerns share them
- Document any decisions made, including the reasons behind them

When disclosing to parents

- Generally encourage young people to share information, where appropriate, with their parents and to involve them in making important decisions
- Ask whether they would like to disclose the information themselves or whether they would like you do it for them; if the latter, ask whether they would like to be present or not
- Ask the child how they would like to frame the information; alternatively, explain what you are going to say and ask them to suggest how they might edit it
- Have a moment with child and parents all present before the session ends in order to evaluate how everyone has responded

(Taylor 1989; Sullivan 2002; GMC 2007, 2009; Jellinek 2010; Jackson 2014)

MCQ answers

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MCQs

Select the single best option for each question stem

1 Deontological ethical philosophy argues that:

a the consequences of an action are what defines whether it is ethical or not
b we can never know exactly the subjective experience of other beings
c the morality of an action relates to the action itself and not its consequences
d free will is impossible
e consciousness is an illusion.

2 Article 8(1) of the European Convention on Human Rights specifies that:

a everyone has the right to have their private and family life respected
b everyone has the right to freedom of thought, conscience and religion
c everyone has the right to liberty and security
d everyone has the right to freedom of expression
e everyone's right to life shall be protected by law.

3 The case law that most explicitly relates to a young person's rights to confidentiality is:

a *Gillick v West Norfolk and Wisbech Area Health Authority*
b *Palmer v Tees Health Authority*
c *Re R (A Minor)*
d *Re W (A Minor)*
e *R (Axon) v Secretary of State for Health.*

4 Research shows that:

a a young person's belief that information will invariably be shared with parents does not affect the likelihood that they will disclose risky behaviours or attend healthcare services
b parents generally believe that they do not have a right to know about risks relating to their adolescent children
c aspects of confidentiality are rarely discussed with adolescent patients and their families in primary care
d when deciding whether to breach confidentiality, clinicians prioritise the risk of patient disengagement more than the seriousness, frequency, intensity and duration of the risky behaviour
e ethnic and religious factors rarely influence parents' attitudes towards their child's right to confidentiality.

5 Which factor does not support the protection of confidentiality in a competent young person?

a confidentiality may increase the likelihood of the young person disclosing information that helps guide treatment
b the individual has a right to autonomy, the development of which constitutes an important part of adolescence
c confidentiality may help to protect or enhance the therapeutic relationship and service engagement
d society has an interest in maintaining trust between doctor and patient, and so confidential medical care is recognised in law as being in the public interest
e parental rights to know information in order to help safeguard their child.

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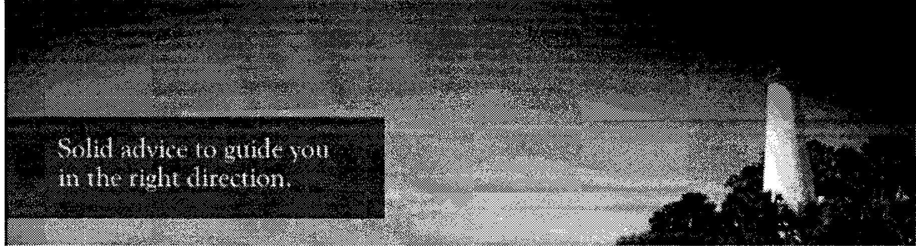

Family Law Rights Blog - Your Source For Information On Florida Family Law

Wednesday, March 26, 2014

Florida Psychotherapist Patient Privilege: Protecting Mental Health Records in Divorces and other Family Law Cases

Divorce and family law cases sometimes get ugly. And, in ugly cases, it is not uncommon for one or both of the parties to have a personality disorder or other mental health condition. Under certain circumstances, a party's mental health is legitimately relevant to a proper determination of child custody or alimony. Many times, however, there are improper motivations for seeking confidential mental health records and information. Your family law attorney should know when this evidence is subject to discovery.

A party to a divorce or family law proceeding normally has the right to prevent disclosure of communications or records made for the purpose of diagnosis or treatment of a mental or emotional condition, including alcoholism and other drug addiction. *See* Fla. Stat. § 90.503(2). This privilege applies to communications between a patient and a psychotherapist, or persons who are participating in the diagnosis or treatment under the direction of the psychotherapist. *Id.* The term "psychotherapist" is broadly defined, and includes doctors, psychologists, therapists, social workers, drug and alcohol abuse counselors, and nurse practitioners who are engaged primarily in the diagnosis or treatment of a mental or emotional condition. *See* Fla. Stat. § 90.503(1)(a).

This psychotherapist-patient privilege, however, is not absolute. In a child custody dispute, the mental and physical health of both parents is a factor that must be considered by the trial judge in determining the best interests of the children. *See Leonard v. Leonard*, 673 So. 2d 97, 99 (Fla. 1st DCA 1996). A party does not waive the psychotherapist-patient privilege merely by seeking child custody. *See Leonard*, 673 So. 2d at 99. But, in situations where a calamitous event such as an attempted suicide occurs during a pending custody dispute have courts have found that the mental health of the parent is sufficiently at issue to warrant an exception to the statutory privilege. *See, e.g., Miraglia v. Miraglia*, 462 So. 2d 507 (Fla. 4th DCA 1984); *Critchlow v. Critchlow*, 347 So. 2d 453 (Fla. 3d DCA 1977).

In extreme circumstances, evidence concerning the party's mental health is so vital to a proper determination of custody that a patient-litigant exception to the privilege is justified. *Id.* The rationale for this exception is that a litigant waives the psychotherapist-patient privilege by proceeding on a claim for custody where the party's mental condition is an essential element.

Absent a "calamitous event," the law requires courts to preserve the privilege. *See, e.g., Koch v. Koch*, 961 So. 2d 1134, 1135 (Fla. 4th DCA 2007). Courts will not find a waiver of the privilege based on mere allegations of mental or emotional instability. *See Leonard*, 673 So. 2d at 99. Competent substantial evidence is required. "To hold otherwise would eviscerate the privilege; a party seeking privileged information would obtain it simply by alleging mental infirmity." *Peisach v. Antuna*, 539 So. 2d 544, 546 (Fla. 3d DCA 1989).

If evidence of mental health is still necessary in a custody case, the more appropriate method of securing the information is to require an independent psychological or psychiatric examination of the parent or parents. *Schouw v. Schouw*, 593 So. 2d 1200, 1201 (Fla. 2d DCA 1992). In this way, the trial court balances the need to determine the parents' mental health as

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it relates to the best interest of the child, and the need to maintain the confidentiality between a treating psychotherapist and the patient. *Id.*

Courts have also upheld the psychotherapist-patient privilege when a parent is trying to obtain information or records concerning a child's mental health. *See Attorney ad Litem for D.K. v. Parents of D.K.*, 780 So. 2d 301, 307 (Fla. 4th DCA 2001); *see also Kasdaglis v. Dep't of Health*, 827 So. 2d 328 (Fla. 4th DCA 2002) (holding that social worker is under no obligation to furnish privileged therapy records of a sixteen year old to the child's mother without the child's consent). The statutory privilege applies to children, and parents do not have standing to waive the privilege. *See Attorney ad Litem for D.K.*, 780 So. 2d at 307. If a child lacks the age or maturity to make a decision concerning the waiver or invocation of the privilege, the court should appoint an attorney *ad litem* for the child. *Id.* at 308.

In *Attorney ad Litem for DK*, the court explained its reasoning:

> We recognize the tension apparent in the law between the rights and responsibilities of parents and the rights of children. Certainly, to promote strong families, parents should be involved and active in the lives of their children, including their health care, for which the parents are held responsible. Unfortunately, sometimes the parents are the cause of abuse, both emotional and physical, of their children. Allowing parents complete access to their children's health care records under all circumstances may inhibit the child from seeking or succeeding in treatment. The tension between the child's need for confidentiality and privacy to promote healing may conflict with the need of the court for information to inform its judgment as to the child's best interest.

See Attorney ad Litem for D.K., 780 So. 2d at 308. Courts have also held that even a court appointed guardian *ad litem* for the child may be excluded from accessing the child's confidential mental health records.

If you have questions about how mental health issues might affect your rights in a family law case, contact an experienced Florida family law attorney.

Posted by Richard Mockler at 11:47 AM

Labels: Confidential, Confidentiality, Lawyer, Notes, Patient, Privilege, Psychiatrist, Psychologist, Records, Subpoena

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Florida's Psychotherapist-Patient Privilege in Family Court

by Bruce G. Borkosky and Mark S. Thomas

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Divorce litigation is widespread in Florida[1] and often involves mental health professionals (MHPs). Many MHP licensing[2] and ethics[3] complaints can result because the litigation can be both complex and emotionally charged. One area of particular challenge[4] is when MHPs are faced with a request for records or a subpoena.[5] Problems may occur if the MHP discloses private information without consent, refuses to disclose information when it is required, or obtains consent from the wrong "patient." It is common practice for child custody evaluators to automatically request therapy records, but all involved may not fully understand the potentially negative consequences of records release.[6] Compounding these issues, patients may have various motivations for seeking treatment[7] and judges may not be entirely familiar with the potential ramifications of the release of privileged and confidential records in part because privilege laws vary considerably from state to state and are highly dependent on case law.[8] Professionals armed with accurate information about this area of the law can assist the courts, while protecting the rights of litigant- and child-patients.

Differences Between Confidentiality and Privilege

Disclosures of mental health records to the legal system are easily confused with disclosures to other parties because they have overlapping, but distinct, rules for disclosure.[9] HIPAA does not apply to matters of privilege.[10] Privilege requests are, instead, governed by F.S. §90.503, regulating professions, and case law. A full definition of privilege is beyond the scope of this article,[11] but the general rule of law is "everyone testifies," whether via submittal of records or in-person testimony. Some persons are permitted not to testify — a *privilege* — because legislatures have decided that some relationships are important to protect. Privilege is, thus, a partial derogation of the law. Privileges, however, are not absolute. Legislatures have enacted exceptions to privilege, and some circumstances void the privilege — a *waiver*. If either an exception or a waiver applies, it means that testimony is required.

Determining Whether Privilege Applies

The courts should follow[12] strict construction of the statute when determining whether the elements of a privilege claim are met.[13] There is a presumption of no privilege unless all of the following conditions are met:[14]

1) Was the professional a *psychotherapist*?[15]

2) Was the client a *patient*?[16]

3) Is the information requested privileged?[17]

4) Does the person asserting privilege have standing to do so?[18]

Exceptions

Once privilege is established, the next analysis is to determine whether any exceptions to privilege apply.[19] The Florida statutes have four exceptions: 1) communications involving the known or alleged perpetrator of known or suspected child abuse;[20] 2) Baker Act proceedings; 3) subsequent to court-ordered evaluations; and 4) when the patient relies on his or her condition as an element of the patient's claim or defense.

F.S. §39.204 provides that, in cases of child abuse, the psychotherapist-patient privilege should not operate as a shield to hide evidence of abuse. This is consistent with the statutory requirement to breach confidentiality — termed "abrogation" — by mandated reporting of child abuse.[21] The abrogation

statute specifies that reporting of child abuse trumps both confidentiality and privilege. Abrogation applies to all types of proceedings, not merely charges of child abuse.[22] However, this exception to privilege is limited only to that information relevant to the abuse itself.[23]

Determining Whether Privilege, Once Applied, Is Waived

With privilege comes a prima facie case for protection.[24] The party requesting records must then prove that privilege is waived; state laws vary widely in this area.[25] Florida uses a balancing test to determine whether privilege should be pierced.[26] The court must balance the privacy rights of the patient with other considerations, including societal interests, the government's police powers, the best interests of the child, the court's need for information, etc.

Generally, the prior mental health of the parents is rarely relevant or material to a child custody case. The primary legal issue in custody cases is the child's best interest, so even the parent's present circumstances may be only tangentially relevant.[27] Seeking custody does not make a parent's mental condition an element of his or her defense.[28] Allegations of a parent's mental or emotional instability are insufficient to place the parent's mental health at issue,[29] as are when a parent denies such allegations.[30] Instead, the piercing of privilege in family court requires a calamitous event — one that has a direct bearing on current parental fitness — and when probative evidence cannot be obtained via other means.[31]

Research literature suggests consideration of the weight and independence of the evidence, treatment type, recency of treatment, seriousness of the psychological disorder, relevancy of communications made in the course of treatment, availability of the evidence elsewhere, and whether court-ordered evaluations are an adequate substitute for disclosure.[32]

• *Examples When Privilege Is Not Waived* — Case law provides a few examples when courts have found no waiver. Privilege remains when there is another person in the room — as in couples or family counseling.[33] Mere allegations made by a parent's attorney do not pierce because courts "reject the use of unsworn assertions made by attorneys as evidence."[34] Prior substance abuse problems and treatment are insufficient.[35] There is no waiver for prior unfounded allegations of child abuse and when there is no ongoing issue of abuse.[36] The filing of a disability claim or releasing records to a disability insurance company does not waive privilege.[37] Finally, sending a client to a therapist as part of trial preparation protects work product/attorney-client privilege.[38]

• *Examples When Privilege Is Waived* — Failure to timely assert privilege will waive privilege,[39] as will a litigant eliciting privileged information from his or her own therapist.[40] Privilege can be voided when a spouse relies on a mental condition for a claim or defense, such as by alleging that he or she was too emotionally distraught to enter into a settlement agreement.[41] There is no privilege when there is no expectation of privacy, such as court-ordered counseling.[42] Privilege is waived if the information sought relates directly to the well-being of the child or to the parent's ability to adequately care for the child, and the child may be in danger.[43] Voluntary admission to an inpatient facility can waive privilege[44] as when a calamitous event has occurred, such as an attempted suicide.[45] A court is not required to wait until a calamitous event becomes a tragedy in order to find a privilege waiver.[46] The "totality of circumstances" can operate as a waiver to privilege.[47] A mental health professional can be required to testify to the danger posed by a patient, which necessarily waives privilege.[48]

The "Mature Minor" Privilege

A child's right to assert privilege depends on widely varying state laws.[49] The Florida Constitution may create a greater child privacy right than the U.S. Constitution.[50] However, the statutes are silent on this issue and the only guidance is provided by case law.

Beginning in 2001, the Fourth District Court of Appeal decided a number of cases that created a "mature minor" privilege.[51] In *Atty. Ad Litem for D.K. v. Parents of D.K.*, 780 So. 2d 301 (Fla. 4th DCA 2001), the court upheld a minor's independent privacy right over the state's, her parents', and the evaluator's interests.[52] The court opined that :

The parents both assert that they can waive this claim for their child. In the instant case, it is questionable whether either or both parents are acting solely on their daughter's behalf in attempting to waive the privilege and obtain the records of confidential communications, when each has his or her own interests at stake in this lawsuit.[53]

The court likewise extended a teen's privacy right[54] over the interests of the Department of Children and Families (DCF) and the Guardian ad Litem (GAL) Program,[55] requiring a due process hearing, an in camera review, and release of only *minimum necessary* records. Further, parents may not have standing to assert or waive the "mature minor's" privilege.[56] The GAL program's policy presumes that teens 14 years and older have sufficiently mature capacity to consent, but unilaterally decides whether children under 14 have capacity.[57]

These cases may not necessarily assist the court in determining whether a particular minor is due an independent privilege right. There is no singular answer, but case law and the literature consider several factors.[58] An oft-cited, non-Florida case, *In re Berg*, 886 A.2d 980 (N.H. 2005), advised consideration of the child's age, intelligence, and maturity; the child's intensity of preference; and the existence of undesirable or improper influences. The literature suggests consideration of the child's needs, desire, cognitive capacity, and perception of fairness, as well as parental concerns, the particular presenting problem, state statutes, the effect on the therapy, and respect for the minor's constitutional rights.[59]

Alternatives to Waiving Privilege

Courts have several tools available to avoid wholesale waiver of a patient's privilege, including court-ordered evaluations, in camera record review, partial or limited release, and protective orders. An independent psychological evaluation may be ordered,[60] but the parent's mental condition must be in controversy and good cause must be shown.[61] Should the court find that privilege is waived, it should review the records in camera and release only probative records,[62] but the use of records should be limited.[63] Courts may enter protective orders to impose sanctions should one of the parties make the

Data, 37 Prof. Psychol.: Research & Prac. 215-222 (Apr. 2006), *available at* http://www.apa.org/about/offices/ogc/private-practitioners.pdf.

[6] Three quarters of custody case litigants rescinded their psychotherapist records request after review of potential consequences. L. Kevin Hamberger, *Requests for Complete Record Release: A Three-step Response Protocol*, 37 Psychotherapy: Theory, Research, Prac., Training 89-97 (2000).

[7] Elizabeth M. Ellis, *Should a Psychotherapist Be Compelled to Release an Adolescent's Treatment Records to a Parent in a Contested Custody Case?*, 40 Prof. Psychol.: Research & Prac. 557-563 (Dec. 2009) [hereinafter Ellis, *Psychotherapist 2009*]; Denis K. Lane, Jr., *Limitations on Testimony by Mental Health Clinicians in Domestic Actions: Practical and Ethical Considerations*, http://www.centerforethicalstudies.com/notes_and_info/colo-lawyer-testimony.pdf; Carlton D. Stansbury, *Accessibility to a Parent's Psychotherapy Records in Custody Disputes: How Can the Competing Interests Be Balanced?*, 28 Behavioral Sciences & L. 522-541 (July/Aug. 2010) [hereinafter Stansbury, *Accessibility 2010*]; Cynthia A. Reynolds, Kelly Duncan & Rita Sommers-Flanagan, *"Please Don't Tell!": Custody Battles and Confidentiality*, Critical Incidents in Counseling Children 197-204 (2007).

[8] Marcia M. Boumil, Debbie F. Freitas & Cristina F. Freitas, *Waiver of the Psychotherapist-Patient Privilege: Implications for Child Custody Litigation*, 22 Health Matrix 1-31 (2012) [hereinafter Boumil, *Waiver 2012*].

[9] Ellis, *Psychotherapist 2009*; Elizabeth M. Ellis, *Should Participation in a Child Custody Evaluation Compel the Release of Psychotherapy Records?*, 7 J. Child Custody 138-154 (Apr. 2010) [hereinafter Ellis, *Child Custody 2010*]; *see also* Fla. Stat. §§490.0147 & 491.0147 (2012).

[10] 45 CFR §§164.512(a) & 164.512(e)(i) (2012). Disclosures required by law and court orders do not require a written authorization from the patient. *Evenson v. Hartford Life & Annuity Ins. Co.*, 244 F.R.D. 666, 668 (M.D. Fla. 2007).

[11] *Guerrier v. State*, 811 So. 2d 852, 854 (Fla. 5th DCA 2002); *Atty. Ad Litem for D.K. v. Parents of D.K.*, 780 So. 2d 301, 305 (Fla. 4th DCA 2001); Deborah Paruch, *The Psychotherapist-Patient Privilege in the Family Court: An Exemplar of Disharmony Between Social Policy Goals, Professional Ethics, and the Current State of the Law*, 29 N. Ill. U. L. Rev. 499, 500 (2008); Stansbury, *Accessibility 2010*; Courtney Waits, The Use of Mental Health Records in Child Custody Proceedings, 17 J. Am. Acad. Matrimonial L. 159-161 (2001) [hereinafter Waits, *Mental Health Records 2001*]; Boumil, *Waiver 2012*.

[12] Stansbury, *Accessibility 2010*.

[13] National Legal Research Group, Inc., *Discovery of a Party's Mental Health Records in Child Custody Matters* (1995), http://www.divorcesource.com/research/dl/discovery/95oct219.shtml (stating "if the legislature of a particular jurisdiction has not enacted a privilege, the privilege simply does not exist") [hereinafter National Legal, *Discovery 1995*].

[14] Presumably, the burden is on the patient to establish that privilege applies. The authors know of no case law on the matter, so it is likely that the preponderance of the evidence burden applies here, as it does with other privileges in Florida. *See Eight Hundred, Inc. v. Fla. Dep't of Rev.*, 837 So. 2d 574, 576 (Fla. 1st DCA 2003) (discussing accountant-client privilege); *see also O'Neill v. O'Neill*, 823 So. 2d 837, 839-40 (Fla. 5th DCA 2002) (strictly construing the statute establishing psychotherapist-patient privilege); and *Guerrier v. State*, 811 So. 2d at 854 (stating evidentiary privileges are generally disfavored, particularly those unknown at common law, therefore, they are strictly construed to limit their application).

[15] Fla. Stat. §90.503(1)(a) (2012). Privilege may not apply if the professional was working as a teacher or coach at the time.

[16] Fla. Stat. §90.503(1)(b) (2012). Privilege may not apply if someone else was officially the patient, as during family therapy. *See, e.g., Estape v. Scherer*, 67 So. 3d 428 (Fla. 4th DCA 2011).

[17] Fla. Stat. §90.503(2) (2012). Privilege may not apply if the information requested is outside of the statutory definition, such as for medical records, *Oswald v. Diamond*, 576 So. 2d 909, 910 (Fla. 1st DCA 1991) (stating there is no statutory restriction of relevant medical records "other than those made for the purpose of diagnosis or treatment of a mental or emotional condition"); or medical professionals' contact information, *Wilder v. Wilder*, 993 So. 2d 182 (Fla. 2d DCA 2008).

[18] Fla. Stat. §90.503(3) (2012). Persons who have standing to assert privilege include the patient, psychotherapist, attorney, guardian, conservator, or personal representative. Case law is somewhat contradictory in this area. Although parents may have no standing to assert or waive privilege when their interests conflict with the minor's, *Atty. Ad Litem for D.K.*, 780 So. 2d at 308, the appointment of a guardian ad litem is not required when the conflict arises, *Baron v. Baron*, 941 So. 2d 1233, 1237 (Fla. 2d DCA 2006). Instead, both *Baron* and *Hughes v. Schatzberg*, 872 So. 2d 996, 998 (Fla. 4th DCA 2004), appear to make the guardian ad litem and/or therapist responsible for asserting privilege. *C.f. Wray v. Dep't Prof. Reg.*, 410 So. 2d 960 (Fla. 1st DCA 1982) (holding the privilege inures to the patient, therefore, it can only be waived by the patient or someone acting directly on the patient's behalf).

[19] Some states have statutory exceptions in child custody disputes. Boumil, *Waiver 2012*. Florida does not.

[20] Fla. Stat. §39.204 (2012).

[21] Fla. Stat. §39.201 (2012).

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[11] *Guerrier v. State*, 811 So. 2d 852, 854 (Fla. 5th DCA 2002); *Atty. Ad Litem for D.K. v. Parents of D.K.*, 780 So. 2d 301, 305 (Fla. 4th DCA 2001); Deborah Paruch, *The Psychotherapist-Patient Privilege in the Family Court: An Exemplar of Disharmony Between Social Policy Goals, Professional Ethics, and the Current State of the Law*, 29 N. Ill. U. L. Rev. 499, 500 (2008); Stansbury, *Accessibility 2010*; Courtney Waits, *The Use of Mental Health Records in Child Custody Proceedings*, 17 J. Am. Acad. Matrimonial L. 159-161 (2001) [hereinafter Waits, *Mental Health Records 2001*]; Boumil, *Waiver 2012*.

[12] Stansbury, *Accessibility 2010*.

[13] National Legal Research Group, Inc., *Discovery of a Party's Mental Health Records in Child Custody Matters* (1995), http://www.divorcesource.com/research/dl/discovery/95oct219.shtml (stating "if the legislature of a particular jurisdiction has not enacted a privilege, the privilege simply does not exist") [hereinafter National Legal, *Discovery 1995*].

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[20] Fla. Stat. §39.204 (2012).

[21] Fla. Stat. §39.201 (2012).

[22] *State v. Jett*, 626 So. 2d 691, 693 (Fla. 1993).

[23] *Doherty v. Doe*, 957 So. 2d 1267, 1269 (Fla. 4th DCA 2007); *Carson v. Jackson* 466 So. 2d 1188, 1190-91 (Fla. 4th DCA 1985); *Hill v. State*, 846 So. 2d 1208, 1214 (Fla. 5th DCA 2003).

[24] Stansbury, *Accessibility 2010.*

[25] Boumil, *Waiver 2012*; National Legal, *Discovery 1995*; Waits, *Mental Health Records 2001*; Ellis, *Child Custody 2010*; Ike Vanden Eykel & Emily Miskel, *The Mental Health Privilege in Divorce and Custody Cases* (symposium, mid-year meeting of Am. Acad. Matrimonial Law., Mar. 2012), *available at* http://www.emilymiskel.com/pdfs/AAML.pdf [hereinafter Eykel, *Mental Health Privilege 2012*]; Gale Humphrey Carpenter, *Overriding the Psychologist-Client Privilege in Child Custody Disputes: Are Anyone's Best Interests Being Served?*, 68 UMKC L. Rev. 169, 170 (1999). Although the most frequently cited case regarding psychotherapist privilege appears to be *Kinsella v. Kinsella*, 696 A.2d 556 (N.J. 1997), Florida courts do not appear to rely on it.

[26] *Peisach v. Antuna*, 539 So. 2d 544, 546 (Fla. 3d DCA 1989); *Roper v. Roper*, 336 So. 2d 654, 657 (Fla. 4th DCA 1976) (stating "the trial court must maintain a proper balance, determining on the one hand the mental health of the parents as this relates to the best interest of the child, and on the other maintaining confidentiality between a treating psychiatrist and his patient").

[27] *Ashleman v. Ashleman*, 381 So. 2d 364, 365 (Fla. 4th DCA 1980).

[28] *Roper*, 336 So. 2d at 656.

[29] *Leonard v. Leonard*, 673 So. 2d 97, 99 (Fla. 1st DCA 1996); *Oswald v. Diamond*, 576 So. 2d at 910; *Mohammad v. Mohammad*, 358 So. 2d 610, 613 (Fla. 1st DCA 1978); *Schouw v. Schouw*, 593 So. 2d 1200, 1201-02 (Fla. 2d DCA 1992); *O'Neill*, 823 So. 2d at 840.

[30] *Peisach*, 539 So. 2d at 546 ("[T]he custodial parent's denial of allegations of mental instability does not operate as a waiver of the patient-psychotherapist privilege. To hold otherwise would eviscerate the privilege; a party seeking privileged information would obtain it simply by alleging mental infirmity.").

[31] *Atty. Ad Litem for D.K.*, 780 So. 2d at 309 ("Only in situations where calamitous events such as an attempted suicide occur during a pending custody dispute have courts found that the mental health of the parent is sufficiently at issue to warrant finding no statutory privilege exists."); *Hastings v. Rigsbee*, 875 So. 2d 772, 779 (Fla. 2d DCA 2004); *Flood v. Stumm*, 989 So. 2d 1240, 1241 (Fla. 4th DCA 2008); *Smith v. Smith*, 64 So. 3d 169, 171 (Fla. 4th DCA 2011); *see also* Ellis, *Child Custody 2010*; *O'Neill*, 823 So. 2d at 840.

[32] Am. Psych. Ass'n., *Disclosure of Psychiatric Treatment Records in Child Custody Disputes* (Task Force Report #31, 1991); Paruch, *Psychotherapist-Patient Privilege 2008.*

[33] *Segarra v. Segarra*, 932 So. 2d 1159, 1161 (Fla. 3d DCA 2006).

[34] *Smith*, 64 So. 3d at 171.

[35] *Koch v. Koch*, 961 So. 2d 1134, 1135 (Fla. 4th DCA 2007).

[36] *Flood*, 989 So. 2d at 1241.

[37] *Cohen v. Cohen*, 813 So. 2d 1060, 1261 (Fla. DCA 2002).

[38] Edward J. Imwinkelried, Evidentiary Foundations 837 (8th ed. 2012).

[39] *Critchlow v. Critchlow*, 347 So. 2d 453 (Fla. 3d DCA 1977).

[40] Stansbury, *Accessibility 2010.*

[41] Known as the "shield and sword rule." One cannot present favorable testimony or evidence on a subject (sword), and then claim that subject is privileged to withhold disfavorable testimony or evidence (shield). *Davidge v. Davidge*, 451 So. 2d 1051, 1052 (Fla. 4th DCA 1984).

[42] *Segarra*, 932 So. 2d at 1161. The psychotherapists' consent form should reflect this and an authorization for disclosure should be completed to document that the patient is aware of the required disclosure. However, if the court order does not indicate that a report will be made to the court or another person, the counseling could be privileged. Stansbury, *Accessibility 2010.*

[43] Waits, *Mental Health Records 2001.*

[44] *Mohammad*, 358 So. 2d at 613; *Critchlow*, 347 So. 2d at 455.

[45] Miraglia v. Miraglia, 462 So. 2d 507, 508 (Fla. 4th DCA 1984).

[46] *O'Neill*, 823 So. 2d at 840.

[47] *Id.*; *see also Daly v. Daly*, 624 So. 2d 304 (Fla. 4th DCA 1993).

[48] *Guerrier*, 811 So. 2d at 856 (finding that because the purpose of the "dangerous patient" statute, Fla. Stat. §456.059, is to protect the potential victim, MHPs can be asked to testify against their patients); *but see Boynton v. Burglass*, 590 So. 2d 446, 451 (Fla. 3d DCA 1991) (holding no requirement to breach confidentiality); Phyllis Coleman & Ronald A. Shellow, *Warning a Patient's Intended Victim While Preserving Testimonial Privilege: A Statute to Regulate All Psychotherapists*, 77 Fla. B. J. 20 (July/Aug. 2003) (discussing the *Guerrier* ruling in light of psychotherapist-patient privilege and confidentiality).

[49] Eykel, *Mental Health Privilege 2012*.

[50] Bernard P. Perlmutter, *More Therapeutic, Less Collaborative? Asserting the Psychotherapist-Patient Privilege on Behalf of Mature Minors*, 17 Barry L. R. 45, 70-77 (2011) (comparing federal and state constitutional considerations relating to psychotherapist-patient privacy and privilege) [hereinafter Perlmutter, *More Therapeutic 2011*]; Gerald P. Koocher & Patricia C. Keith-Spiegel, Children, Ethics, and the Law: Professional Issues and Cases (1990).

[51] *See, e.g.*, *E.C. v. Guardian Ad Litem Program*, 867 So. 2d 1193 (Fla. 4th DCA 2004); *S.C. v. Guardian Ad Litem*, 845 So. 2d 953 (Fla. 4th DCA 2003); *Atty. Ad Litem for D.K.*, 780 So. 2d at 308. As no similar cases have yet appeared in other district courts of appeal, nor before the Florida Supreme Court, the decisions may be binding only in southeast Florida.

[52] *Accord Kasdaglis v. Dep't of Health*, 827 So. 2d 328 (Fla. 4th DCA 2002) (upholding a MHP's right to assert privilege on behalf of a minor when facing a parent's records request).

[53] *Atty. Ad Litem for D.K.*, 780 So. 2d at 306.

[54] *E.C. v. Guardian Ad Litem Program*, 867 So. 2d 1193 (Fla. 4th DCA 2004); *S.C. v. Guardian Ad Litem*, 845 So. 2d 953 (Fla. 4th DCA 2003).

[55] The GAL has no requirement to maintain confidentiality. Marcia M. Boumil, Cristina F. Freitas & Debbie F. Freitas, *Legal and Ethical Issues Confronting Guardian Ad Litem Practice*, 13 J. L. & Fam. Stud. 43, 52 (2011).

[56] *Accord C.M. v. Dep't Children & Fam.*, 854 So. 2d 777 (Fla. 4th DCA 2003); *Shea v. Global Travel Marketing, Inc.*, 870 So. 2d 20, 24 (Fla. 4th DCA 2003), *rev'd on other grounds*, 908 So. 2d 392 (Fla. 2005); *Hughes*, 872 So. 2d at 997.

[57] Perlmutter, *More Therapeutic 2011*.

[58] Ellis, *Psychotherapist 2009*; Ellis, *Child Custody 2010*; Perlmutter, *More Therapeutic 2011*; Mitchell, *When Parents Want to Know 2002*; Kathryn E. Gustafson & J. Regis McNamara, *Confidentiality with Minor Clients: Issues and Guidelines for Therapists*, 18 Prof. Psychol.: Research & Prac. 503-508 (1987) [hereinafter Gustafson, *Confidentiality with Minor Clients 1987*]; Linda Taylor & Howard S. Adleman, *Reframing the Confidentiality Dilemma to Work in Children's Best Interests*, 20 Prof. Psychol.: Research & Prac. 79-83 (1989).

[59] Gustafson, *Confidentiality with Minor Clients 1987*; Perlmutter, *More Therapeutic 2011*.

[60] *Leonard*, 673 So. 2d at 99; *Schouw*, 593 So. 2d at 1201; *Peisach*, 539 So. 2d at 546; *Flood*, 989 So. 2d at 1242 n. 1; *Koch*, 961 So. 2d at 1134-1135; *Ashleman*, 381 So. 2d at 366.

[61] Fla. R. Civ. P. 1.360(a) (2012); *In re G.D.*, 870 So. 2d 235, 237 (Fla. 2d DCA 2004); *Williams v. Williams*, 550 So. 2d 166, 167 (Fla. 2d DCA 1989).

[62] *Smith*, 64 So. 3d at 172; *Doherty*, 957 So. 2d at 1269; *E.C.*, 867 So. 2d at 1194-1195; *S.C.*, 845 So. 2d at 959; *see also Peisach*, 539 So. 2d at 547 (permitting only the production of relevant medical information).

[63] *Hastings*, 875 So. 2d at 779; *McIntyre v. McIntyre*, 404 So. 2d 208, 209 (Fla. 2d DCA 1981).

[64] *See, e.g.*, Eykel, *Mental Health Privilege 2012*, National Legal, *Discovery 1995*; Perlmutter, *More Therapeutic 2011*; Stansbury, *Accessibility 2010*.

[65] Stansbury, *Accessibility 2010*.

[66] Gustafson, *Confidentiality with Minor Clients 1987*; Am. Psychol. Ass'n, *Ethical Principles of Psychol. & Code of Conduct*, Standard 4.02 (2002); Susan A. Dwyer, *Informed Consent in Court-Involved Therapy*, 9 J. Child Custody 108-125 (2012); Gail L. Perlman, *A Judicial Perspective on Psychotherapist-Client Privilege: Ten Practical Tips for Clinicians*, 9 J. Child Custody: Research, Issues, & Prac. 126-152 (2012).

[67] Am. Psychol. Ass'n, *Ethical Principles of Psychol. & Code of Conduct*, Standard 1.02 (2002).

[68] Floyd L. Jennings & J. Ray Hays, *How are Treating Psychologists to Respond to Requests for Court Testimony?*, 3 Open Access J. Forensic Psychol. 19, 26-29 (2011).

[69] Am. Psychol. Ass'n, *Ethical Principles of Psychol. & Code of Conduct*, Standard 4.04 (2002).

[70] *E.g.*, Fla. Admin. Code R. 64B19-18.007(1).

[71] *Atty. Ad Litem for D.K.*, 780 So. 2d at 310 ("We do not think that the patient/psychotherapist privilege should be overcome simply to satisfy the routine practice of the evaluator and psychologist.").

[72] Bruce G. Borkosky, *Why Forensic Records Are No Longer "Owned" by the Referral Source: Psychologists Are Required to Permit Patient Access and Release of Forensic Records*, 63 Fla. Psychol. 8-9, 22-23 (2012).

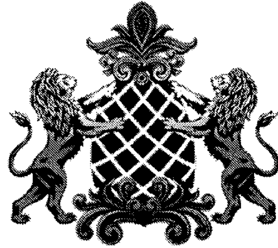
[73] *Atty. Ad Litem for D.K.*, 780 So. 2d at 310 ("[U]nder section 90.705(1) an expert testifying to an opinion may be required, on cross-examination, to reveal the underlying facts and data upon which the opinion is based. Therefore, the expert could not rely on confidential psychotherapist/patient communications without revealing them to the parties and the court.").

***Mark S. Thomas**, of the Thomas Health Law Group, P.A., in Gainesville and Santa Rosa Beach, is board certified in health law. Previously, he was chief of staff for the Florida Agency for Health Care Administration and director of the Florida attorney general's Medicaid Fraud Control Unit.*

***Bruce Borkosky** received a B.A. in psychology from Ohio Wesleyan University, an M.CS in computer science from the University of Dayton, and M.A. and Psy.D. degrees from the Miami Institute of Psychology, in 1991 and 1993, respectively. Dr. Borkosky has been in the independent practice of psychology since becoming licensed in 1994.*

This column is submitted on behalf of the Family Law Section, Carin Marie Porras, chair, and Sarah Kay, editor.

[Revised: 05-02-2013]



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Mental Health and Florida Child Custody: When is Mental Health Status Relevant?

Child custody cases can often get heated. When they do, many parents don't hold back in trying to show why the other parent should not be awarded custody of the children. If one parent has a history of mental illness or has visited a therapist, the other parent may try to use that as proof of parental unfitness. But how much weight does such evidence carry in a child custody determination, and can it be used in court?

Florida Psychotherapist-Patient Privilege

Under Florida law, communications between a psychotherapist and her patient are generally confidential. Known as the psychotherapist-patient privilege, it applies not only to patients who seek treatment for mental or emotional conditions such as depression or being bipolar, but treatment for alcoholism and drug addiction as well.

LIVE CHAT

The privilege prevents the psychotherapist from disclosing the information obtained in treatment, including all notes of sessions, to anyone not involved in the patient's care.

The Florida court has ruled that the act of seeking custody is not enough to waive the privilege and require that the records be turned over to the other parent. The fact that the father regularly sees a therapist, by itself, is insufficient to order the therapist to turn over treatment notes. Instead, the parent requesting admission of the therapist notes must show the occurrence of "calamitous events". If, for example, the father seeks therapy for depression that leaves him incapacitated for lengths of time, or makes him suicidal – both of which could negatively impact his ability to properly care for the children, or possibly put them at risk for physical harm – then the court may order they be turned over. But even then, the court has ruled that the calamitous event must occur during the custody proceeding; so the fact that the father *was* suicidal in the past may still be insufficient to have the notes turned over.

In these circumstances, where mental fitness is a concern but no calamitous event justifies ordering the records turned over, the judge can order either or both parents to undergo an independent psychological evaluation to help guide its decision. The court may order a mental health evaluation regardless of whether the parent already receives treatment from a therapist. The psychotherapist-patient privilege does not apply in these circumstances, as the evaluation is being conducted solely for trial.

Whether the psychotherapist notes are turned over due to a calamitous event, or the court orders an independent evaluation, evidence of a mental health condition or alcohol/drug problem does not automatically mean a parent is unfit for custody. It is simply one of many factors the court must consider in determining what time-sharing agreement is in the best interests of the child, and the judge will evaluate it in terms of its potential impact on the children's physical and mental well-being.

Experienced Boca Raton Child Custody Attorneys

The Boca Raton child custody attorneys at Schwartz I White have more than 50 years' combined experience helping client's draft reasonable time-sharing and parenting plans. Together we will sit down and discuss what arrangement is in your child's best interests. Our goal is to work toward a mutually agreeable plan with the child's other parent and, if that is impossible, to aggressively advocate for your position in court. Contact our office today at 561-391-9943 to schedule your free initial consultation.

By Schwartz | White | Posted on June 29, 2015 LIVE CHAT

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CE CORNER

How should a psychologist handle a parent's request for a minor's potentially harmful health records?

Clinicians have several ethical issues to consider

By Rebecca A. Clay

June 2017, Vol 48, No. 6
Print version: page 30

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Learning objectives: After reading this article, CE candidates will be able to:

1. Identify the Ethics Code Standards involved in treating minors in high-conflict families.
2. Describe alternatives to releasing potentially harmful health records.
3. Discuss the importance of informed consent and consultation with an attorney around legal issues.

Several times a year, "CE Corner" presents an ethical quandary and asks ethics experts to offer insights on how to address it. Here is this month's vignette:

Sixteen-year-old "Mary" has been in therapy with a psychologist as a result of her parents' bitterly contested divorce. During the course of therapy, she disclosed that she has had a sexual relationship with a boy who graduated from her high school several years ago and the psychologist included that information in her record. Mary was extremely reluctant to disclose the information to her psychologist because she feared that if it were ever disclosed to her father, he would react angrily, possibly violently. Mary reports that her father is strongly opposed to sex outside of marriage and that he has threatened to "make her pay" for any unhealthy choices she makes.

One morning, Mary's psychologist receives a letter from the father's attorney, which includes an authorization signed by Mary's father for the release of all of Mary's therapy records as part of his seeking custody through the divorce proceedings.

What should the psychologist do?

Legal issues

This vignette raises challenging legal issues,* in addition to ethical considerations. Cases involving high-conflict families are particularly sensitive. The psychologist needs to understand the Health Insurance Portability and Accountability Act (HIPAA), state privacy law, and his or her role in the process.

Any time a clinician has a doubt or question about how to proceed in any case, he or she should seek the advice of an attorney, says Thomas Pearson, JD, a former public member of the APA Ethics Committee and attorney based in Bloomington, Minnesota. Not all states let minors consent to treatment and some states specifically grant or deny parents access to their children's records, so this vignette is a prime example of why it is key to reach out to an attorney who is familiar with HIPAA and the laws in the jurisdiction on record-keeping, patient privacy and confidentiality, he says.

"Psychologists are often concerned about the cost of consulting with an attorney, but in most situations they can get a legal opinion in an hour or less of an attorney's time that can really save a lot of time and expense later on," Pearson says.

One of the first questions the psychologist should consider in this case is who legally provided consent for Mary's psychological treatment, says Linda Knauss, PhD, past chair of the APA Ethics Committee. Each state has a different law dictating at what age a person can give consent to treatment. In Pennsylvania, for example, the legal age of consent is 14 years old, meaning that Mary may have consented to her own treatment—which is often encouraged if a person is old enough.

If she did provide the consent to treatment, then she likely controls patient confidentiality and access to her records. She would need to be the one to sign the authorization for a third party to access her information, not her father, explains Knauss, who is also a professor of clinical psychology at Widener University.

However, if Mary's parents consented to treatment with the psychologist because they have the legal right, then they likely control confidentiality and access to her records. If the parents had already gone through divorce and custody proceedings, there may be court orders determining what rights each parent has regarding their child's medical information. Assuming the court order is silent on whether both parents must agree to release medical information, it would be advisable to obtain both parents' agreement, says retired Minnesota clinical psychologist Jack Schaffer, PhD, former president of the Association of State and Provincial Psychology Boards. After the psychologist consults with his or her own attorney on this issue, it would likely be appropriate to communicate back to the father's attorney that he or she would need a consent signed by Mary's mother or a court order in order to release the child's records.

Another legal issue to consider is whether the sexual contact that Mary described meets the definition of child sexual abuse in her jurisdiction, advises Janet Thomas, PsyD, a clinical psychologist in St. Paul, Minnesota, who provides ethics consultation and clinical supervision for mental health professionals. It's unclear from the vignette how old the boy was when the alleged sexual contact occurred, as well as the age difference between the two. If the age difference meets the definition of child abuse, the clinician likely is required to report it to authorities, says Thomas, a former chair of the Minnesota Psychological Association Ethics Committee and former member of the APA Ethics Committee.

"In many cases, psychologists can get a free initial read of these issues from APA, if they are members, and from their professional liability insurer," says Alan Nessman, JD, senior special counsel for the APA Practice Directorate's Legal and Regulatory Affairs Office. Those sources may also be able to recommend attorneys who can counsel the psychologist, but Nessman notes that finding a private attorney with real expertise in this area can be challenging.

Ethical issues

Clinicians have several ethical issues to consider in this case, particularly those related to competence, multiple relationships, informed consent and record keeping.

Competence, as spelled out in the APA Ethics Code's **Standard 2.01: Boundaries of Competence**, requires clinicians to practice only in the boundaries of their competence, which can be demonstrated by their education, training and experience. Psychologists working on cases involving divorce or child custody should have familiarity with child psychology, family psychology, psychological assessment and a basic understanding of the boundaries with forensic psychology, as well as the legal issues that may arise. Even if the psychologist's role is that of a treating professional, the psychologist must be prepared to address scenarios that are likely to transpire when family relationships devolve.

"As a board member, I saw lots of cases where clinicians who were very competent at providing psychological services knew nothing about the legal arena and ended up overstepping on custody issues, without having any idea of what the implications might be," Schaffer says. "Having some familiarity with the boundary between therapy practice and forensic psychology is really important if you decide to take on these types of cases."

If the psychologist has not treated clients who are involved in contentious divorces or custody matters, he or she should seek supervision and receive additional training before accepting clients in these cases.

It may be possible to avoid conflicts and disagreements by clearly defining the psychologist's role and responsibilities before treatment begins. If the psychologist is retained to provide therapy to children or a parent involved in a divorce or custody situation, it is important for the psychologist to clarify what the parents can—and cannot—expect. For example, the psychologist can explain that he or she cannot be an advocate for either side and will not be able to testify as an expert witness regarding issues such as visitation, custody or fitness to parent. The psychologist may have to testify as a fact witness regarding the therapy. (See "Providing information in a patient's lawsuit: FAQs on subpoenas and depositions (http://www.apapracticecentral.org/update/2011/11-17/subpoenas-depositions.aspx) ," *PracticeUpdate* Nov. 17, 2011.) This role clarification will help clinicians stay in line with **Standard 3.05: Multiple Relationships**. "The [psychologist's] sense of caring can get in the way of being objective about what roles and behaviors are appropriate," Schaffer says.

Informed consent is also crucial in this case. **Standard 3.10: Informed Consent** and **Standard 10.01: Informed Consent to Therapy** require that psychologists inform clients about the limits of their privacy at the outset of treatment. Some states even require a signed written consent, but at minimum, the psychologist should have had a detailed discussion with Mary and her parents about the parents' legal right to her therapy records, Thomas says.

If the state in which the psychologist practices allows minors to consent to treatment, and therefore to control access to their records, it is good to clarify that arrangement at this stage. In instances where the parents have control over their child's records, it is sometimes possible to get them to agree to keep therapy details private, with limited exceptions (such as illegal substance use, dangerous activity and suicidal ideation). That informed consent may also include the parents' agreement to receive periodic updates on their child's treatment, rather than full summaries after each session—a procedure that can enable children to speak more freely with the therapist, Thomas says. "Most of the time, parents will agree to this," she says, adding that such agreements may not always override the parents' legal right to the information, depending on state law. In states that give the parents the right to access despite such an agreement, the child needs to know that even if the parents agree to allow the therapy to remain confidential, they could change their minds and the psychologist would be required to share that information, she says.

According to Nessman, many of the legal issues and uncertainties can be avoided if the psychologist has the parents—particularly parents of older minor patients—sign an informed consent at the start of therapy that covers what will stay confidential during therapy sessions. Where the parents are likely to control the child's records, it may also be helpful to have them agree up front on whether one or both of them must consent to the release of the child's records, especially if there is actual or potential conflict between the parents.

Making sure that Mary understands her rights is paramount, says Knauss. "I'd much rather a patient not tell me something than end up in the situation that Mary is in."

Psychologists should also be mindful of the information they include in their progress notes, Knauss adds. **Standard 6.01: Documentation of Professional and Scientific Work and Maintenance of Records** as well as APA's 2007 Record Keeping Guidelines provide direction on this. Clinicians should record who attended each session, the length of the session, and the client's treatment goals and progress.

But some sensitive information may not need to be written down if it's not relevant to a client's treatment. It's unclear from the vignette, for example, whether Mary's previous sexual relationship is pertinent to her treatment, Knauss says. "Certainly, sometimes it's relevant and so it should be in the notes, but the point is that one should think carefully about what one writes in one's notes."

How should the psychologist proceed?

Once the psychologist has determined who has control over the records, the psychologist must consider whether there is any limitation on access to the minor's records or other ways to approach the matter.

For example, if the father has the right to access the records, and the psychologist is subject to HIPAA, how should the psychologist react to Mary's concerns that her father will "make her pay" if he finds out about her sexual relationship? Nessman suggests that the psychologist consider the HIPAA provision giving the psychologist discretion not to let a parent access records if the psychologist determines that that access would not be in the minor patient's best interest, and has a reasonable belief that access could endanger Mary or subject her to abuse.

However, the question of potential harm can be tricky, Pearson notes: If a client is simply going to be upset that a parent or someone else has gained access to the information in their records, that's not necessarily the harm contemplated by HIPAA or state laws allowing psychologists to withhold records because of potential harm. In fact, a psychologist could get in trouble later on with a psychology board or even in a civil case for refusing to release information.

Turning to clinical strategies, the psychologist might let Mary know he or she received this request, and ask if she would be comfortable if the therapist discussed it with her father, Knauss says. (If Mary controls the records, HIPAA would require that she sign an authorization for that discussion.)

"Then the father can ask questions and perhaps get more insight about Mary's state of mind and what's in the records," she says. If he's extremely angry about the information shared, the psychologist could intervene and perhaps be able to decrease his anger, whereas if he just read it on a piece of paper and he's alone in a room or with his attorney, his anger could escalate.

Another option in scenarios not involving a custody dispute might be for the psychologist to offer to write a report about Mary and the work that's been done in therapy—a therapy summary—rather than sending the record, Knauss says. (If the father has the right to records, under HIPAA the psychologist needs to make it clear that the father understands that right when offering a summary instead.) Sometimes, that is enough to satisfy the person requesting the information, and it also gives the therapist another opportunity to think about what they want to include in the report, she says.

In this example, let's assume the psychologist appropriately consulted with the psychologist's malpractice carrier, APA's Legal and Regulatory Affairs Office and a local licensed attorney and that the legal advice received was that the minor patient had control over her therapy records because of a state law that grants minors the right to consent to treatment beginning at age 15. Therefore, under HIPAA and this state's law she—rather than her father—was the one to authorize the release of her records. The father's request would not be sufficient for the release of records. Under this fact pattern, the psychologist was advised that under her state's law and HIPAA, since Mary consented to treatment, the father did not have the right to demand her records. The psychologist should respond to the father's attorney that he or she cannot release Mary's records or testify without her authorization or a court order.

Resources

APA Record Keeping Guidelines

www.apa.org/practice/guidelines/record-keeping.aspx (/practice/guidelines/record-keeping.aspx)

APA's Ethics Code

www.apa.org/ethics/code (/ethics/code/index.aspx)

Assessing and Managing Risk in Psychological Practice

Bennett, B.E., et al., The Trust, 2013

Providing Information in a Patient's Lawsuit: FAQs on Subpoenas and Depositions

PracticeUpdate, 2011

The Privacy Rule: A Primer for Psychologists

2013

Working With Children and Adolescents

Good Practice, Winter 2011

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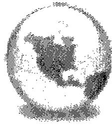

RE: case study for grad student
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I would not release any information about the mother at all unless she was willing to sign a release allowing me to disclose that information.
Regarding the son, he is the father and I imagine he would have a right to information about the things that are being addressed in counseling but first I would just make sure I consulted my school's policy regarding the disclosure of information. I would explain to the mother that I will not release any information about her, but if he asks about the progress the child is making, I may disclose information about that – enough to satisfy his questions without disclosing sensitive or confidential information.
I would also discuss all of this with my supervisor so they are aware of what is going on and to receive any guidance or feedback they have to offer.

From: Jasmin.McKinnie@bhcpns.org [mailto:Jasmin.McKinnie@bhcpns.org]
Sent: Tuesday, October 30, 2018 9:14 AM
To: Kendra Bozard <kbozard@cdac.info>
Subject: Fw: case study for grad student

Good morning,

I am working on case study for Clinical Mental Health program at Troy University. They are wanting the students to speak/consultation with other counselors regarding how they would handle situation. I have attached the document below. Any feedback, would be greatly appreciated!

Thanks!
Jasmin McKinnie
Child Welfare Case Manager
FamiliesFirst Network
340 Beal Parkway, NW
Fort Walton Beach, FL 32548
Cell 850-572-2367
Fax 850-833-3913

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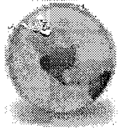

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Subject: FS and Profession Code of Ethics
To: Jessica Mayo <jmayo@lsfnet.org>, Jaime Aughtman <jaughtman@lsfnet.org>, (Andrea) Lynn Carper <acarper@lsfnet.org>

The FS on Mental Health Records
394.4615 Clinical records; confidentiality.—
This cites the applicability of professional ethics in records release.

(I'm going to send the MH ethics on this also.
For the NASW, I am directed to request a court order be rescinded, and that only narrow scope be released.)

(9) Nothing in this section is intended to prohibit the parent or next of kin of a person who is held in or treated under a mental health facility or program from requesting and receiving information limited to a summary of that person's treatment plan and current physical and mental condition. Release of such information shall be in accordance with the code of ethics of the profession involved.
--
Pamela S. Powers
M.Ed., MSW, LCSW, CAP, QS
Program Therapist, S/PATP
51-B Yacht Club Drive
Fort Walton Beach, FL 32548
Phone: (850) 664-0145, Fax (850) 664-0187

Extension of services from the S/PATP in the Gulf Coast Kids House
http://www.gulfcoastkidshouse.org/

"(c) The court orders such release. In determining whether there is good cause for disclosure, the court shall weigh the need for the information to be disclosed against the possible harm of disclosure to the person to whom such information pertains."

On Tue, Jun 7, 2016 at 4:18 PM, Pamela Powers <ppowers@lsfnet.org> wrote:

You have this, from the MH Ethics. "only information necessary "

I certainly see where the entire record is not "necessary".

The judge in my case Did choose to release progress notes and drawings that specifically addressed ONLY the abuse, (I had a ROI on "overview and disclosure")
He kept the Rest of the record confidential. He made that decision after conducting an "in-camera review" of the record, which the DCF attorney had requested - to start with.
That in camera review is also cited in the Bar Journal.

On Tue, Jun 7, 2016 at 4:14 PM, Pamela Powers <ppowers@lsfnet.org> wrote:

Right.... However...this, from NASW, is.

Also, the Jaffee v Redmond Case formally added LCSW to those profession that already had the privilege.
So, I think there is a case to be made for this applying as well.
Also, the Bar Journal article site the options of records under seal, limited scope of disclosure.

"(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection. "

http://socialworkers.org/pubs/code/code.asp

On Tue, Jun 7, 2016 at 4:09 PM, Jessica Mayo <jmayo@lsfnet.org> wrote:

That isn't nearly as specific as I would like...

Jessica Mayo, MS, LMHC
Program Coordinator & Therapist
Lutheran Services Florida
Sexual/Physical Abuse Treatment Program at Gulf Coast Kids House
(850) 595-5817

On Jun 7, 2016, at 4:02 PM, Pamela Powers <ppowers@lsfnet.org> wrote:

MH

- "The release of information without consent of the client may only take place under the most extreme circumstances: the protection of

life (suicidality or homicidality), child abuse, and/ or abuse of incompetent persons and elder abuse. Above all, mental health counselors are required to comply with state and federal statutes concerning mandated reporting.

- Mental health counselors (or their staff members) do not release information by request unless accompanied by a specific release of information or a valid court order. Mental health counselors make every attempt to release only information necessary to comply with the request or valid court order. Mental health counselors are advised to seek legal advice upon receiving a subpoena in order to respond appropriately."

https://amhca.site-ym.com/?codeofethicsia#anchor_ethicsl

On Tue, Jun 7, 2016 at 3:57 PM, Pamela Powers <ppowers@lsfnet.org> wrote:

The FS on Mental Health Records
394.4615 Clinical records; confidentiality.—
This cites the applicability of professional ethics in records release.

(I'm going to send the MH ethics on this also.
For the NASW, I am directed to request a court order be rescinded, and that only narrow scope be released.)

(9) Nothing in this section is intended to prohibit the parent or next of kin of a person who is held in or treated under a mental health facility or program from requesting and receiving information limited to a summary of that person's treatment plan and current physical and mental condition. Release of such information shall be in accordance with the code of ethics of the profession involved.

--

Pamela S. Powers
M.Ed., MSW, LCSW, CAP, QS
Program Therapist, S/PATP
51-B Yacht Club Drive
Fort Walton Beach, FL 32548
Phone: (850) 664-0145, Fax (850) 664-0187

Extension of services from the S/PATP in the Gulf Coast Kids House
http://www.gulfcoastkidshouse.org/

--

Pamela S. Powers
M.Ed., MSW, LCSW, CAP, QS
Program Therapist, S/PATP

Fwd: FS and Profession Code of Ethics
Pamela Powers
to:
Jasmin.McKinnie
11/02/2018 03:29 PM
Hide Details
From: Pamela Powers <ppowers@lsfnet.org>
To: Jasmin.McKinnie@bhcpns.org

* ATTENTION - This is an EXTERNAL email - Please CHECK THE FULL SENDER address to assure the message came from the correct person and NEVER open attachments or links in unexpected emails. *

MH Code of Ethics

---------- Forwarded message ---------
From: **Pamela Powers** <ppowers@lsfnet.org>
Date: Tue, Jun 7, 2016 at 3:02 PM
Subject: Re: FS and Profession Code of Ethics
To: Jessica Mayo <jmayo@lsfnet.org>, Jaime Aughtman <jaughtman@lsfnet.org>, (Andrea) Lynn Carper <acarper@lsfnet.org>

MH

- "The release of information without consent of the client may only take place under the most extreme circumstances: the protection of life (suicidality or homicidality), child abuse, and/ or abuse of incompetent persons and elder abuse. Above all, mental health counselors are required to comply with state and federal statutes concerning mandated reporting.
- Mental health counselors (or their staff members) do not release information by request unless accompanied by a specific release of information or a valid court order. Mental health counselors make every attempt to release only information necessary to comply with the request or valid court order. Mental health counselors are advised to seek legal advice upon receiving a subpoena in order to respond appropriately."

https://amhca.site-ym.com/?codeofethicsia#anchor_ethicsl

On Tue, Jun 7, 2016 at 3:57 PM, Pamela Powers <ppowers@lsfnet.org> wrote:

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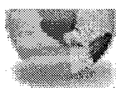
Pamela Powers
to:
Jasmin.McKinnie
11/02/2018 03:27 PM
Hide Details
From: Pamela Powers <ppowers@lsfnet.org>
To: Jasmin.McKinnie@bhcpns.org

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Privilege

---------- Forwarded message ---------
From: **Pamela Powers** <ppowers@lsfnet.org>
Date: Tue, Jun 7, 2016 at 3:36 PM
Subject: Re: FS and Profession Code of Ethics
To: Jessica Mayo <jmayo@lsfnet.org>
Cc: Jaime Aughtman <jaughtman@lsfnet.org>, (Andrea) Lynn Carper <acarper@lsfnet.org>

Authority to claim the privilege, on behalf of the client.

FS 90.503

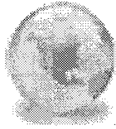
Title VII	**Chapter 90**	**View Entire Chapter**
EVIDENCE	EVIDENCE CODE	

90.503 Psychotherapist-patient privilege.—

(2) A patient has a privilege to refuse to disclose, and to prevent any other person from disclosing, confidential communications or records made for the purpose of diagnosis or treatment of the patient's mental or emotional condition, including alcoholism and other drug addiction, between the patient and the psychotherapist, or persons who are participating in the diagnosis or treatment under the direction of the psychotherapist. This privilege includes any diagnosis made, and advice given, by the psychotherapist in the course of that relationship.
(3) The privilege may be claimed by:
(a) The patient or the patient's attorney on the patient's behalf.
(b) A guardian or conservator of the patient.
(c) The personal representative of a deceased patient.
(d) The psychotherapist, but only on behalf of the patient. The authority of a psychotherapist to claim the privilege is presumed in the absence of evidence to the contrary.

On Tue, Jun 7, 2016 at 4:28 PM, Pamela Powers <ppowers@lsfnet.org> wrote:

> Be Aware, THIS is in the FS 394.4615, and is the Crux of safeguarding.



RE: case study for grad student
Cynthia Oille
to:
Jasmin.McKinnie
10/31/2018 02:08 PM
Hide Details
From: "Cynthia Oille" <cynthia.oille@bridgeway.org>
To: <Jasmin.McKinnie@bhcpns.org>
History: This message has been replied to.

0 Attachment

image001.jpg

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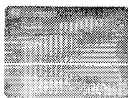
I think this is definitely a tricky case. My desire would be to protect the child and not want to release records but father may have the legal right to request them. I think an important thing to look at would be if there is any type of legal restrictions in place on the father already, for example a no contact or restraining order. Another thing to consider might be whether the father is the legal father, is he on the birth certificate or were they married at the time of his birth. If there is no legal reason to withhold the records I would make sure that he makes the request through official channels, such as making a request to the records department. Depending on the way the request is made you may be able to send a summary of treatment rather than the actual progress note from the file. (This would be something to talk to a supervisor records department about how to do) At this point in the case it is too late but something you could have done from the beginning is to write your notes with the idea that the father or court could request them so not put in information that is not necessary for treatment that might be interpreted negatively. For example, rather than saying "the child stated that I hate my father and wish that I could kill him" (if you know that there is no real danger/duty to report) or "mother has started dating a co-worker" you might say "child discussed feelings related to father" and "mother discussed current personal progress related to divorce".

Hope this helps.

CynthiaOille

Child and Family Therapist
Bridgeway Center, Inc
(850) 833-7500 x269



Re: Fw: case study for grad student
EJ Dickens to: Jasmin McKinnie 11/01/2018 12:34 PM

I think statute 490.0147 covers your situation

E.J. Dickens, MS , RMHCI # IMH14452
School Overlay Services Counselor

Lakeview Center Inc.
Children's Services Building
1221 W. Lakeview Ave.
Pensacola, Florida 32501

EJ.Dickens@bhcpns.org
Voicemail: (850) 469-3534
Cell: (850) 602-8115
Fax: (850) 469-3664

"Unless someone like you cares a whole awful lot, nothing is going to get better, it's just not."

-Dr. Seuss'

The Lorax

Jasmin McKinnie This sounds like a legal/professional issue. I wo... 11/01/2018 12:26:56 PM

From: Jasmin McKinnie/PNS/BHC_Notes
To: EJ Dickens/PNS/BHC_Notes@BHC_NOTES
Date: 11/01/2018 12:26 PM
Subject: Re: Fw: case study for grad student

Are these guidelines based off Florida's requirements?

Sent from IBM Verse

EJ Dickens --- Re: Fw: case study for grad student ---

From: "EJ Dickens" <EJ.Dickens@bhcpns.org>
To: "Jasmin McKinnie" <Jasmin.McKinnie@bhcpns.org>
Date: Thu, Nov 1, 2018 10:42 AM
Subject: Re: Fw: case study for grad student

This sounds like a legal/professional issue. I would consult my immediate supervisor regarding how to proceed. On a basic level, if the father's rights are in place, he can ask questions about the client but not about the client's mother. The mother would likely need a court order to prevent you from sharing information with him. There has to be legal proof that the client may be in danger, if you share information with him. I would give him a scheduled time to discuss his son's treatment after you manage up. They will likely use the Code of Ethics/Legal Advice as a guide for what and how you will share information with him. Here are some decision making charts to help. But, remember you have to have legal proof, it cannot just be based off what one of the parents say. Overall, you will do what the organization tells you to do.