It’s Your Right
Surviving the Mountain of Paperwork
W. Bryce Hagedorn, PhD, LMHC, NCC, MAC

Client Rights
• Disclosure to Clients
  – Confidentiality
  – Client records
  – Participation in the process
  – Right to refuse
  – Confidentiality
• Inability to Give Consent

Counselor Responsibilities
• Standards Knowledge
  – Professional Competence
  – Boundaries of Competence
  – New Specialty Areas of Practice
  – Qualified for Employment
  – Monitor Effectiveness
  – Ethical Issues Consultation
  – Continuing Education
  – Impairment
• Advertising and Soliciting Clients
  – Accurate Advertising
  – Testimonials
  – Recruiting
  – Professional Association Involvement
• Credentials
  – Credentials Claimed
  – ACA Professional Membership
  – Doctoral Degrees From Other Fields
• Public Responsibility
  – Nondiscrimination
  – Sexual Harassment
  – Reports to Third Parties
  – Unjustified Gains
• Responsibility to Other Professionals
  – Different Approaches
  – Personal Public Statements
  – Clients Served by Others
Informed Consent

- Clients have the __________________________ (or for research purposes)
- 3 elements necessary in giving consent
  - __________________________
  - __________________________
  - __________________________
- Explanation is crucial
- Possible consequences – Malpractice, Negligence, or Breach of Contract

Content of Informed Consent

- The therapeutic process
- Background of therapist
- Costs involved in therapy
- The length of therapy and termination
- Consultation with colleagues
- Interruptions in therapy
- Clients’ right of access to their files
- Rights pertaining to diagnostic labeling
- The nature and purpose of confidentiality
- Benefits and risks of treatment
- Alternatives to traditional therapy
- Tape-recording or videotaping sessions

Checklist for Informed Consent

- Voluntary participation
- Client involvement
- Counselor involvement
- No guarantees
- Risks associated with counseling
- Confidentiality and privilege
- Exceptions to confidentiality and privilege
- Counseling approach or theory
- Counseling and financial records
- Ethical guidelines
- Licensing regulations
- Credentials
- Fees and charges
- Insurance reimbursement
- Responsibility for payment
- Disputes and complaints
- Cancellation policy
- Affiliation membership
- Supervisory relationship
- Colleague consultation
Involuntary Commitment

• Most common reasons (__, ___, ___)
  – Suicidal Ideations
  – Homicidal Ideations
  – Audio/Visual Hallucinations (psychosis)
  – Not responding to ______________________
    (significant deterioration – e.g., unable to care for self)

Involuntary Commitment

• Consult
• Encourage ______________________
• Determine outcomes
• Consider all options
• ______________________
• Know your state laws
  – The Florida Mental Health Act or Baker Act
  – The Marchman Act

The Marchman Act

• A law under the Florida Statute that enables family members to obtain help for a loved one who is unwilling to seek substance abuse services voluntarily.
The Marchman Act

• Individual must meet the following:
  – Has ______________________________ with respect to substance use; and EITHER
  • Has __________________________________ physical harm on himself or another; OR
  • Is in need of substance abuse services and, by reason of substance abuse impairment, is incapable of __________________________ for such services and of making a __________________________ in regard to receiving services.

  However, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to the need for such services.

The Marchman Act

• How does one obtain a petition?
  – In Orange County the family contacts the __________________ for assistance.
  – In the other counties, the __________________ at the courthouse is the first point of contact.

• Then what happens?
  – The petition is reviewed by a judge to determine if the situation is an emergency
  – ___________________________________ picks up the person and takes him/her to the ______________________________

  The Marchman Act

• The facility has up to _______________________ to complete an evaluation
• During that time, the facility may:
  – Ask the court for an extension
  – Release the client, or
  – __________________________ with the courts asking for the judge to court-order treatment services.
The Baker Act

- (1971 revised in 2005), widely known as the “Baker Act” (in honor of Maxine Baker, the former state representative who sponsored the Act).
- A law which allows for an evaluation of an individual who meets certain criteria.

The Baker Act

- Person must meet the following criteria:
  - Reason to believe that and because of the illness:
    - The person has explained the purpose of the examination; or after being determined by willingness to him/herself, which poses a present threat of substantial harm to his/her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
    - There is a substantial likelihood that without care or treatment the person will cause to him/herself or others in the near future, as evidenced by recent behavior.

The Baker Act

- Then what happens?
  - Paperwork (an initiated by a (LMHC, LMFT, LCSW, psychiatrist, clinical psychologist, psychiatric nurse) law enforcement officer, physician, or judge
  - Law enforcement picks up the person and takes him/her to the nearest receiving facility
    - Person receives a physical exam within
      - “” is determined within 24 hours
    - Psychological evaluation occurs (psychologist, physician, or psychiatrist) – and then there’s more...
The Baker Act

- Outcomes of the evaluation
  - If the person warrants treatment for involuntary
    ____________, a petition is filed with
    the court, who then decides the validity of this
    evaluation: it can order placement for __________
  - If the person does not meet criteria for either
    involuntary inpatient treatment or involuntary
    outpatient placement, he or she must be discharged

Client Rights (Minors)

- Autonomy dependent on age
  - _______ – governed by parents _______ – gray area
  - _______ – act like adults
- Challenges with confidentiality
- Criteria to decide confidentiality: age, cognitive
  maturity, identified problem, client wishes, parent wishes
- Dual relationships
- The “big 3” of confidentiality
  - __________________
  - __________________
  - __________________

Record Keeping

- What’s in the record?
  - Demographics
  - Intake assessment and report
  - Psychosocial history
  - Medical history
  - Treatment plan
  - Progress notes
  - Signed consent forms
  - Formal assessment results (e.g., OQ, MMPI-2, SASSI-A2)
  - Homework assignments
  - Insurance information
  - Treatment summary
Why Keep Records?

• Aids in understanding the client
• Helps in formulating a ________________
• Helps to evaluate accomplishments
• Serves as a reference or learning tool
• Facilitates the treatment process
• Reminds you of unfinished business
• How long do we keep client records?
  – __________

Why Keep Records?

• Keep homework assignments – progress
  ___________________________ before the
  session
• Keeps the goals of therapy in mind
• Continuity of care
• Billing purposes
• Court ordered
• Always write as if someone else is going to read
  them
  ___________________________

Taking Notes

• May be structured according to the plan/theory
• Note highlights – don’t write everything
• Summarize issues
• Note decisions/interventions/shifts
• Capture generalizations
• Note-taking increases accountability
• Notes, notes, notes...
  – __________________ notes: formally describe the session and
    remain a part of the client’s file
  – __________________ notes: notes recorded (in any
    medium) that document/analyze the content of conversation
Everything You Ever Wanted To Know About Progress Notes
• Think about what you are going to write and formulate before you begin
• Be sure you have the right chart!
• Date and sign every entry
• Proofread
• Record as “late entry” anytime it doesn’t fall in chronological order; be timely
• Think about how the client comes through on paper
• Watch abbreviations-use only those approved
• Errors should have a line through incorrect information. Write “error”, initial and date
• Write neatly and legibly; print if handwriting is difficult to read

Everything You Ever Wanted To Know About Progress Notes
• Use proper spelling, grammar and sentence structure
• Don’t leave blank spaces between entries; can imply vital information left out
• Put client name/case number on each page
• Avoid slang and curse words
• Another provider should be able to continue quality care
• Use quotes from client that are clinically pertinent
• Describe what you observed, not just your opinion of what you observed

Everything You Ever Wanted To Know About Progress Notes
• Reference identified problems from the treatment plan
• Reference diagnostic criteria from DSM
• Use power quotes:
  - “Client remains at risk for __________ as evidenced by __________”
  - “The current symptoms include __________”
  - “Limited progress in __________”
  - “Continues to be depressed as evidenced by __________”
  - “Client continues to have suicidal ideation as evidenced by the following comment made to this writer: __________”
**Progress Notes**

- Document all contact with the client
  - Include phone calls
  - Contact with client’s family/friends/support network
  - Document all releases of records

**The SOAP Note**

- __________________________ – write the patient’s story, normally in his or her own words. Include relevant past psychological history
- __________________________ – everything that can be observed, measured, & quantified
- __________________________ – your conclusions about the findings (S & O). What is your diagnosis?
- __________________________ – treatment plan, homework assignments, follow-up plans, and return appointments

**Other Progress Notes**

- **DAP**
  - __________________________
    - Subjective and objective data about the client
    - Description of both the content and process of the session
  - __________________________
    - Intervention, assessment – what’s going on (based on Data)?
    - Working hypotheses, gut hunches (use theoretical language)
  - __________________________
    - What you’re going to do about it
    - Any topics to be covered in next session(s), and HW given
Other Progress Notes

- **PIRP**
  - Problem: What was the treatment goal being treated?
  - Intervention: What happened related to the treatment goal? What interventions were used?
  - Results: What were the results of the interventions? What progress is being made related to the treatment goal?
  - Plan: How did you evaluate your client’s progress? What are your recommendations based on this evaluation? What homework was assigned (if any)?

- **1st Session Goals**
  - Complete intake process
  - Establish rapport with client(s)
  - Determine motivation to seek counseling

- **2nd Session Goals**
  - Establish rapport with client(s)
  - Determine motivation to seek counseling
  - Establish treatment goals

Treatment Planning

- A *general guide* for a **SMART Tx Plan**:
  - ____________________________ – prioritized concrete goals
  - ____________________________ – partialized and observable
  - Achievable – attainable within time frame
  - ____________________________ – for the client, setting, time frame
  - Time-Limited – set a date

- **Contracting & Evaluation**

Malpractice

- The ____________________________ professional services or to exercise the degree of skill that is ____________________________ generally by professional in a ____________________________
Reasons for Malpractice Suits

- Failure to obtain or document informed consent
- Client abandonment
- Marked departures from established therapeutic practices
- Practicing beyond the scope of competency
- Misdiagnosis

- Crisis intervention
- Repressed or false memory
- Unhealthy transference relationships
- Sexual abuse of client
- Failure to control a dangerous client
- Managed care and malpractice

Ways to Avoid a Malpractice Suit

- Work only with those that you should
- Professional honesty and openness
- Define your fees
- Maintain competence
- Document a treatment plan
- Keep records (7/2)
- Maintain business/financial records
- Do not barter

- Avoid dual relationships
- Tell clients of your absences
- Seek consultation/supervision
- Know state laws
- Know the ethical codes
- Avoid undue influence
- Be aware of confidentiality
- Have insurance

Managed Care

- What is it for?
  - ________________________________
  - Increased accountability and cost containment
How it Works

• A network of clinicians is provided
• These clinicians:
  – Agree to accept a specific (_____________________) fee
  – Agree to accept ____________________________
• The care that is provided is determined by:
  – Requiring preauthorization
  – Requiring clinical justification before authorization is given

How has Managed Care Impacted our Work?

• Symptom based treatment
• Determining the appropriate level of care
• The shift toward brief therapy
• Clinically integrated paperwork
• Provider efficiency

HIPAA Law

• The Health Insurance Portability and Accountability Act of 1996
  – Aims to ___________________________ in health care system.
  – Requires that privacy and security be built into the policies and practices of health care providers and health plans.
  – New privacy rights for patients
  – ___________________________
  – Allowing for the free flow of protected health information for treatment, payment and health care operations.
HIPAA Law

• How it applies directly to us:
  – __________________________: Mental health providers may not disclose psychotherapy notes without first obtaining a patient’s voluntary authorization, except in specific instances.

• A good site for more information:
  – http://www.healthprivacy.org/

How You Get Paid

• Real payment = your rate per hour divided by the sum of your clinical time and your paperwork time (including phone calls)
  – Payment = rate/clinical time + paperwork time
  – Examples:
    • No paperwork time: $60 divided by 1 (1 clinical hour) = $ __________ per hour
    • ½ hour paperwork: $60 divided by 1½ (1 clinical hour + ½ hour paperwork) = $ __________ per hour
    • 1 hour paperwork: $60 divided by 2 (1 clinical hour + 1 hour paperwork) = $ __________ per hour