Law and Ethics for Clinicians:
Burdens, Dilemmas, Possibilities

Supplementary Materials

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Mandated Reporting of Suspected Child Abuse

Michael Donner, Ph.D. and the 2004 Expertise Series Task Force

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California law and the American Psychological Association Ethical Principles Of Psychologists and Code of Conduct (2002) require psychologists to protect confidentiality. It is a violation of law, and unprofessional conduct, to disclose confidential information received in psychotherapy unless permitted to do so by law. The Child Abuse and Neglect Reporting Act (CANRA) is a law which mandates or permits certain disclosures in specific situations.

Psychologists must keep in mind that CANRA defines most, if not all, of the terms that apply to the mandate or permission to report. Some behaviors that psychologists may consider abusive will not be defined as such in CANRA. Psychologists must be aware of CANRA's definitions, and apply those definitions to reporting situations. (Penal Code Section 11164-11174.4)

CANRA makes an important distinction between mandated reporting and permissible reporting. Failure to make a mandated report is illegal, subject to discipline by the Board of Psychology, and may lead to civil suit. Permissible reports are left to the psychologist's discretion and psychologists are legally permitted to go against the wishes of the child or parent in making them.

Psychologists who make mandatory or permissible reports may be sued but are immune from civil liability if they follow the law. The immunity applies to the decision-making leading to a report as well as to the report itself. However, the immunity may not apply to post-reporting actions that are outside the scope of the mandated report, such as, taking on an investigative role.

Civil immunity does not prevent the Board of Psychology from taking disciplinary action where a psychologist has made a frivolous report or has made a report for an improper purpose. To impose discipline, the Board of Psychology would need to establish that the psychologist engaged in an extreme departure from the standard of care, not just a mistake or error of judgment.

MANDATED REPORTING

When psychologists acting in their professional capacity have knowledge or a reasonable suspicion that a child has been the victim of abuse or neglect *as defined by CANRA*, an oral and a written report must be completed.

Reports should be made as soon as reasonably possible by telephone. A report may be directed to a Police Department, Sheriff's Department, or Children's Protective Services, which are typically a part of the County Welfare Offices. A written report (a form for which can be provided by any of the above) must be submitted within 36 hours (PC 11166 [a]). If the suspected abuse occurred outside of California, the psychologist still must report in California because psychologists may not have immunity for reports made to officials outside of California.

DEFINITIONS

"Reasonable Suspicion"—This means that the edu-cation and training of psychologists in child abuse and neglect would lead a reasonable psychologist to suspect abuse. There must be some *objective* basis for suspecting abuse. A hunch, intuition or impression does not constitute an objective basis.

"A child has been the victim"—(1) The victim must still be a child, not an adult who was victimized as a child. (2) The abuse must have already occurred. A concern that abuse COULD occur is not reportable.

BEHAVIOR THAT MUST BE REPORTED

1. Sexual Abuse—Any form of non-consensual sexual activity between an adult and a child, i.e., someone 18 or over with someone under 18. Sexual activity includes any sexual or sexualized behavior that is intended to arouse the sexual desire of either the adult or the child, or sexually exploit the child. This includes intercourse, oral and anal sex, and a wide range of behaviors such as kissing, touching, fondling or groping (even through clothing), or showing of pornography (Penal Code Section 11165.1). A coerced agreement to perform sexual acts is not consent.

2. Reportable Consensual Sexual Activity - The rules involving CONSENSUAL activity are complicated and not necessarily intu- itive. These should be read carefully and referred to as the situation requires. See table for further clarification.

a. Any consensual sexual activity between minors where one is 15 years old or over and the other is 13 or younger. This requirement includes the entire range of sexual activities, and probably includes behaviors that are normative and even age appropriate. However the CANRA mandates a report.

b. Any sexual activity between a child 14 or 15 years old and an adult at least 10 years older.

c. Sexual intercourse between a child 15 or younger and someone 21 or over. "Sexual intercourse" is genital intercourse between a male and a female.

d. Anal or oral sex when either partner is a minor 14 or older is a mandated report, even when the partner is also a minor, and even when intercourse would be permissible. For reasons not specified in CANRA, oral and anal sex are treated differently than intercourse.

e. SPECIAL NOTE - Voluntary sexual activity of any sort between children who are both under the age of 14 years and who are of similar age, maturity, and sophistication is not a mandated report.[1] This means that younger children can engage in voluntary sexual activity that would mandate a report if one of the minors were 14 or older.

3. Physical Abuse—Any *injury* caused *deliberately*. An accident is not abuse. An injury is defined in CANRA as a traumatic condition. This means serious harm, including cuts, burns, severe bruises, broken bones, welts or scars.[2]

a. Willful harming or injuring of a child or the endangering of the person or health of a child—This means behaviors in which the probability of serious flagrant disregard for the health and safety of children, or which result in significant psychological trauma. For example, a nine year old child was beaten with a wooden dowel so severely she was still bruised and swollen days later.[3]

b. Unlawful corporal punishment—Cruel or inhuman behavior that causes an injury. Beatings that leftscars from belt buckles, black eyes, dragging a child by the hair, are all examples of unlawful corporal punishment. Physical discipline of a child, such as slapping, spanking or grabbing to correct or punish breaches of rules, have been found to be acceptable as long as it is not excessive as described above. (In re Jose M.(1988), People v Checketts (1999) People v. Smith (2002) , Cal.App.4th)

4. Neglect—Neglect means risking, causing or permitting the health of a child to be seriously endangered by intentionally failing to provide adequate food, clothing, shelter or medical care. The emphasis in this section is on the severity of the neglect, behaviors that could cause great bodily harm. The courts have defined "intentionally" to mean "know or should know of the severity of the risk."(People v Sargent, 2002, Section 11165.2.[a],11165.3)

WHAT IS NOT A MANDATED REPORT OF PHYSICAL ABUSE?

An accidental injury.

When an ADULT victim reports abuse that occurred to them when they were a child. Corporal punishment that did not cause a physically Traumatic condition and was not excessive. Parents may use "instruments." Thus, for example, leaving a red mark by hitting a child with a belt does not, in itself, constitute abuse, under a conservative interpretation of the law.

A positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis or reporting child abuse or neglect. (11165.13 [a])

A child receiving treatment by spiritual means as long as the health of the child is not seriously endangered. (11165.2.[b])

A mutual fight between minors.

PERMISSIBLE REPORTING

A psychologist is PERMITTED but not mandated to make a report only if he or she suspects that a child is suffering serious emotional damage or is at a substantial risk of suffering serious emotional damage in the future (Penal Code Section 11166.05). Examples of evidence of serious emotional damage would include severe anxiety, depression, withdrawal, or agressive behavior. Psychologists should note the use of the word SEVERE symptoms, even for PERMISSIBLE reporting. Psychologists who make PERMISSIBLE reports have the same protections as when making MANDATED reports, but those who decide to maintain patient confidentiality by not reporting are also fully in compliance with the law.

Mandated Reporting continued on next page

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[1] Planned Parenthood v. Van de Kamp

[2] In re Edward C. 1981, In re Jose M, 1988, People v Whitehurst 1992.

[3] People v. Jaramillo (1979), Cline v. Superior Court (1982), People v. Valdez (2002)

REPORTING IN AGENCY OR INSTITUTIONAL SETTINGS

A supervisor or employer may not prevent, or retaliate against, a subordinate from making a report. (PC Sec. 11166 [g]1)

A supervisor or employer may not require a subordinate to tell them if you made a report. (PC Sec. 11166 [g]2)

Only one member of a treatment team is required to make a report (PC Sec. 11166[f]), although all members may if they wish.

SPECIAL NOTE:

Psychologists must not provide the written child abuse reports to anyone other than the agencies previously described, even if the record has been subpoenaed. To do so is a misdemeanor. (PC 11167.5)

Disclaimers:

This document is educational in nature and is not intended to replace the advice of an attorney. In addition, although the information in this document was accurate at the time of publication, psychologists using this information should bear in mind that laws and regulations change over time and that the interpretation of laws and regulations by courts and the Board of Psychology may change from time to time.

The Board of Psychology (Board) is committed to including guest articles in the BOP Update. *The Board of Psychology takes no responsibility for the accuracy or veracity of any comments or statements contained in a guest article, and the Board remains neutral on any position statements made in a guest article.*

This table indicates specific acts that must be reported, even if the act is consensual. Identify the cell at the intersection of the ages of the parties involved. Forced or coerced behavior is not consensual. Any behavior deemed abusive by the therapist is a mandatory report.

Age	13	14	15	16	17
13	No mandated report for any consensual activity	Anal or Oral Sex Mandated*	Any Sexual Activity-Mandated Report	Any Sexual Activity-Mandated Report	Any Sexual Activity-Mandated Report
14	Anal or Oral Sex Mandated Report*	Anal or Oral Sex Mandated Report	Anal Or Oral Sex Mandated Report	Anal or Oral Sex Mandated Report	Anal or Oral Sex Mandated Report
15	Any sexual behavior mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report
16	Any sexual behavior mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report
17	Any sexual behavior mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report
18	Any sexual behavior mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report
19	Any sexual behavior mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report
20	Any sexual behavior mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report
21	Any sexual behavior mandated report	Anal, oral and intercourse-mandated report	Anal, oral and intercourse-mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report
22	Any sexual behavior mandated report	Anal, oral and intercourse-mandated report	Anal, oral and intercourse-mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report
23	Any sexual behavior mandated report	Anal, oral and intercourse-mandated report	Anal, oral and intercourse-mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report
24	Any sexual behavior mandated report	Any sexual activity-mandated report	Anal, oral and intercourse-mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report
25	Any sexual behavior mandated report	Any sexual activity-mandated report	Any sexual activity-mandated report	Anal or oral sex mandated report	Anal or oral sex mandated report

* Although there is some disagreement, our interpretation is that some consensual sexual activity between a 14 year old child and a child under 14 does not mandate a report.

Sexual Activity: Sexual activity includes any behavior intended to arouse the adult or child or sexually exploit the child. This can include intercourse, oral and anal sex, and a wide range of behaviors such as kissing, touching, fondling, groping, or showing of pornography.

Sexual Intercourse: Genital intercourse between a male and a female.

Elder Abuse definitions

All statutes in California Welfare and Institutions Code

15610.65. "Reasonable suspicion" means an objectively reasonable suspicion that a person would entertain, based upon facts that could cause a reasonable person in a like position, drawing when appropriate upon his or her training and experience, to suspect abuse.

15610.23. (a) "Dependent adult" means any person between the ages of 18 and 64 years who resides in this state and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age.

15610.25. "Developmentally disabled person" means a person with a developmental disability specified by or as described in subdivision (a) of Section 4512.

15610.27. "Elder" means any person residing in this state, 65 years of age or older.

15610.63. "Physical abuse" means any of the following:

(a) Assault, as defined in Section 240 of the Penal Code.
(b) Battery, as defined in Section 242 of the Penal Code.
(c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code.
(d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water.
(e) Sexual assault, that means any of the following:
(1) Sexual battery, as defined in Section 243.4 of the Penal Code.
(2) Rape, as defined in Section 261 of the Penal Code.
(3) Rape in concert, as described in Section 264.1 of the Penal Code.
(4) Spousal rape, as defined in Section 262 of the Penal Code.
(5) Incest, as defined in Section 285 of the Penal Code.
(6) Sodomy, as defined in Section 286 of the Penal Code.
(7) Oral copulation, as defined in Section 288a of the Penal Code.
(8) Sexual penetration, as defined in Section 289 of the Penal Code.
(9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code.
(f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
(1) For punishment.
(2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.
(3) For any purpose not authorized by the physician and surgeon.

15610.05. "Abandonment" means the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

15610.06. "Abduction" means the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, of any elder or dependent adult who does not have the capacity to consent to the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, as well as the removal from this state or the restraint from returning to this state, of any conservatee without the consent of the conservator or the court.

15610.43. (a) "Isolation" means any of the following:

(1) Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls.

(2) Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons.

(3) False imprisonment, as defined in Section 236 of the Penal Code.

(4) Physical restraint of an elder or dependent adult, for the purpose of preventing the elder or dependent adult from meeting with visitors.

15610.30. (a) "Financial abuse" of an elder or dependent adult
occurs when a person or entity does any of the following:

(1) Takes, secretes, appropriates, or retains real or personal property of an elder or dependent adult to a wrongful use or with intent to defraud, or both.

(2) Assists in taking, secreting, appropriating, or retaining real or personal property of an elder or dependent adult to a wrongful use or with intent to defraud, or both.

(3) Takes, secretes, appropriates, obtains, or retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence, as defined in Section 1575 of the Civil Code.

15610.57. (a) "Neglect" means either of the following:

(1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise.

(2) The negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise.

(b) Neglect includes, but is not limited to, all of the following:

(1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter.

(2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.

(3) Failure to protect from health and safety hazards.

(4) Failure to prevent malnutrition or dehydration.

(5) Failure of an elder or dependent adult to satisfy the needs specified in paragraphs (1) to (4), inclusive, for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health.

Child abuse definitions

All statutes from California Penal Code

11166. (a) (1) For the purposes of this article, "reasonable suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. "Reasonable suspicion" does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any "reasonable suspicion" is sufficient.

11165.1. As used in this article, "sexual abuse" means sexual assault or sexual exploitation as defined by the following:

(a) "Sexual assault" means conduct in violation of one or more of the following sections: Section 261 (rape), subdivision (d) of Section 261.5 (statutory rape), 264.1 (rape in concert), 285 (incest), 286 (sodomy), subdivision (a) or (b), or paragraph (1) of subdivision (c) of Section 288 (lewd or lascivious acts upon a child), 288a (oral copulation), 289 (sexual penetration), or 647.6 (child molestation).

(b) Conduct described as "sexual assault" includes, but is not limited to, all of the following:

(1) Any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen.

(2) Any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person.

(3) Any intrusion by one person into the genitals or anal opening of another person, including the use of any object for this purpose, except that, it does not include acts performed for a valid medical purpose.

(4) The intentional touching of the genitals or intimate parts (including the breasts, genital area, groin, inner thighs, and buttocks) or the clothing covering them, of a child, or of the perpetrator by a child, for purposes of sexual arousal or gratification, except that, it does not include acts which may reasonably be construed to be normal caretaker responsibilities; interactions with, or demonstrations of affection for, the child; or acts performed for a valid medical purpose.

(5) The intentional masturbation of the perpetrator's genitals in the presence of a child.

(c) "Sexual exploitation" refers to any of the following:

(1) Conduct involving matter depicting a minor engaged in obscene acts in violation of Section 311.2 (preparing, selling, or distributing obscene matter) or subdivision (a) of Section 311.4 (employment of minor to perform obscene acts).

(2) Any person who knowingly promotes, aids, or assists, employs, uses, persuades, induces, or coerces a child, or any person responsible for a child's welfare, who knowingly permits or encourages a child to engage in, or assist others to engage in, prostitution or a live performance involving obscene sexual conduct, or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, drawing, painting, or other pictorial depiction, involving obscene sexual conduct. For the purpose of this section, "person responsible for a child's welfare" means a parent, guardian, foster parent, or a licensed administrator or employee of a public or private residential home, residential school, or other residential institution.

(3) Any person who depicts a child in, or who knowingly develops, duplicates, prints, or exchanges, any film, photograph, video tape, negative, or slide in which a child is engaged in an act of obscene

sexual conduct, except for those activities by law enforcement and prosecution agencies and other persons described in subdivisions (c) and (e) of Section 311.3.

11165.2. As used in this article, "neglect" means the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person.
(a) "Severe neglect" means the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. "Severe neglect" also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered, as proscribed by Section 11165.3, including the intentional failure to provide adequate food, clothing, shelter, or medical care.
(b) "General neglect" means the negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury to the child has occurred. For the purposes of this chapter, a child receiving treatment by spiritual means as provided in Section 16509.1 of the Welfare and Institutions Code or not receiving specified medical treatment for religious reasons, shall not for that reason alone be considered a neglected child. An informed and appropriate medical decision made by parent or guardian after consultation with a physician or physicians who have examined the minor does not constitute neglect.

11165.3. As used in this article, "the willful harming or injuring of a child or the endangering of the person or health of a child," means a situation in which any person willfully causes or permits any child to suffer, or inflicts thereon, unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of the child to be placed in a situation in which his or her person or health is endangered.

11165.4. As used in this article, "unlawful corporal punishment or injury" means a situation where any person willfully inflicts upon any child any cruel or inhuman corporal punishment or injury resulting in a traumatic condition.

11165.6. As used in this article, the term "child abuse or neglect" includes physical injury inflicted by other than accidental means upon a child by another person, sexual abuse as defined in Section 11165.1, neglect as defined in Section 11165.2, the willful harming or injuring of a child or the endangering of the person or health of a child, as defined in Section 11165.3, and unlawful corporal punishment or injury as defined in Section 11165.4. "Child abuse or neglect" does not include a mutual affray between minors.

11166.05. Any mandated reporter who has knowledge of or who reasonably suspects that a child is suffering serious emotional damage or is at a substantial risk of suffering serious emotional damage, evidenced by states of being or behavior, including, but not limited to, severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others, may make a report to an agency specified in Section 11165.9.

Confidentiality of Mental Health Information

Bram Fridhandler, Ph.D. and the 2004 Expertise Series Task Force

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The following outline summarizes California law as it governs the disclosure of information to third parties *without the permission of the client/patient*.

I. When *must* a psychologist disclose confidential information without permission of the client/patient?

A. Reasonable suspicion of abuse/neglect of a child, a dependent adult, or an elder.

B. Tarasoff situations

C. After client/patient's death, when directed to by the holder of the privilege (i.e., the client/patient's "personal representative")

D. If the client/patient files a worker's compensation claim of psychological injury and the Worker's Compensation Appeals Board orders the production of reports (although the client/patient may elect to withdraw the emotional injury claim and thereby eliminate the need for reports)

E. When a client/patient has a conservator who has authorized the release of information.

II. When *may* a psychologist disclose confidential information without permission from the client/patient?

A. "Permissible" reporting of suspected elder or dependent adult abuse or endangerment of emotional well-being (see Welfare and Institutions Code 15630(c)(1)).

B. "Permissible" reporting of suspected child abuse. (See the Expertise Series document "Mandated Reporting of Suspected Child Abuse.")

C. When a client/patient is a danger to others, or to himself or herself, or gravely disabled.

D. When a parent of a patient under 18 years old provides a written release. However, in some legal situations, the parent may not be able to waive the child's privilege.[1] A psychologist may need to obtain legal consultation to determine whether a parent can waive privilege in the particular situation they are facing.

In addition, a psychologist may withhold information from a parent if he or she believes that revealing the information would be harmful to the treatment or to the child.

E. If a minor under the age 16 is the victim of a crime, a mental health professional may disclose confidential information for the purpose of preventing additional harm.

[1] in re Daniel C. H.

III. Special situations and issues

A. See "Dissemination of Raw Test Data" for special considerations applying to release of raw test data.

B. Couples or Group therapy: The consent of both partners, or all group members, would be necessary to disclose information, unless information can be "sanitized" so that only communications between the therapist and the client/patient who has provided a release are revealed.

C. Consultation: Law and APA Ethics permit a psychologist to seek consultation without client/patient knowledge or permission if potentially identifying information is not shared. However, it is widely recommended that psychologists inform client/patients of this possibility in the initial informed consent.

D. With or without client/patient permission, California law requires *requestors* of information from psychotherapy to inform the client/patient in writing about the uses that will be made of the information, how long it will be kept, and certain other facts (Civil Code 56.104).[2]

E. Disclosure may be permitted in a legal context (i.e., civil suit, criminal trial, or administrative hearing) when a written request or subpoena comes from an attorney, a judge, or an administrative law judge in the appropriate form *and* there is no privilege or the privilege has been waived.[3] (See "Responding to Subpoenas.")

[2] SB 598 has lifted this requirement from communications between providers for treatment purposes.

[3] The law on psychotherapist-patient privilege is complex. If a decision about disclosure appears to rest on whether the information is legally privileged, the psychologist should seek the advice of his or her own attorney. Prudence would dictate that the psychologist not release privileged information if there are reasonable questions about whether the release would violate the patient's privilege.

Responding to Subpoenas

Bram Fridhandler, Ph.D., O. Brandt Caudill, Esq., and the 2004 Expertise Series Task Force

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Subpoenas are a legal demands for records, testimony in a trial or deposition, or both. They are usually issued by attorneys, but they may also be issued by judges and law enforcement agencies. The present document primarily applies to subpoenas issued by attorneys.

The overall points to bear in mind about subpoenas is that they *do* have legal force but, on the other hand, the mere issuance of a subpoena by an attorney does not mean that a psychologist will have to comply and thereby break confidentiality. In fact, most of the information a psychologist receives from client/patients is legally protected by privilege and she or he is required to assert the privilege until she or he knows that it does not apply or has been given a release by the client/patient. For this reason, immediate compliance with a subpoena is rarely necessary and often prohibited.

1. Subpoenas are usually delivered in person by process servers. A psychologist should not attempt to avoid receiving a subpoena. (This is unlikely to accomplish anything and can create an impression that he or she is uncooperative.)

2. Examine the subpoena to determine

    a. whether it is a Federal or state subpoena; the response times may be different and some of the rules applicable to state subpoenas do not apply in Federal court

    b. who issued it and whom he or she is working for (generally, it will not be an attorney working for the psychologist's client/patient)

    c. what is being requested

    d. what deadline has been given

    e. whether it includes a release of information from the client/patient and, if so, whether that release specifically names the psychologist and the records or testimony that have been requested[4]

    f. look for a document entitled "notice to consumer," without which the subpoena is invalid.

3. If no valid release has been provided, attempt to make the client/patient aware of the subpoena. If the psychologist is able to contact the client/patient, he or she may authorize the psychologist to comply with the subpoena by signing a release. Without a release, the requested information is likely to be legally privileged, in which case the psychologist's first response should be to refuse to disclose the information. Under the California Evidence Code, if the psychologist does not have a valid release, or a court order, or if the client/patient is not available, the psychologist is required

[4] California law requires a release to be specific in these ways. Otherwise, it is invalid.

to invoke the privilege by refusing to produce the requested materials. The fact that a client/patient is dead does not waive the privilege, nor does the client/patient's involvement in litigation automatically waive the privilege. The law on psychotherapist-patient privilege is complex. If a decision about disclosure appears to rest on whether the information is legally privileged, the psychologist should seek the advice of his or her own attorney. A psychologist may not rely on a statement by any attorney for a party in a case as to the client/patient having waived his or her privilege.

4. Contact the attorney who issued the subpoena, preferably in writing, and provide an update on the situation. In order to be collegial, this should be done within a few days. The psychologist may explain that the requested information is privileged and therefore cannot be disclosed. If the notice referenced in section 2 (e), above, has not been provided, the psychologist should indicate that the subpoena does not appear to be valid. If the psychologist has been given a release, he or she can state that the appropriate information will be provided.

   A subpoena can never be ignored. At a minimum, a written response raising a privilege should be made in the specified time frame. If a subpoena is not resolved prior to an ordered court appearance, the psychologist may need to appear in court and express his or her concerns to the judge.

5. The client/patient and his or her attorney may seek to have a judge review the information in chambers prior to its disclosure to the opposing attorney in order to determine how much should be disclosed.

6. Except under extraordinary circumstances, the privilege is the client/patient's to waive. That is, the psychologist is almost never legally empowered to withhold information that has been subpoenaed if the client/patient has waived his or her privilege.

7. Fees: The copying fees that can be charged for complying with the subpoena are set by statute. See "Record Keeping."

8. Expert witness fees: A psychologist may be entitled to be paid a reasonable hourly fee for any testimony he or she gives in deposition or trial if his or her *opinions* are requested. That fee has to be agreed upon in advance of the testimony date. If the psychologist is only asked to read her or his notes into the record and not to render an opinion, she or he may not be entitled to an expert fee. In Federal court, the psychologist is not entitled to be paid an expert fee, unless he or she has been retained for the litigation.

9. See "Responding to Requests for Raw Test Data" for further information about subpoenas for raw test data.

10. Some psychologists who testify may choose to bring their own attorneys to protect their interests. If the psychologist feels personally threatened in any way—for example, if the issuing attorney has pressured him or her with references to litigation or Board complaints—the psychologist should consider hiring his or her own attorney. If the *patient's* attorney offers to represent a psychologist, the psychologist should decline. There may be a conflict between the interests of the psychologist and the litigation interests of the client/patient. Moreover, only the psychologist's

personal attorney can instruct him or her not to answer a question that may be intrusive or improper.

The great majority of subpoenas are resolved quickly and collegially. Additionally, psychologists should bear in mind that all CPA members can call the Director of Professional Affairs for advice, and that Division I members can also use their free annual attorney consultation.

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Note to professionals: I have developed this information sheet for use in my practice and share it with you in this handout as a source for you to consider as you develop your own forms. It has not been reviewed by attorneys for its adequacy in legal settings. It reflects my own balancing of legal, ethical, and clinical considerations.

Information about my practice

I am a licensed psychologist in independent practice since 1987. In addition to my private practice, I have taught and supervised psychotherapy at California Pacific Medical Center, University of California, San Francisco, and the California School of Professional Psychology.

I ask patients to pay me at the time of each session for the first few sessions. Once a regular schedule of sessions is set up, I bill at the beginning of each month for the previous month's sessions. I ask that patients pay me at the time I bill them or within a week or so afterward.

I am not on any insurance "panels," which may have an impact on whether insurance will cover any of the cost of seeing me. If you wish to request reimbursement for my fees from an insurance company, I am glad to provide you with a bill that includes the information insurance companies typically ask for.

Regarding canceled sessions, I charge for appointments unless the session is canceled a week in advance. However, I may make exceptions to this under certain circumstances, such as sudden illness or other emergency, if you contact me as far in advance as possible. I charge for all "no-shows."

You can leave confidential messages for me at any time on my voicemail. My voicemail greeting also has information about how to reach me in emergencies. (Although I am available in emergencies, I am generally not immediately available. I work with patients who need emergency assistance to develop backup plans in case I am unavailable.)

Please feel free to ask me questions about any of these issues.

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Information about confidentiality

Like other therapists, I do not share what we discuss with others. However, there are some potential exceptions to this.

"Abuse reporting": Therapists, like certain other professionals, are required to contact relevant authorities if they are informed of possible serious abuse of children, people over 65, and "dependent adults," that is, adults who are not able to take care of themselves. Also, if it appears likely that you will seriously physically hurt someone, I am required to take steps to try to prevent this. I encourage you to ask me any questions you have, at any time, about these issues and how I handle them.

Professional colleagues: There are two situations where I may share some information about our work together. First, I sometimes discuss my work with colleagues in order to improve the quality of my work. Second, I sometimes share aspects of my work in teaching, professional presentations, or publications for professional audiences. Whenever I share my work in these ways, I do not reveal names and conceal information that might allow someone to identify the person I'm talking about.

Insurance: When medical insurance is used to help pay for therapy, the insurance company usually requires information about our work. Sometimes the only thing required is a diagnosis, and sometimes more information is required. If you ask me to send anything directly to your insurance company, I can let you know exactly what I am sending to them if you wish.

Couples' release of information: I ask for permission from both people before disclosing information from couples therapy.

Please ask me any questions you have about these potential exceptions to confidentiality, whenever the questions come up for you.

Sample Progress Note Template

Patient

◉ Session ○ Pt Call--Chg ○ Pt Call--NC ○ Pt Call ○ Collat Call

Date

Date | Yest | Psychotherapy 40-50

Auth thru session number

Auth Due ○ Now! ○ Soon ○ No ○ UBH

Amt Paid by Pt

HIPAA Psychotherapy Note

Summary

Pt Call

Find recent notes

F nd Pt

New Note

Need to bill pt:

○ Yes ○ No

New History

[illegible]

Waiting for pt pmt:

○ Yes ○ No

Formulation (included in HIPAA Psychotx Note)

Plan

Informed Consent

Gave Forms

Last date modified 1/10/2007

Billed? Unbilled

(This is the format that I have developed for my clinical database in FileMaker Pro software.)

Selected published resources

Reference	Notes
American Association for Marriage and Family Therapy. (2001). User's guide to the AAMFT Code of Ethics. Washington, D.C.: AAMFT.	Vignettes illustrating every standard in the AAMFT Code. Concise and very helpful.
American Psychiatric Association. (1987). Guidelines on confidentiality. Am J. Psychiatry, 144, 1522-1526.	The Assn's official statement. Advocates strict confidentiality, e.g., urges psychiatrists to fight subpoenas when they feel disclosure would be damaging, even at risk of being held in contempt.
APA. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. American Psychologist, 58, 377-402.	An authoritative consideration of cultural competence for psychologists in several domains, including practice.
APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. American Psychologist, 61, 271-285.	A prominent group of psychologists assembled by APA President Ron Levant reached a consensus that many types of evidence are relevant and that clinical expertise is required in order to apply research-based treatments effectively.
Atkins, Catherine. (2009). Confidentiality and privilege: group, conjoint, family and collateral therapy. The Therapist, 21:4, 40-42.	CAMFT attorney ably handles the legal complexities. Legal aspects apply to all the mental health disciplines whereas ethics code references are specific to MFTs.
Behnke, S.H. (1998). Testimonial privilege and the problem of death: The Vincent Foster case and beyond. J. Am Acad. Psychiatry Law, 26, 639-648.	Analyzes two pivotal US Supreme Court decisions and concludes we should "take heart in knowing that clinically meaningful values...carried the day." The author is now Director of Ethics for APA.
Behnke, S.H., Preis, J.J. & Bates, R. T. (1998). The essentials of California mental health law: A straightforward guide for clinicians of all disciplines. NY: Norton.	The one to own. Better than Caudill and Pope in some respects, and it's by our APA Director of Ethics, so if you consult it when you have a decision to make, you're bound to be ok (right?).
Bennett, B, Bricklin, P.M. Harris, E., Knapp, S., VandeCreek, L, & Younggren, J.N., (2006). Assessing and managing risk in psychological practice: an individualized approach. The Trust.	A sound model with a great deal of pertinent information. Most helpful for psychologists but should be of use to others. Despite being written and published by a malpractice insurance company, not excessively focused on risk management at the expense of clinical priorities.
Bersoff, D.N. (Ed.). (2008). Ethical conflicts in psychology (4th ed.). Washington, D.C.: American Psychological Association.	Superbly edited collection of over 100 excerpts from ethics article and books, with commentary. But the third edition wasn't really updated for the 2002 Ethics Code revision; I don't know about this 4th edition.

Besharov, D. J. (1990). Recognizing child abuse: A guide for the concerned. NY: Free Pr.	A clear guide to identifying and reporting child abuse, suitable for professionals or laypersons, by the first director of the U.S. National Center on Child Abuse and Neglect.
Bollas, C. & Sundelson, D. (1995). The new informants: The betrayal of confidentiality in psychoanalysis and psychotherapy. Northvale, NJ: Jason Aronson, Inc.	Calls the current situation of compromised confidentiality "a clinical and ethical disaster" and proposes professional and legislative remedies. Sundelson is an Oakland attorney, I hear.
Bucky, S. F., Callan, J. E., & Stricker, G. (Eds.). (2005). Ethical and legal issues for mental health professionals: A comprehensive handbook of principles and standards. Binghamton: Haworth Maltreatment and Trauma Press/The Haworth Press.	Many excellent chapters. Written by psychologists but with reasonably good attention to others.
Burka, J. B. (2008). Psychic fallout from breach of confidentiality: A patient/analyst's perspective. Contemporary Psychoanalysis, 44, 177-198.	Analyst affiliated with PINC and The Psychotherapy Institute describes the experience of learning that her analyst had engaged in a sexual relationship with another patient and had revealed her own confidences to this patient.
Celenza, A. (2007). Sexual boundary violations: Therapeutic, supervisory, and academic contexts. Jason Aronson.	A comprehensive and, I am confident, excellent treatment of this issue. Andrea Celenza is a Boston psychoanalyst.
Celenza, A., & Gabbard, G. O. (2003). Analysts who commit sexual boundary violations: A lost cause? J. American Psychoanalytic Association, 51, 617-636.	A very thoughtful consideration of how to evaluate and explore possible rehabilitation for analysts (and others) who violate sexual boundaries.
Clemens, N. A. (2001). Documenting psychotherapy: Getting hep on HIPAA. J. Psychiatry Practice, 138-140.	A brief explanation of this aspect of HIPAA. Describes HIPAA as "a great boon to psychotherapy."
Daniels, D. & Jenkins, P. (2000). Therapy with children: Children's rights, confidentiality, and the law. London: Sage Publications.	Prioritizes the needs of the child as the client as they explore the legal and ethical dimensions of working therapeutically with children.
Dewald, P.A. & Clark, R.W. (Eds.). (2001). Ethics case book of the American Psychoanalytic Association. NY: American Psychoanalytic Assn.	Contains the updated ethics code and case examples raising major ethical issues for analysts.

Reference	Annotation
Donner, M.B., VandeCreek, L, Gonsiorek, J.C. & Fisher, C.B. (2008). Balancing confidentiality: Protecting privacy and protecting the public. Professional Psychology: Research and Practice, 39, 369-376.	A debate on whether mental health professionals should return to valuing confidentiality above other important values, such as protecting others from a potentially dangerous patient. Michael Donner is currently Chair of the Calif. Psychological Assn. Ethics Committee.
Ellis, E.M. (2009). Should a psychotherapist be compelled to release an adolescent's treatment records to a parent in a contested custody case? Professional Psychology: Research and Practice, 40, 557-563.	Very thoughtful and informative, relevant to other situations when parents want to know information from their adolescent child's therapy. Doesn't take specific California law into account, however, which is relevant to this issue. Nevertheless, very relevant ethically.
Fisher, C. B. (2003). Decoding the Ethics Code: A practical guide for psychologists. Thousand Oaks, CA: Sage Pub.	A clear, well presented guide by the *chair of the task force* that wrote the new Code. I consider this the most authoritative interpretation of the current Code, although I'm not in agreement with her on all points, of course.
Gladding, S.T., Remley, T.P, & Huber, C.H. (2001). Ethical, legal, and professional issues in the practice of marriage and family therapy (3rd ed.). Upper Saddle River, N.J.: Merrill Prentice-Hall.	A well-regarded text for MFTs.
Gottlieb, M. C., & Younggren, J. N. (2009). Is there a slippery slope? Considerations regarding multiple relationships and risk management. Professional Psychology: Research and Practice, 40, 564-571.	A subtle albeit highly condensed discussion of how to avoid harmful multiple relationships. Concludes that rigid rules are undesirable but that our ability to deceive ourselves means we should regularly seek input and feedback from our colleagues.
Greenberg, S.A. & Shuman, D.W. (1997). Irreconcilable conflict between therapeutic and forensic roles. Prof. Psychology, 28, 50-57.	An excellent article arguing that therapists should not testify in a forensic context about their patients because therapeutic methods of knowing patients, while very adequate for treatment purposes, do not yield forensic evaluations.
Griffin, M. (Sept./Oct. 2006). Revisiting informed consent. The Therapist, 18, 35-48.	A very thorough discussion by a CAMFT staff attorney who is also an LCSW. Includes a form. I recommend that all Calif. MFT's read this.
Hansen, N.D. & Goldberg, S.G. (1999). Navigating the nuances: A matrix of considerations for ethical-legal dilemmas. Professional Psychology, 30, 495-503.	Presents a useful (if complex) model for sorting out situations and deciding how to act.

Jobes, D.A., Rudd, M.D., Overholser, J.C. & Joiner, T.E. (2008). Ethical and competent care of suicidal patients: Contemporary challenges, new developments, and considerations for clinical practice. Prof. Psychology, 39, 405-413	An excellent summary of current findings and recommendations.
Kalichman, S.C. (1999). Mandated reporting of suspected child abuse: Ethics, law, policy (2nd ed.). Washington, D.C.: APA.	Provides an in-depth examination of mandatory reporting laws, their history and goals, and how they could be improved. An important book, but the writing could be clearer.
Kleepsies, P.M., Deleppo, J.D., Gallagher, P.L., & Niles, B.L. (1999). Managing suicidal emergencies: Recommenda-tions for the practitioner. Prof. Psychology, 30, 454-463.	A pithy summary. Not legalistic.
Knapp, S. & VandeCreek, L. (2003). A guide to the 2002 revision of the American Psychological Association's Ethics Code. Sarasota, FL: Professional Resource Press.	A useful and detailed discussion of our professional ethics (though I find the Fisher book somewhat more useful).
Levin, C., Furlong, A., O'Neil, M.K. (Eds.) (2003). Confidentiality: Ethical perspectives and clinical dilemmas. Hillsdale, N.J.: Analytic Pr.	Excellent collection of psychoanalytic articles, growing out of a conference in Montreal, people like Kernberg, Ronald Britton, Bollas, and David Sundelson.
Levine, M. & Doueck, H. J. (1995). The impact of mandated reporting on the therapeutic process: Picking up the pieces. Thousand Oaks, CA: Sage Pub.	Authors studied practices in mandated reporting of suspected child abuse, eliciting honest opinions from therapists and CPS workers. They offer their own opinions about issues such as informed consent.
Lidz, CW, Appelbaum, PS, Meisel, A. (1988). Two models of implementing informed consent. Arch. Intern. Med., 148, 1385-1389.	Advocates the "process" model of informed consent. Same issue of journal includes an editorial describing this as an "improved perspective." Authors are psychiatrists.
Melchert, T.P & Patterson, M.M. (1999). Duty to warn and interventions with HIV-positive clients. Prof. Psychology, 30, 180-186.	Proposes decision-making model for when therapist should warn people at risk for contracting HIV from a patient (despite lack of legal protection for therapist).
Monahan, J. (1993). Limiting therapist exposure to Tarasoff liability: Guidelines for risk containment. American Psychologist, 48, 242-250.	Non-hysterical guidelines.

Nagy, T. F. (2005). Ethics in plain English: An illustrative casebook for psychologists (2nd Edition). Washington, D.C.: American Psychological Association.	Clear explanations by the Chair (1986-1989) of the task force that drafted a previous APA Ethics Code. A very useful book, although, in my opinion, some of his recommendations are clinically ill-advised.
Pope, K.S. & Vasquez, M.J.T. (1999). Ethics in psychotherapy and counseling (2nd ed.). San Francisco, CA: Jossey-Bass.	All the major issues related to psychotherapy receive clear-sighted, forthright, informed discussion. Cited by BoP. If you only read one book on ethics...
Riemersma, M. (2000). What about record keeping? The California Therapist, 12, pp. 22-24.	A detailed statement for MFT's about content and retention of records, written in response to the passage of legislation requiring BBS licensees to keep records "consistent with sound clinical judgment." I think she is excessive in her recommendations of how much detail is required in a record, however.
Shavit, N. (2005). Sexual contact between psychologists and patients. In S. F. Bucky, J. E. Callan & G. Stricker (Eds.), Ethical and legal issues for mental health professionals: A comprehensive handbook of principles and standards. (pp. 205-239). Binghamton: Haworth Maltreatment and Trauma Press/The Haworth Press.	Good summary of the literature.
Thomas, J.T. (2005). Licensing board complaints: Minimizing the impact on the psychologist's defense and clinical practice. Prof. Psychology, 36, 426-433.	A resource for anyone facing a licensing board complaint. Describes the emotional impact and how to minimize it.
Van Horne, B. A. (2004). Psychology licensing board disciplinary actions: The realities. Professional Psychology, 35, 170-178.	A corrective to alarmist ideas about how predatory boards are.