

Medical Error Prevention for Mental Health Professionals

Lenore Walker, Ed.D. & David Shapiro, Ph.D.

SECTION I: WHAT ARE MEDICAL ERRORS?

What is a Medical Error in a Behavioral Health Setting?

A medical error occurs when there is a failure to complete a planned action or the wrong plan is used to achieve an aim. It is important to note that a bad outcome from an appropriate treatment is not considered a medical error. Medical errors are more likely to occur in vulnerable areas where the system in which you work is not well enough designed to accommodate the diversity of clients being served. In learning to prevent these errors, it is best not to attribute blame to an individual. Rather, it is more helpful in prevention to consider an error that has occurred as a failure in the system. Everyone can, at times, have less than favorable outcomes. The focus is on how to develop and carry out an appropriate assessment and the treatment plan, especially in areas where it is known that there is high risk.

What is an Adverse Event?

An adverse event occurs when there is an injury that is caused by the assessment or treatment and is not the result of an underlying problem or condition of the patient. Typical adverse events in the mental health setting most often occur when there is a failure to adequately assess for factors other than psychological causation. Examples include behaviors that may be due to brain damage, injuries due to medication reactions, or suicide attempts and other self-destructive behaviors. We will spend time learning about adverse events that may be caused by violence toward self and others because of its prevalence in society today and how trauma may cause more serious medical and psychological injuries. The adverse event often comes when the clinician fails to do an adequate assessment to look at these various possibilities.

What is a Sentinel Event?

A sentinel event is an unexpected outcome that involves serious physical or psychological injury or death. Sentinel events occur after a medical error is made and an adverse event has occurred. It is always important to assess the potential for a sentinel event to occur and take appropriate steps to reduce the risk.

SECTION II – ROOT CAUSE ANALYSIS

Root cause analysis is an approach used by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) to assist in reviewing any sentinel event. To do a root cause analysis it is necessary to study errors retrospectively in a very specific way. Training in root cause analysis includes the following:

Ways to Conduct a Root Cause Analysis

Mental health professionals can use different methodologies to conduct a root cause analysis. This includes putting together a multidisciplinary team trained in qualitative analysis of data. Once the data is compiled, it will be necessary to corroborate the results with others involved with the case.

Collecting Root Cause Analysis Data

When conducting a root cause analysis it is necessary to compile different data sources and create a timeline or sequence of events before and after the sentinel event occurred. It will be important to review documents that are available. These will include any materials available to the clinician. If necessary, the clinician may conduct structured interviews and field interviews.

Analysis of Root Cause Data

Once the data is compiled, the sequence of events that occurred leading up to the adverse event should be reviewed. Although obtaining the data may be difficult, once they are obtained, they should be assembled in a step-by-step sequential process. Underlying factors need to be identified including active and latent errors. Finally, factors that have had no impact on the sentinel event but still occurred should be understood.

What are Typical Root Causes?

Typical root causes include patient characteristics as well as systemic factors. These factors include the way the team works together, the work environment itself, the management of the entire organization and institutional regulations that may relate to the work required.

Is Root Cause Analysis Effective?

JCAHO research suggests that the closer to a 'blame-free' analysis, the more likely the system will change to meet the needs of patients. In their review of 65 cases in which a sentinel event of suicide occurred, JCAHO researchers found that 34 suicides occurred in psychiatric hospitals, 27 in general hospitals with 14 on a psychiatric unit and 12 in a medical surgical unit, and 1 in the Emergency Room. Interestingly, the method of suicide for 75% of these cases, no matter where they occurred, was by hanging in the bathroom or closet while 20% jumped out of the window or off the roof. Using this root cause analysis there is sufficient data to understand that trying to prevent the ability to hang oneself in the bathroom or closet, in any of these locations, will reduce the number of completed suicides. Root cause analysis would also suggest that there would be a reduction in suicide events if access to windows and the roof was more carefully monitored or barred.

SECTION III – PRINCIPLES OF ERROR REDUCTION

Errors can be prevented if it is assumed that they *can* be prevented. Very often, there is an attitude that the error was inevitable. As we have been saying, prevention occurs more easily when prior experiences are analyzed with the intention of learning from them. The goal is to look in a non-accusatory manner at what was possibly overlooked in a previous experience that may have contributed to the responsibility for the error. Claims of privacy, privilege and confidentiality can be misused to cover up errors. Very often, when attempting to gain information regarding these areas, people will hide under a veil that the material is private and confidential and cannot be accessed. Be aware that this is a misuse of these laws. It is important not to let those making such claims use them to prevent you from obtaining the necessary data to do the root cause analysis.

Another important issue is creating the time and facilities to conduct discussion of clinical practices with colleagues. The necessity for consultation, no matter how long you have been practicing or how well trained you may be, is well documented and is known to increase patient safety. It is important for each individual to take responsibility to establish a culture of patient safety for the group. This is especially important when high risk and vulnerable clients are being treated.

Reducing Errors in Diagnosis for Mental Health Professionals

Awareness of common errors that can occur when making a diagnosis is an important way to help reduce medical errors. Most of these types of errors are cognitive in nature in that they will require good thinking skills in order to reduce or prevent them from occurring. Here we list some of the more common cognitive errors of diagnosis to help you become more aware of the possibility that they can and will occur.

Cognitive Errors of Diagnosis

Aggregate Bias. Aggregate Bias may occur when aggregated data used to develop clinical guidelines does not apply to individual patients. This often occurs when using a standardized psychological test interpretation by itself, without incorporating other data. All computerized psychological test scoring programs note that the computerized statements should not stand by themselves, but should be integrated with other material that takes into account specific individual factors, as well as specific situational factors. The increasing use of actuarial statistics in order to make statements about a given individual is another example of this aggregate bias.

Anchoring is the tendency to focus on features in the patient's initial presentation that are most compelling, without considering less obvious features. Frequently, in a busy practice or when time is limited, a clinician will focus only on these most obvious features, without even bothering to ask a client about other more subtle features.

Ascertainment Bias occurs when prior expectations, such as stereotyping and gender bias, shape the thinking of the clinician. A common way this error occurs is when a woman has complained about feeling ill to her primary care doctor who cannot find any medical cause for her complaints. He refers her to the psychologist who labels her as hysterical or somatic and does not explore what other symptoms and diagnoses might be present.

Confirmatory Bias is a tendency to look for evidence that confirms the diagnosis you first considered, rather than also trying to refute it. Usually an initial diagnostic impression is formed and then the clinician selectively attends only to material which confirms that original diagnosis, rather than keeping an open mind and looking at other possibilities. This is often coupled with another error called *Diagnostic Momentum*. This occurs once a diagnosis is given and the clinician finds it difficult to change to a different diagnosis. This can occur even when a rule/out diagnosis is given.

Feedback Sanction refers to a situation when colleagues are not asked to participate in the diagnosis until it is made and then they are asked to give their feedback. The request for feedback occurs so late in the process that it is clear any challenges to the diagnosis presented are really unwanted. Then, approval by other colleagues may occur, but such approval may be nothing more than a rubber stamp by colleagues.

Framing Effect occurs when healthcare professionals frame the risk of outcomes for different diagnoses. If the clinician feels favorable towards someone on a subjective basis, he or she may tend to give a diagnosis with a more potentially successful outcome. On the other hand, if the clinician does not like or understand the client's behavior, a more negative diagnosis might be assigned. For instance, the misuse of the term, "Borderline Personality Disorder", often occurs when a clinician has a negative reaction to a particular patient's hostility, even when there may be other explanations for that behavior, such as trauma.

Overconfidence Bias is a cognitive error of diagnosis when a clinician believes that he or she knows more than he or she really does but is treated by others as having all the answers. The clinician becomes overconfident and does not look as carefully as needed for all explanations of behavior.

Outcome Bias is a tendency to opt for diagnostic decisions that could lead to a good outcome. In this case, the clinician will tend to ignore, or selectively omit, diagnoses that may involve lengthier or more involved treatment. The patient will then be diagnosed with a condition that is relatively simple to treat, especially within a limited number of sessions. This error is most commonly made in situations where the clinician is limited to the treatment time, either by system requirements like in managed care organizations, or by too many other cases leaving little time to do long-term treatment when necessary.

Premature Closure is related to a number of others that we just discussed and essentially refers to closing or terminating the decision-making process before all data is gathered and the diagnosis can be fully verified. This may also be associated with what is sometimes referred to as an *Unpacking* principle, which involves looking only at the surface rather than thoroughly identifying all the symptoms. This results in not soliciting the necessary relevant data in determining a differential diagnosis. This is clearly related to the biases that we have just discussed with clinicians not going far enough to rule out alternative hypotheses or alternative diagnoses.

Psych Out Error is the term that may be used for the diagnostic error that occurs when medical illnesses may be overlooked or not diagnosed properly. Clinicians who make this error may not bother to ask or obtain a careful medical history or are unaware of medical conditions that can lead to various forms of psychological distress. This can be particularly critical. If a medical illness is not appropriately diagnosed and the symptoms are seen as perhaps psychosomatic or even some form of Conversion Disorder, a serious medical condition that may be dangerous to the patient could go untreated.

Preventing Diagnostic Errors

The most important principle in preventing diagnostic errors is to understand these common cognitive errors that we have just delineated and adhere to appropriate Standards of Care. The Standard of Care is defined as the level of practice of the average or relatively prudent professional. It consists of adhering to validated techniques for comprehensive assessment following the *Code of Ethics* of the mental health discipline the clinician is a member. For example, the American Psychological Association ethical standards include basing diagnoses on multiple data sources, avoiding innovative techniques unless there is no other option, and doing a sufficiently comprehensive assessment to perform a differential diagnosis and to rule out diagnoses. As noted earlier, sensitivity to physical illnesses that may cause symptoms similar to certain psychological conditions is very important. In terms of recent developments, it should be a part of the Standard of Care to include a careful assessment of the contribution of trauma and utilization of appropriate trauma assessment instruments.

Negligent Diagnosis

It is important to understand that a negligent diagnosis is not merely misdiagnosis. Anyone can misdiagnose an individual. As noted above, the injuries that we are talking about do not refer to unforeseen injuries that come from a diagnosis based on an appropriate assessment. When we are talking about a negligent diagnosis, we are referring to diagnostic procedures that do not adhere to the Standard of Care, involving a failure to follow a comprehensive assessment that uses well-validated techniques. Often when a negligent diagnosis occurs, there is an innovative use of testing that has not been validated. This is, as noted above, parallel to the *Code of Ethics* of the American Psychological Association. A negligent diagnosis frequently occurs when there

is a lack of sensitivity to physical illness presenting as psychological problems. Some of the most frequent examples of these are brain tumors that have various effects on cognition and emotion, and Hodgkin's disease, which can mimic symptoms related to depression.

SECTION IV – HIGH-RISK CLIENTS

Who are high-risk clients? They are clients who have major psychiatric disorders or who have co-morbid mental illnesses. Other high-risk clients are children, elderly persons, the homeless, the hearing impaired, language or communication impaired, individuals with culture differences, individuals with financial problems and individuals who lack medical insurance. These special groups of clients are considered high risk because they are less able to communicate their needs to clinicians or they are dangerous to themselves or others at the time they are being evaluated or treated. When working with people in these special groups, it is important to be aware of the potential for errors to occur that will cause an adverse or sentinel event.

Managed Care Clinical Culture

Some form of managed health care appears to be here to stay, at least at this time, even though it can be difficult for this system to deliver appropriate mental health services given the limitations posed by the very nature of the system itself. We call this the culture of managed care and it is more likely for adverse and sentinel events to occur in this culture for the mentally ill. People who are often not trained clinicians will make decisions regarding nature and length of treatment for people with serious mental disorders. Managed health care organizations are frequently very complex with multiple layers of bureaucracy, difficult enough for a mentally intact individual to navigate. Mentally ill individuals are ill equipped to deal with such bureaucratic roadblocks that are inherent in managed care organizations. Managed care organizations are less willing to provide appropriate care for chronically mentally ill clients whose appropriate treatment is often expensive. These bureaucracies pay more attention to financial costs than to individual patient needs. Patient advocates are needed to obtain care for the individuals who must obtain services through a managed health care organization.

Whether or not it is a managed health care organization, other areas within the clinical culture that can lead to medical errors involve mental health providers who encourage patients to "take responsibility for their own actions". When there are system errors and the problems are not due to the individual's psychiatric disorder, such advice as "taking responsibility" may inadvertently cause guilt feelings when the disorder does not go away. Rather than be seen as 'inadequate' or 'bad', some clients may not tell the clinician that they are still having the same symptoms and therefore not get the help that they need. Clinicians must be responsible for creating the culture of safety so the client will discuss what treatment may be working and what may not. It is important not to dismiss system errors as a defense mechanism by clients but rather study the clinical culture's role in perpetrating diagnostic errors. For example, when a

particular patient talks about difficulties that he or she is having getting financial coverage or services, this should not be interpreted as part of the client's own pathology. The clinician needs to be sensitive to the errors in the system that make the person's mental disorder more troublesome.

Multicultural Sensitivity

Over the last ten years, there has been attention focused on the level of sensitivity of the clinician to multicultural issues for clients. Research has shown that discrimination of any kind can negatively impact a person's mental health. It is important to be aware of the results of discrimination for clients who are outside of the mainstream in their community. This often includes members of diverse ethnic and racial groups, those who may not look like others within a more homogeneous culture, those whose behaviors are considered 'different' from the mainstream, or even those who have a mental or physical disability. In communities where the man is still considered the 'head-of-the-household', women continue to be discriminated against, particularly those women who are stay-at-home moms without their own source of income. Those who speak a different language or those whose religious beliefs are different also may face discrimination that can cause or complicate mental health issues. Becoming multi-culturally competent is a goal to strive to achieve so that medical errors are not made because of lack of knowledge of a particular cultural practice.

For example, in some cultures, particularly those in the Caribbean, evil spirits are thought to enter into people's minds and cause them to behave in strange ways. Calling in members of the community thought to have special powers to remove these evil spirits is considered an important remedy. For people who have these beliefs, it may be necessary for the mental health clinician to work together with the community healer, in order for the client to truly heal.

SECTION V – RISK ASSESSMENT

Risk Assessment: Suicide

Clinicians need to be familiar with the suicide assessment literature. This has changed over the course of the years and now there is a body of literature that provides for the parameters of a suicide assessment. A suicide assessment should be incorporated into all intake interviews, not just to those of patients complaining of suicidal ideation or of severe depression. It is critical for the clinician to take a careful history, avoiding the rationalization that the therapy approach utilized deals only with the "here and now" and therefore does not involve history. Past behavior is the best predictor of future behavior and, for this reason, a careful history-taking is essential to making an appropriate diagnosis. If a patient expresses suicidal ideation at any point in contact with the clinician or has at some point in their history, this is a matter that should be continually assessed session-by-session and appropriate action taken when necessary.

Reasonable Foreseeability

The Standard of Care dictates that careful and comprehensive assessments should assess what is also termed, *reasonable foreseeability*. The term, "reasonable foreseeability", is based on a clinician having gathered a sufficiently comprehensive set of information to make an appropriate decision as to whether or not the client will make a suicide attempt. Such adherence to the Standard of Care will promote the sharing of best practices. In addition, clinicians should encourage the development of protective registries and conferences to learn from suicide. There should be a funding of research related to suicidal risk in minority, pediatric and adolescent populations, as well as research on the impact of suicide on families and providers.

Adolescent Suicide Prevention

Depression is not always a precipitant of suicide, especially with adolescent and pre-puberty children. In this age group, suicidal thinking and behavior is more likely to be related to family dysfunction, physical or sexual abuse, substance abuse or the onset of a psychotic disorder such as schizophrenia. The clinician must become sensitized to these differences and not to generalize the literature on adult suicides to children and adolescents. Adolescents and children at high risk are those with suicidal ideation and disruptive behavior. Suicidal behavior during childhood, of course, increases the risk of suicidal behavior during adolescence. Suicidal ideation by itself is insufficient to determine risk. In one study, it was found that almost 60% of teenagers who reported suicidal ideation or behavior were not identified by staff at schools.

Risk Assessment: Violence to Others

Within the past twenty years, there has been an extensive body of literature dealing with the assessment of potential violence toward others. Performing a risk assessment is a very complex assessment that goes far beyond the traditional clinical interview that had been the approach used prior to this research. John Monahan, principle investigator for the MacArthur Foundation studies, identified well over thirty domains pertinent to risk assessment for potential violence. These domains are available in instruments called actuarial assessments. Most of the domains are based on knowledge of the person's history in addition to current behavior. Clinicians should be aware of these different domains and incorporate them into their assessments.

Risk assessment is different from the prediction of dangerousness. The prediction of dangerousness results in a dichotomous statement, indicating that the person is dangerous or not. The recent research shows that it is clearly inadequate to assess in "yes, dangerous" or "no, not dangerous" terms, especially with a minimum of thirty domains to assess for a more accurate appraisal of risk for violence. With all of these different domains relevant to the

potential for violence, it is more relevant to speak of the number of dimensions on which a person "loads" as being the appropriate methodology in risk assessment. We can then talk about, based on the number of dimensions that are relevant, as to whether the risk of violence is low, medium or high. Based on these different parameters, we can also design intervention strategies and make probability statements of the likelihood of violence given a particular context.

There is an ongoing controversy in the mental health field between what is called clinical and actuarial assessment. Clinical assessment is usually based on clinical interviews and, at times, standardized psychological tests. It requires a good deal of subjective clinical judgment. Actuarial assessment is based on assessment of factors that have already occurred. Actuarial assessments do not require much clinical judgment as many of the events assessed either did or did not occur. The actuarial assessment results rarely will change while the clinical assessment may be different depending upon who completes it. To resolve this controversy, the structured clinical assessment that may include some of the historical facts from the various risk assessment domains is considered the most appropriate assessment based on the research literature. The clinician is free to pursue his or her own hunches and diagnostic interviews, but must do so within the context of the risk assessment domains identified. When there is an extremely dangerous situation requiring physical restraints, it should be utilized by trained personnel and rarely done with children.

Mandatory Reporting: Child Abuse, Elderly and Disabled

All states have child abuse reporting statutes but there is some variation in the nature of reporting. Some states also have mandatory reporting of elder abuse and of those who are disabled. The language in these statutes generally speaks about *reasonable suspicion* of abuse or *has reason to believe* that abuse has occurred. Unfortunately, these terms are not well defined in any state statute. In some states, *the willful non-reporting of abuse* is regarded as a criminal offense. Initially, these abuse reporting laws allowed for clinical discretion. The laws stated that the abuse had to be reported if there was reasonable suspicion based on an individual's clinical judgment. This has changed in virtually all states, such that the clinical discretion no longer exists. There needs to be a reporting of possible abuse even without a careful clinical assessment. The reasoning behind this is that the clinical judgment is too variable and it has to be weighed against the protection of the child, the elderly person or the disabled individual.

Informed Consent

The mandatory reporting requirements for abuse must be included in the "Informed Consent" documents that the clinician utilizes. A potential psychotherapy client must be told about the exceptions to confidentiality that occurs when there is a reasonable suspicion of child abuse. The clinician should not make vague statements about exceptions to confidentiality being based

on "dangerousness" but rather must specify the specific mandatory reporting requirements. In some states, a form must be given to the client that specifies this information, is signed by both the therapist and client and is kept in the client's file.

In forensic settings, this may be somewhat more complex because clinicians in such settings may be acting under the umbrella of attorney-client privilege, which is different from psychotherapist-patient privilege. It is clear that exceptions to psychotherapist-patient privilege occur when there is mandatory reporting of child abuse. It is less clear whether or not a clinician, doing an evaluation for an attorney, has a similar duty to report. Because of this ambiguity, it is recommended that there be an informed consent statement at the outset of the evaluation that the mental health professional is a mandated reporter and will have to make such reports. This form would then also be shared with the referring attorney.

SECTION VI – RECORD KEEPING

Many medical errors have been found to occur because of poor record keeping. Mental health professionals now have guidelines that can assist in avoiding medical errors that occur because of such poor record keeping. Parenthetically, a well-documented record is also the best protection against a malpractice complaint or a licensing board complaint filed against a clinician.

Why Keep Records?

Records provide a documentation of services that are rendered. A good record will document the assessment and the treatment plan, dates and types of services rendered, how closely the treatment follows the treatment plan and any changes to the treatment plan made. Also, a good record will include notes of referrals made or follow up services for treatment that occur, as well as the provision of information to third parties. When the case is closed, a termination summary is entered in the record. Files are kept for a specified period of time in storage according to the state law.

Keeping good records allows the therapist to review the patient's progress or lack of it. Many therapists have been trained to keep narrative type of records called *progress notes*. Some therapists who use theoretical orientations, such as psychodynamic treatment, believe that progress notes may violate the patient's privilege to confidentiality and do not wish to keep any notes in the chart. This, however, can be a disadvantage to the client and the therapist should there be questions about treatment. It is usually recommended that more transparency for treatment be contained in the records.

All mental health professionals now have an ethical responsibility to keep proper records. For example, the Ethical Standard 6.01 of the American Psychological Association's *Code of*

Ethics describes psychologists as having an ethical and professional responsibility to develop and maintain records. In compiling these records, there also needs to be compliance with ethical and legal standards regarding confidentiality.

There is a new "player" in record keeping these days called HIPAA, the Health Information Privacy and Accountability Act. This is a very complex law but in terms of recordkeeping it does allow the clinician to keep two sets of records, one of which is *general progress notes* and another which is called *process notes* or *psychotherapy notes*. This latter set of notes is for the clinician's own use and need not be revealed to insurance companies. However, it is questionable if clinicians who keep such process notes must turn them over should the client be involved in a lawsuit.

What Is In the Basic Record?

The basic records contain identifying information, contact information, fees and billing information, guardianship and conservator status, documentation of informed consent, documentation of waivers of confidentiality and the documentation of any mandated disclosures of confidential information. In addition, since the advent of HIPAA, there should be forms in the chart dealing with the HIPAA Privacy Act. The basic record needs to have the presenting complaint, the diagnosis, relevant history, a treatment plan and progress notes based on the contact with the client. These should be dated, with type of treatment provided noted. As was stated earlier, any changes to the treatment plan based on progress or lack of it, referrals and collateral services should also be in the file. When services end, a termination summary should be included.

Contacts with Clients

The records for contacts with the client can be highly variable but they should contain certain basic information, such as the date of service, the duration of the session, the type of service provided and the nature of the professional intervention (i.e., individual therapy, group psychotherapy, medication consultation, and collateral visit with family members, etc.). It should also provide session-by-session assessment of the client's status and the client's response to professional interventions. There may be supplemental information related to a particular case, as well. Risk factors to self or others need to be documented on a session-by-session basis and the use of any adjunctive treatment modalities, such as medication or biofeedback, need to be included in the chart. Emergency interventions need to be documented, along with plans for future interventions and information describing the qualitative aspects of the professional and client interaction. There should be assessment data, consultations and referrals, telephone, mail or e-mail contacts, a prognosis, the cultural factors that are relevant in the treatment, and the documentation of termination.

Health Information Privacy and Accountability Act (HIPAA)

As noted, HIPAA is a "new player" in the contact of mental health professionals with individuals. There are some areas that are not well clarified regarding the inter-relationship between HIPAA and state law. Generally, state law trumps HIPAA if it is more protective of the patient's privacy and HIPAA trumps state law if it is more protective of privacy. The problem, of course, is defining what "more protective" means. For instance, problems often occur with mental health professionals regarding the release of raw psychological test data. Traditionally, psychologists have been able to protect that data and withhold it from an individual because of the ethical standard that states that such test data should be interpreted only by another psychologist qualified to interpret it. This, of course, is seen as protective of the patient's privacy since an unauthorized disclosure could well be misused and hurt the patient. HIPAA, on the other hand, says the patient is entitled to the records, believing that the patient's privacy is best protected by having access to all of his or her records. However, the *Code of Ethics* of the American Psychological Association and, in fact, the Florida Administrative Code for Psychologists, state that such records can be withheld if either they would be harmful to the patient or there is the potential for substantial misuse of the data. Further, states such as Florida actually have added limitations to disclosure of records into their rules and regulations regarding conduct of some mental health professionals.

Types of Progress and Process Notes

As discussed, HIPAA rules currently allow for clinicians to keep a separate set of psychotherapy or process notes. These notes may contain hypotheses, hunches, speculations and dynamic formulations, as distinct from the progress notes which merely document the patient's attendance at therapy, various medications and, in general terms, whether progress towards the treatment goals have been made. It has never been legally tested as to whether such process notes or psychotherapy notes as defined by HIPAA are legally discoverable when the records are subpoenaed. Some states do have provisions (i.e., Illinois) for the keeping of a separate set of records that are not subject to legal discovery. The State of Maryland indicates that the records should be kept in separate locations, not just separate files, but is silent on whether they are legally discoverable. The State of Florida has no provision for two sets of records. This is therefore a rather unsettled area and the suggestion, once again, is if these records are kept separate (this is discretionary rather than mandatory), then this be made clear to patients in an informed consent document.

Other aspects of progress notes are what are called SOAP notes with the initials standing for Subjective, Objective, Assessment and Plan. "Subjective" is defined as resulting from feelings, thoughts or temperament of the subject, whereas "objective" is defined as real, actual, and perceptible to others. These notes are always tied to the treatment goals. In some cases, narrative notes will be required after each session, as well as monthly summaries.

Retention of Records

Mental health professionals are legally and ethically required to keep records for a specified number of years. It is important to know how long you must keep these records. In some cases, the basic file must be kept longer than the additional information in the records. For example, the current guidelines published by the American Psychological Association indicate that the psychologist must maintain records for seven years after the last date of service for adults and three years after a minor reaches the age of majority. There needs to be a risk-benefit analysis if the records are retained longer than what is required. To do this risk-benefit analysis, you must consider weighing the risks of harm from outdated information against the benefits of preserving the records for future assistance. There may be some situations in which records need to be kept longer than the mandatory period of time, such as in criminal cases or in custody evaluations. Keeping large record files can be cumbersome, especially in agencies where there are many cases and little space for storage. Some state regulations understand these issues and may require keeping certain information and permit discarding other data. For example, the State of Florida requires keeping the full record for three years after termination. For the next seven years, it is only necessary to keep a summary of the record. It is important to remember to properly shred any documents that will be discarded or at least make sure the records cannot be identified if found in the trash.

Responsibility for Security and Confidentiality of Records

The laws regarding protection of records place the responsibility on the mental health provider, even in the event there are others in the office whose job is to maintain the records. It is therefore necessary to train all office staff in appropriate confidentiality procedures. Many private practitioners with limited practices do not have training in careful electronic record procedures, including identification of what can and cannot be kept confidential when using computers with instant chats or email.

Financial records must be carefully maintained and kept up-to-date. If collection procedures are utilized, clients should be notified what will occur if they fail to meet their financial obligations. If therapists do not accept payment directly from a third party provider, then a notation in the record should indicate the client was so informed.

Provisions should be made in the event of disability or death of a therapist.

Waiver of Privilege in Legal Situations

Records may be released upon proper presentation of a waiver of privilege. A subpoena demanding records signed by a lawyer is not sufficient to waive privilege. Rather, only a court order signed by a judge must be obeyed. If a subpoena requesting records is received, the clinician must respond to it; however, there are several different responses possible.

A first step may be to call the client to find out why you received the subpoena, as it is best not even to disclose that someone is a client. If the client discloses that he or she is involved in a lawsuit that has put the client's mental health at issue, then the client may have waived privilege. It is imperative to check this out with the client and not simply make an assumption based on the subpoena received.

Even if that has occurred, it is possible for the clinician to call the client's attorney and discuss whether the release of records would be helpful or harmful to the client's legal case.

If the therapist believes that the release of the records would be harmful to the client's treatment, then the therapist may request that the subpoena be *quashed* or voided. If that is not possible, then a review of the records by the judge *in camera*, so that non-relevant information be removed or *redacted*.

In some instances, it may be necessary for the therapist to hire an independent attorney who will protect the therapist's interests and not the client's interests. Agencies often have an attorney on retainer to deal directly with these types of issues. However, the agency attorney is hired to protect the agency's interests and not the individual clinician.

Responding to a Grievance or Malpractice Complaint

If a client files a grievance with the relevant licensing board or a malpractice complaint against the mental health clinician, then the client has waived the privilege and the clinician is permitted to disclose the client's records. As this is a complex area, we recommend seeking advice from a lawyer before responding to any complaints. There are also books written that help the clinician get through this difficult process.

Confidentiality and Privilege when Treating Multiple Clients

Couples or Family Therapy

When the clinician is seeing multiple clients, the issues of confidentiality and privilege become somewhat more complicated. In general, no one can waive privilege for anyone else, only for one's self. If a husband and wife are being seen in family psychotherapy and the husband later seeks to obtain the records of the treatment, the clinician cannot reveal the records unless the wife also gives her consent.

Group Therapy

In a similar manner, if a member of a psychotherapy group wants records from the group therapy sessions, the person could only get his or her own records and not the records of the

other members of the group. There had been some earlier laws that stated that the presence of an additional person in group sessions essentially rendered confidentiality null and void but this does not appear to be the case any longer according to case laws. When there are requests of records that also involve other parties, the clinician needs to remind the clients that they can only waive privilege for their own records and that the clinician must protect the other people's records unless everyone has waived privilege. If they all refuse to waive privilege, then the individual requesting the records will need to get a court order before it is released. In some cases, other person's records will have to be redacted in order for the person requesting the file to obtain it.

Release of a child's records

Parents do have the right to request the release of their minor child's records in most but not all situations. For example, if a teenager is in therapy, and the parents request the release of the teen's file, it may be incumbent upon the therapist to protect the teenager's privacy by seeking a court order prohibiting the release. The teen's age and emotional maturity will be important factors if the issue goes to court.

In a different scenario, during a divorce action one parent may demand a child's records as a weapon in a custody battle. In most states it would not be appropriate to release the records to either parent, without both parents' permission or a court order.

In other words, there is a need to resist efforts of one client to obtain other clients' records where it will violate the other clients' privilege. The only way the records may be released is through a court order signed by a judge and placed in the other clients' files.

SECTION VII – REDUCTION OF ADVERSE MEDICATION EVENTS

It is common for mental health providers to provide psychotherapy to clients who are also being prescribed medication for treatment of the same symptoms. Although some mental health providers, such as some psychologists, psychiatric nurses and psychiatrists, may be able to prescribe these psychotropic drugs legally, most other disciplines are not. Research shows that 85% of all medication for psychological problems is prescribed by primary care doctors, not specialists in psychopharmacology. Given the complexity of the interaction of these drugs with other medications the client may be taking, it is important for all clinicians providing services to clients to be aware of the medication side effects.

Physicians are able to use computerized medication orders, monitors, and alerts to stay within standardized treatment orders. However, given the variation in doses from patient to patient and even within the same patient at different times, it is critical for all treating practitioners to learn about appropriate medications, doses, and possible side effects for the different mental health diagnoses. Once this information is learned, it is important to develop a support group

for monitoring. Adoption of a routine procedure to report, analyze, and learn from common adverse medical events with these medications will help develop a best practices model. These steps may prevent more serious adverse medical events.

It is important to stay alert to clients who are at a higher risk when certain types of psychotropic medications are used.

Antipsychotic Medications Prescribed for Children

There has been a six-fold increase in the prescription of antipsychotic drugs for children in the twenty year period from 1983 to 2002. The Federal Drug Administration (FDA) has only approved three antipsychotic drugs for the use in children. However, most prescriptions for children are written for the second generation antipsychotic drugs also called atypicals, even though they are not FDA approved for use with children. This is called prescribing *off-label*. There is insufficient research to know what types of side-effects medications such as clozapine, risperidone, olanzapine or quetiapine can cause in the developing child's body or mind. It is known that risperidone can cause breasts to grow in boys or girls who are given it.

Antipsychotic medications in children are prescribed for:

- 40% disruptive behavior disorders
- 32% mood disorders
- 17% pervasive developmental disorders
- 14% psychotic disorders

Many of these drugs require frequent laboratory tests to make sure they are not negatively impacting other body functions. There simply is not enough known about the metabolic effects of the newer atypicals, especially long-term effects on the developing child.

Antidepressants

The most common type of antidepressants prescribed for children today are in a class called *Selective Serotonin Reuptake Inhibitors (SSRIs)*. Some of these medications are approved by the FDA for use in children but most do not have adequate research to ensure their safety. There are a few known common side-effects that should be carefully noted.

It is known that in some cases *SSRIs* may cause someone with a mood disorder to switch from depression to bipolar disorder with manic-like symptoms.

Paxil, an *SSRI* often used with children, has been implicated in causing suicidal behavior in children as well as adults. Other *SSRI* drugs such as *Prozac* and *Zoloft* are also implicated. Research suggests that, in particular, teenagers who may have suicidal ideation may be more prone to making suicidal attempts while taking these medications. It is therefore important to

closely monitor any child or teen who is prescribed such drugs.

Other medications may also have a high incidence of certain side-effects in addition to the idiosyncratic reactions of individuals.

There are lawsuits against the manufacturer of *Zyprexa* as it is known to cause diabetes-like symptoms.

Wellbutrin is known to cause or increase the risk of seizures in some people.

Attention Deficit Disorder (ADD and ADHD)

Many children who have attention disorders with or without hyperactivity are prescribed medications. Some of these medications are stimulants, such as *Ritalin*. Others have different formulas. Children are often kept on these medications for many years. Again, it is unknown what impact, if any, is had on their growth; however, there are some side-effects that are known. For example:

Strattera may cause an increase in suicidal ideation and behavior.

ADHD drugs are known to cause liver damage in some children.

Stimulant drugs may cause seizures in those who have not had them previously.

SECTION VIII – HUMAN BEHAVIORAL FACTORS

Human behavior involves unintentional and unpredictable behaviors that can result in undesirable outcomes. It is more likely for *at risk* behaviors to occur when a clinician develops unsafe habits and practices while at the same time losing the perception that risk can occur. In these cases, the clinician often takes short cuts or engages in other high-risk activities.

Reckless Behaviors occur when a person recognizes the potential for harm but never the less goes ahead and commits the behavior.

Most medical errors are not a function of negligence, lack of education, or training deficiencies. Rather, they are related to system factors that have been described in this course.

How Mental Health Professionals Can Reduce the Risk of Making an Error:

Develop awareness of childhood and adult medical and psychological disorders.

Refer to physician when a medical disorder may be associated with presenting symptoms.
Develop a systematic routine for how you approach diagnosis and treatment.
Be aware of cognitive biases that may cause diagnostic errors.
Be aware of multi-cultural issues that impact assessment and treatment.
Assess for abuse in adults and children.
Become sensitive to child-rearing practices in cultures that may be physically or emotionally abusive.
Screen for depression and suicidal ideation and behavior.
Assess for substance abuse that may be contributing to a client's difficulties.
Perform additional appropriate risk assessments.
Learn medication use, dosage, and common side effects.
Put together a referral protocol and use it when issues are outside your training.

Maintain records and document all contacts with clients and collaterals.
Pay attention to a client's constitutional rights and protect confidentiality and privilege.
Know the laws and rules in the state in which you practice.
Uphold the ethical standards of your profession.

Keep abreast with current literature related to your practice.
Form or join a support group of colleagues with whom you can share information.
Perform root cause analysis whenever a medical error, adverse medical event, or sentinel event occurs.

Cases Involving Possible Medical Errors

The following scenarios are presented for your own thinking and discussion with colleagues. (There will be two multiple-choice questions on the test related to these cases. You can refer to the course material for your answers.)

Negligent Diagnosis

Dr. Jones is a psychologist in private practice specializing in the treatment of depression using a cognitive behavioral technique. He is consulted by a 38 year old married woman who reveals in her intake that she feels depressed, has a loss of energy, a loss of appetite, often feels sick to her stomach, has difficulty sleeping, and reports that she is feeling distant from her husband and two children. Dr. Jones diagnoses her, based on his history taking, as having a Major Depressive Disorder, recurrent, without psychosis, and commences a program of cognitive behavioral treatment to help her identify and change her dysfunctional thinking patterns. She appears to respond well to the treatment initially, recognizing many of her cognitive distortions and maladaptive schemas. After approximately two months of the treatment, however, she reports

that while she has a better understanding of the roots of her depression, her physical symptoms have become more intense and frequent, with her experiencing frequent nausea and periods of days when she cannot eat anything for fear of vomiting. She tells Dr. Jones that her HMO family physician says that her symptoms are probably due to stress and she should continue working with her psychologist before giving her a referral to a specialist. She asks Dr. Jones whether she should consult again with her family physician to get the referral to the specialist. Dr. Jones tells her that it is up to her, but he is sure the somatic symptoms are merely a manifestation of the depression and will resolve with more cognitive behavioral sessions. Approximately one month later she starts missing appointments and when Dr. Jones follows up on this he is informed by her husband that she has been hospitalized and has been diagnosed as suffering from Hodgkins Disease. Several weeks later she dies. What would the system error be here? What liability might the therapist have?

Retention of Records Case

When Louis was 8 years old, he was seen by a mental health professional who was appointed by the court to perform a custody evaluation when his parents were getting a divorce. His mother claimed that his father was abusing her and that Louis was in danger. The custody evaluator, who was charged with deciding and informing the court as to what was in the best interest of the child, recommended that he spend equal time with each parent. Louis reported that his father was abusive to him and refused to spend parenting time with him. He was referred for therapy by the court. The therapist attempted to help Louis be comfortable with his father. Although he told the therapist that his father was abusing him, the therapist believed he was court ordered to insist that the child spend the parenting time with his father but he did notify the judge of the child's credible allegations of abuse. When Louis was 12 years old, his father beat him and threw him out of a moving car. All visitation was suspended at that time. When Louis turned 19 years old, he asked his father to help him pay for his college education and his father refused. Louis then sought out a lawyer to help him get his father to do so. The lawyer persuaded Louis to file a lawsuit against his father to enforce his parenting responsibilities. The lawyer sent to Louis's therapist and custody evaluator for copies of their records to document the history of abuse. The custody evaluator kept records but the therapist had destroyed his records. What are the record keeping guidelines in this case?

Child on Risperdal

John is a six-year old boy who has been having difficulties in school. He cannot sit still for even short periods of time, he is impulsive, he is not learning the pre-reading concepts, and he is beginning to hurt other children when he gets angry and frustrated. Children in class began teasing him because he has gained weight and has grown small breasts. The teacher referred him to the school counselor who learned that John was recently removed from his home due to suspected child maltreatment and placed in a foster home for the second time by Child Protective Services.

Afterward he had been placed on medication by the CPS psychiatrist but the foster mother didn't know which medication was prescribed. She was giving it to him every day. The counselor contacted John's caseworker and found out he was prescribed 1 mg. Risperdal daily. However, this was off label as there was no FDA approval for this atypical anti-psychotic medication. The counselor then requested permission to speak with the prescribing psychiatrist but learned that there were three different psychiatrists, none of whom had ordered blood work for this child. What should the counselor do?

Cultural Issues

Maria came to the US from Russia when she was 14 years old with her family. Her father had married an American citizen and her father and Maria were excited to move to this country together. Maria's mother remained in Russia. When she was in this country for two months, a man broke into her apartment when her parents were not home and sexually assaulted her. Maria did not speak a lot of English but told the police what happened when questioned. Her father's wife was present and helped with translation where needed. The victim witness assigned by the prosecutor's office to Maria's case recommended she go to see a therapist. What are the issues that a therapist must pay attention to when treating Maria?

ADDITIONAL RESOURCES

Joint Commission on Accreditation of Health Care Organizations (JCAHO)

Sentinel Event Policy and Procedures

Updated: July 2007

<http://www.jointcommission.org/SentinelEvents/PolicyandProcedures/>

Sentinel Event Forms and Tools

<http://www.jointcommission.org/SentinelEvents/Forms/>

Alternatives for Sharing Sentinel Event-Related Information with the Joint Commission

<http://www.jointcommission.org/SentinelEvents/ReportingAlternatives/>

Sentinel Event Alert; Behaviors that undermine a culture of safety, Issue 4

http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm

Sentinel Event Statistics - Updated through June 30, 2009

<http://www.jointcommission.org/SentinelEvents/Statistics/>

Facts about Speak Up™ Initiatives

http://www.jointcommission.org/AboutUs/Fact_Sheets/about_speakup.htm

History Tracking Report: 2009 to 2010 Requirements, Accreditation Program: Behavioral Health Care, 2009 Chapter: Improving Organization Performance

<http://www.jointcommission.org/> Once on the web site, search for “History Tracking Report”.

Suicide Risk Assessment:

Jobes, David A. Managing Suicidal Risk: A Collaborative Approach, Guilford Press, 2006,

<http://www.guilford.com>

American Foundation for Suicide Prevention, <http://www.afsp.org>

American Association of Suicidology, <http://www.suicidology.org>

Risk Assessment for Potential Violence:

Monahan, John, Steadman, Henry J., Silver, Eric, Appelbaum, Paul S., Robbins, Pamela Clark, Mulvey, Edward P., Roth, Loren H., Grisso, Thomas, and Banks, Steven, Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence, Oxford University Press, Inc., 2001 <http://www.oup-usa.org>

HIPPA Information:

Department of Health and Human Services

<http://www.hhs.gov>

Mandatory Abuse Reporting:

National Center on Elder Abuse
<http://www.ncea.aoa.gov/NCEA>

Child Welfare Information Gateway
http://www.childwelfare.gov/systemwide/laws_policies/state/

Responding to a Grievance or Malpractice Complaints:

Shapiro, D.S., Walker, L.E.A., Manosevitz, M., Peterson, M., & Williams, M. (2008). Surviving a Licensing Board Complaint. Zeig, Tucker, & Theissen: NY
<http://www.amazon.com/>

Zuckerman, Edward L., The Paper Office, Fourth Edition, Forms, Guidelines and Resources to Make Your Practice Work Ethically, Legally and Profitably, Guilford Press, 2008.
<http://www.guilford.com>

Barsky, Allan E., and Gould, Jonathan W., Clinicians in Court: A Guide to Subpoenas, Depositions, Testifying and Everything Else You Need to Know, Guilford Press, 2002; 2004.
<http://www.guilford.com>

Reamer, Frederic G., Social Work Malpractice and Liability, Columbia University Press, 2003.
<http://www.amazon.com>

Sloan, Frank A., and Chepke, Lindsey M., Medical Malpractice, Massachusetts Institute of Technology, 2008.
<http://www.amazon.com>

REFERENCES

- Albers, L., Hahn, R., & Reist, C. (2004). *Handbook of psychiatric drugs*. Laguna Hills, CA: Current Clinical Strategies Publishing.
- American Iatrogenic Association. Retrieved from <http://www.iatrogenic.org>
- American Psychological Association (2002). *American Psychological Association Code of Ethics*. Washington, DC: Author.
- American Psychological Association. (2007). Revised Record Keeping Guidelines. *American Psychologist*, 62 (9), 993-1004 or download from www.apa.org
- Berman, A., Jobes, D., & Silverman, M. (2004). *Adolescent suicide: Assessment and intervention*. Washington, DC: American Psychological Association.
- Ferraro, G. *Cultural anthropology: An applied perspective* (2004, 5th ed.). Belmont, CA: Thomson.
- Food and Drug Administration (FDA). Retrieved from <http://www.fda.gov>
- Health Information Privacy and Accountability Act (HIPPA). Retrieved from <http://tools.televoxsites.com/forms/hippa.pdf>
- Hunt, E. & Colander, D. (2008). *Social science: An introduction to the study of society* (13th ed.). New York: Pearson.
- Joint Commission (formerly JCAHO). Retrieved from <http://www.jointcommission.org>
- Koocher, G. & Keith-Speigel, P. (2008). *Ethics in Psychology & Mental Health Professions*. Oxford: NY
- MacArthur Foundation. Retrieved from <http://www.macfound.org/research>
- Matsumoto, D. & Juang, L. (2004, 3rd ed.). *Culture and psychology*. Belmont, CA: Thomson.
- Monaghan, J. & Just, P. (2000). *Social and cultural anthropology*. New York: Oxford University Press.
- Myers, D. (2005). *Social psychology* (2008, 9th ed.) Boston: McGraw-Hill.

Pope, K.S. & Vasquez, M. J. T. (2006). *Ethics in Psychotherapy and Counseling. Third Ed.* Jossey-Bass, San Francisco, CA.

Schaefer, R. (2004). *Sociology: A brief introduction* (5th ed.). St. Louis: McGraw-Hill.

Shapiro, D.S., Walker, L.E.A., Manosevitz, M., Peterson, M., & Williams, M. (2008). *Surviving a Licensing Board Complaint.* Zeig, Tucker, & Theissen: NY

Tesser, A. (1995). *Advanced social psychology.* Dubuque, IA: McGraw-Hill.