Charting the Course of Electronic Health Records

Demonstrating the Benefits of Integrated Care

Dealing with Threatening Client Encounters

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Good Practice is the recipient of a Platinum Award, the highest honor, from the Association of Marketing and Communications Professionals.
Are you worried about electronic health records?

If so, you’re not alone.

Some psychologists just wish they could make it all go away, says Lynn Bufka, PhD, assistant executive director for practice research and policy in the American Psychological Association (APA) Practice Directorate. “People are worried that this will potentially be complicated and costly and will require learning new technology,” she says. “They’re thinking, ‘I have barely enough time to meet my clients’ needs, let alone think about all the things that go into electronic health records.’”

But you shouldn’t feel anxious, say Bufka and other directorate staff. Electronic health records offer many benefits to both patients and practitioners, including more coordinated care, reduced medical errors and an opportunity to showcase the value of psychological treatment. The APA Practice Organization is working hard to ensure that psychologists get the same financial breaks that physicians receive for buying and implementing electronic health record systems (see sidebar on page 3). And psychologists don’t really have to do anything in the near future beyond just keeping abreast of developments.

Staying informed is vital for practitioners, says APA Executive Director for Professional Practice Katherine C. Nordal, PhD, since electronic health records are “intended to provide the information infrastructure that undergirds a reformed health care delivery system. Data from these records will enable integrated systems of care to be evaluated for patient outcomes and costs.”

Understanding electronic health records

For some psychologists, especially those in private practices that rely on paper records, part of their anxiety may stem from not being sure what exactly electronic health records are (see glossary of key terms on page 4). “A lot of psychologists think electronic health records are akin to practice management software,” says Bufka.

Practice management software may give users the opportunity to store notes on clients’ progress, but its main purpose is to facilitate scheduling, billing and other tasks associated with the day-to-day running of a practice. More importantly in this context, it can’t typically communicate with other systems.

In contrast, electronic health record systems are designed to talk with other systems — a concept known as interoperability. “Even if my system isn’t the same as yours, information can be exchanged in a way that’s comparable,” explains Bufka. “The products have the same boxes to hold information, even if the user interface and some features may be different.”

Electronic health records are also different from electronic medical records, adds Stacey Larson, PsyD, JD, the Practice Directorate’s director of legal and regulatory affairs. “Although the two terms are often used interchangeably,” she says, “there is an effort at the federal level to make a distinction between the two.”

While electronic medical records are just a digital version of the paper charts in a practitioner’s office, electronic health...
records go beyond the services provided in one practice. Instead, they focus on the patient’s overall health and include the treatment provided by all the practitioners involved in that person’s health care.

**Meaningful use**

All this attention to electronic health records comes as a result of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. Part of the stimulus package, the HITECH Act expanded the federal government’s efforts to establish a national electronic record-keeping system. The goal? “Meaningful” use of interoperable electronic health records that helps providers significantly improve patients’ care.

The key word is “meaningful,” says David Ballard, PsyD, MBA, assistant executive director for marketing and business development at APA. According to the government, meaningful use means using certified technology that can exchange information to improve the quality of care and provide data on certain clinical quality measures.

“This is not just about transferring your files that were previously in a file cabinet to something that’s on your computer,” Ballard explains. “Meaningful use means using technology to actually improve care, improve safety and promote the coordination of care by enhancing the exchange of information across different providers.”

While physicians must adopt electronic health records by 2014 or face escalating cuts to their Medicare reimbursement over three years, there is no similar mandate for psychologists — at least not yet. But Ballard and others predict that day will eventually come. And private insurers are likely to follow the path laid out by the Centers for Medicare and Medicaid Services and begin requiring electronic health records, too.

The only practicing psychologists who may not be affected are those who work completely outside the organized health system — those who don’t accept insurance and are paid by patients solely on an out-of-pocket basis. But Ballard doesn’t see why they would want to shun electronic health records.

“Even if you’re not working with third-party payers, having access to accurate, complete health records has tremendous value,” he says.

**SEEKING PSYCHOLOGISTS’ INCLUSION AS “MEANINGFUL USERS”**

The federal government is so eager to establish electronic health records that it is giving physicians a financial break for buying and implementing such systems. For psychologists, there’s no such incentive — at least not yet.

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 excluded psychologists and most other non-physician providers from the list of “meaningful users” of electronic health records. As a result, psychologists aren’t eligible for Medicare and Medicaid incentive payments and grant funds designed to encourage adoption of these pricy, complex systems.

“Obviously the lack of eligibility for incentive payments may make it more difficult for psychologists to set these systems up,” says Stacey Larson, PsyD, JD, director of legal and regulatory affairs in the APA Practice Directorate. “These systems may be expensive when you consider start-up cost, training costs and then usually a monthly fee per provider in your office. Being able to apply for and utilize incentive payments may help ease that burden for many providers.”

Now the American Psychological Association (APA) and the APA Practice Organization (APAPO) are working to make the transition easier on psychologists’ pocketbooks. As a member of the Behavioral Health Information Technology Coalition — an advocacy group that also includes such organizations as the National Association of Psychiatric Health Systems and the National Council for Community Behavioral Health care — APA is supporting a congressional initiative to include psychologists in the incentives program.

Introduced by Sen. Sheldon Whitehouse (D-RI), the Behavioral Health Information Technology Act of 2011 would extend eligibility as a meaningful user to mental health professionals and facilities. Thanks to ongoing advocacy by the APAPO, the Senate bill had 14 cosponsors as of December 2011, when psychologist Tim Murphy, PhD, (R-PA) is expected to introduce a companion bill in the House of Representatives.

For more information, see www.apapracticecentral.org/update/2011/08-02/incentive-payments.aspx.

When a new patient comes in, for example, psychologists have to get the person’s basic health background to develop an overall picture of their health and rule out physical health problems that may be causing their mental health symptoms.
Electronic health records also make things easier on patients, he adds, since they don’t have to repeat their health history every time they see a new professional or visit a different facility.

**Potential benefits**

Of course, the main advantage of electronic health records is the ability to coordinate care across different health-care professionals and institutions.

“The intention is that if we all have electronic health records, our care — both routine and emergency — will be better integrated,” says Bufka, adding that easy, routine access to complete, accurate health information will also mean fewer mistakes. Being able to better coordinate care is especially important given health care reform’s emphasis on multidisciplinary teams providing integrated care, she adds.

While such integration is crucial for physical health care, she says, it will also help psychologists meet their treatment goals. “Sometimes as a clinician, you may find that other providers don’t understand what you’re hoping to accomplish clinically and may be saying or doing things counter to it,” she says. In her own work treating anxiety, for example, Bufka asks patients to confront their fears and do things they’ve been avoiding. “I’ve been in a situation where a physician has told the patient, ‘If it makes you uncomfortable, don’t do it,’” she says. “Sharing the treatment plan with that physician may reduce some of those problems.”

In addition to improving the quality of care, electronic health records should also reduce costs by increasing efficiency. “If you look at the economics of health care, there’s a lot of duplication,” says Bufka. “When they’re working with someone with a chronic illness, for example, multiple offices are doing the same labs instead of sharing one set of lab results for the patient.”

Electronic health records will also make it easier to report quality and quantity measures — a feature that will be critical given health care reform’s emphasis on greater accountability and the use of outcomes measures.

Electronic health records may even serve as a way to promote the value of psychological services, adds Bufka. “In many settings, what psychologists do is still seen as sort of a black box,” she says. “Seeing more of the psychological record will help other professionals better understand the care being provided and the necessity of that care.”

In addition to helping other health-care professionals see psychology in a new light, electronic health records may also change the way patients see their own health care. The ability to easily access their own records may increase patients’ engagement and view of themselves as partners in their own care, she says.

It may also change what psychologists put in their records, she adds. Although patients are already allowed to view their paper records, she points out, they rarely exercise that right. “Electronic health records may change how psychologists think about content and how to write things, because they

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**KEY TERMS**

The terminology thrown about in the evolving health care arena can be tricky. Here are some key terms to help you understand what electronic health records are and are not:

**Electronic health records:** Electronic health records focus on the total health of a patient, often going beyond standard clinical data and generally including a broader view of a patient’s care. Built to share information with other health care providers, these records generally contain information from all of the clinicians involved in a patient’s care.

**Electronic medical records:** Electronic medical records are simply a digital version of the paper charts in a clinician’s office. They contain the medical and treatment history of a patient in one practice. Critically, that information is not easily shared with other practices.

**Practice management software:** Practice management software deals with the day-to-day operation of a practice. It typically allows users to schedule patient appointments, perform billing tasks, capture patient demographics and generate reports for insurance, billing and clinical purposes.

**Interoperability:** Interoperability refers to the ability of electronic health record systems to exchange information and be able to understand and use that information.

**Role segregation:** Role segregation refers to an electronic health record function that limits which personnel can access which content of the record based on their role within the organization. For instance, a billing clerk would not have the same access to information as a clinician.
may need to think about how it’s going to be received by a patient,” she says.

**Privacy and security issues**

APA Practice Organization (APAPO) staff are currently exploring the various electronic health record products that are already available. “Things are still in the early stages,” says Ballard. “Most of the products out there remain geared toward larger practices and health-care institutions.”

And because there’s not yet a mandate for psychologists to adopt electronic health records, says Bufka, software designers have been slower to design products specifically targeting psychologists and other mental health practitioners. APAPO plans to create resources — including a future Good Practice article — to help practicing psychologists evaluate products in terms of their features, cost per user, learning curve and other variables to choose the product that best suits their needs.

One big issue APAPO will be looking at is ensuring that all products address the special privacy and security concerns of psychologists.

Some psychologists fear that using electronic health records means they will be required to make sensitive patient information available to anyone with access to the records, says Bufka. Not so, she and other APAPO staffers emphasize.

The privacy and security provisions of the Health Insurance Portability and Accountability Act and HITECH Act apply to electronic records, they point out. And thanks to “role segregation” features built into the products, users will be able to control who has access to what information. A billing clerk, for instance, would be able to see that a session occurred but not the content of that session.

“Part of an electronic health record product being certified is having to meet security and privacy measures,” says Ballard. “One thing that is still being worked out is an added level of protection for mental health records, so they’re available and accessible by people who need that information but not reported the same way basic health information would be.”

**Still unknown**

There are still plenty of other unknowns. One of the main questions is whether electronic health records will actually live up to the hype. “There’s this idea that electronic health records will have benefits, but do we know that?” asks Bufka. “There’s a lot of theory that electronic records will be very beneficial and provide all these improvements in how health care is delivered, but I don’t know that we’ve seen any documentation on that.” The Department of Defense and Department of Veterans Affairs, which have long used electronic records and are now integrating their systems, may offer important lessons, she says.

Much still needs to be worked out at a practical level as well, such as what information needs to be kept truly private and what can be shared and for what purpose. Plus, says Ballard, the federal government is still ironing out standards on interoperability and building a national infrastructure for health data that will allow information to be shared regardless of setting.

Cost is another unknown. “Early on, pricing models even for physicians in private practice were outrageous,” says Bufka. “We’re starting to see pricing models be a little more reasonable.” Vendors are beginning to shift to a subscription model, where users pay monthly fees and records live “in the cloud” rather than on users’ own computers — a model that’s much more feasible for smaller offices.

When all this will kick in for psychologists is still another unknown.

“Psychologists shouldn’t feel like they have to completely overhaul the way they do everything in the next three years,” emphasizes Ballard. “This is going to happen gradually over the course of a number of years, so they should stay on top of things, but there’s no need to panic.”

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**WHERE TO LEARN MORE**

Sources of additional information include:

APA Practice Organization: [www.apapracticecentral.org/advocacy/technology/index.aspx](http://www.apapracticecentral.org/advocacy/technology/index.aspx)


Office of the National Coordinator for Health Information Technology: [http://www.healthit.gov](http://www.healthit.gov)
Demonstrating the Benefits of Integrated Care

Practitioner Profile: Robin J. Henderson, PsyD

For some psychologists, what drives them is the chance to help improve the lives of their patients. For Robin Henderson, PsyD, the goal is much bigger than that: She wants to improve the mental and physical health of all of eastern Oregon.

As acting director of a public-private collaborative called the Central Oregon Health Council, she is determined to achieve the Triple Aim — better care, better health and lower costs — for the region’s most low-income, high-risk, high-need population. That’s on top of her day job as director of behavioral health services at St. Charles Health System and her role as a member of the American Hospital Association’s Governing Council. It’s also why, she laughs, “I’m always emailing people at seven in the morning and 10:00 at night.”

Codrdinating care

The Central Oregon Health Council’s goal is to create what the state calls a coordinated care organization and integrate health care delivery and funding streams across a variety of settings.

Over the last two years, multiple organizations — including PacificSource Health Plans, a coalition called HealthMatters of Central Oregon, a federally qualified health center called Mosaic Medical, and St. Charles — have taken on one project after another. So far, they’ve tackled inappropriate emergency room usage, created a neurodevelopment assessment clinic for babies who leave the neonatal intensive care unit and integrated psychologists into primary care, among other efforts.

Psychologists are integral to all of the collaborative’s efforts. Psychologists are part of what the group calls health engagement teams, which include physicians, social workers, nurse care coordinators and community health workers. “In the beginning, I would get calls from physicians with psychologists in their clinics and they would say, ‘I don’t know if I need this,’” says Henderson. “Six months later, they were saying, ‘You can never take this away!’”

At one clinic, the psychologist noticed that physicians were writing many prescriptions for attention deficit hyperactivity disorder medications. She persuaded the physicians to refer patients to her for a quick screening before they got out their prescription pads. In the first week alone, says Henderson, she found that one patient actually had anxiety and another was psychotic.

The projects are also helping to improve patients’ physical health.

Take the council’s emergency department diversion project, an effort prompted by the fact that many of the region’s residents use the emergency room (ER) in lieu of more appropriate health care settings.

“They don’t want to be in the ER, but they have no other option,” says Henderson, explaining that most of the so-called “high utilizers” are Medicaid recipients. “Maybe they don’t have a primary care home. Maybe they were kicked out of their primary care home. Maybe they have a mental health condition, but haven’t been connected to mental health services.”

To change that, the health engagement team meets routinely to look at what’s bringing people back to the emergency room again and again. Together they come up with solutions to whatever problems they identify. Since psychologists are embedded in the primary care clinics, they’re able to do brief assessments and interventions and provide what Henderson calls “a warm handoff” to more specialized care as necessary.
As a result, emergency room utilization dropped by almost 50 percent with the first cohort and by 77 percent in the latest one. And although assessing cost savings is difficult, St. Charles saw a 66 percent drop in costs from the year before the project began. (A full report is available at www.cohealthcouncil.org/resources/reports.)

Now the list of possible projects is growing to include better integrating psychologists in cardiac rehab. “It’s like playing the game Whac-A-Mole,” says Henderson. “You hit one; something else pops up over here.”

Enhancing access
Henderson isn’t just making sure residents get the right care. Since earning her clinical psychology doctorate from George Fox University in 1996, she has also spent her career making sure psychological care is there when they need it.

When she first arrived at St. Charles Health System a decade ago, for example, she discovered there were no acute psychiatric services east of the Cascade Mountains. “That’s a 32,000 square mile region, the size of 13 East Coast states,” she says. Henderson took action, designing, fundraising and building two psychiatric units — one a 15-bed unit and the other a five-bed unit for acute cases. Today she manages those two facilities, plus an outpatient clinic with services in 13 locations, acute social work services across two hospitals, consultations with five psychiatrists, an employee assistance program and spiritual care services.

“My role as a leader is to facilitate an environment where my staff can provide the most effective, efficient care they can.”

Although Henderson worked in private practice after she was licensed, she quickly gravitated to a hospital setting. She served as clinical director of the adolescent psychiatric unit at Woodland Park Hospital, then became the director of behavioral health services at Eastmoreland and Woodland Park Hospitals before heading to St. Charles in 2001.

“I like the collaboration of care in hospitals,” says Henderson, who credits her psychology training for teaching her how to make decisions quickly based on often conflicting information from a wide range of sources. “And I feel that as a psychologist, I went to school to work with the sickest of the sick.”

Henderson’s work to gain prescriptive privileges for psychologists is part of that same urge to ensure access to care in a region that includes urban, rural and even frontier areas. “I got involved in prescriptive privileges legislation not because I wanted to prescribe myself, but because I saw a critical shortage of providers, especially in rural Oregon,” says Henderson, a past president of the Oregon Psychological Association. “I saw that primary care providers were hungry for that expertise.” In 2010, a prescriptive privileges bill made it all the way to the governor’s desk, where it was vetoed.

Henderson’s efforts to improve care go beyond her home state of Oregon, too. For the past five years, she has been a member of the American Hospital Association Governing Council’s section on psychiatry and substance abuse services. The group looks at policy changes and makes recommendations to inform the broader agenda—a process that Henderson says has been fascinating in the run-up to health care reform.

“It’s almost like being part of a think tank,” says Henderson, who will complete a term as chair in January. “It has really helped me understand what’s going on at the federal level and use it to inform my practice at the state level.”

When she’s not working, Henderson loves to cook and enjoy the outdoors with her husband and nine- and 10-year-old sons. Making the community a healthy place for her boys is part of what motivates her, she says.

“We get to live in one of the most beautiful places on the planet,” says Henderson, who describes the high desert resort community of Bend as the “Vail of Oregon.” “We have the opportunity to be one of the healthiest communities in the nation if we just work together to change the trajectory of where we’re headed. That’s what drives me and the rest of the Health Council so hard to make these projects work.”
Dealing with Threatening Client Encounters

Consider clinical issues, confidentiality concerns and other factors in determining what to do.

At some point in their career, many psychologists will face a situation in which they feel threatened by one of their clients. Clinical issues, ethical and legal duties, confidentiality concerns and therapist safety must all be taken into consideration in determining how to anticipate and handle such a stressful situation.

Estimates vary, but studies suggest that almost half of psychotherapists will at some time experience at least one incident of physical attack, verbal abuse or other harassment by a client. According to the American Psychological Association Advisory Committee on Colleague Assistance, 15 to 25 percent of psychologists may be at risk of being physically assaulted by a client during their careers. (See sidebar on page 9 for references and additional resources.) Although instances of serious injury are rare, any type of threat, violence or harassment can cause significant emotional distress.

Policies and procedures

For psychologists who work in hospitals or other institutional settings, there likely will be institutional policies and procedures designed to protect clinicians. For example, institutions that serve client populations with a known risk for violence may have security personnel onsite or panic buttons in clinicians’ offices. Psychologists in private and small group practices, however, need to develop their own safety plans and policies.

To reduce the likelihood that a dangerous situation will develop, it is important to consider your office setup and procedures. Some practical steps to increase safety are easy to implement. For example:

• Make sure seating arrangements allow you to exit your office quickly if needed.
• Keep potentially dangerous objects such as letter openers or heavy paperweights out of reach.
• Establish a method of communicating with or notifying others if you need help. For example, some psychologists decide to install security alarm systems in their offices.

Also make sure you are comfortable with your procedures for initial client evaluations and with the hours you make available for appointment scheduling. For example, you may wish to limit appointment times for new patients to times when professional colleagues and/or security personnel are nearby.

A nationwide survey of practicing psychologists (Guy, Brown & Poelstra, 1992) found that protective measures taken by private practitioners often include avoiding working alone in an office, declining to publicly list their home address, avoiding solo practice and obtaining training in management of assaultive behaviors.

A variety of responses

Responses to threatening or potentially dangerous situations vary, but should include careful consideration of clinical factors. For example, have you done a thorough evaluation for risk of violence? It is important to consult with experienced colleagues early on if a particular situation is causing concern. Trust your instincts: If you are feeling uncomfortable working with the client, you probably need to modify your approach to treatment. You may need to consider the advisability of making a referral to a different provider — especially someone with more expertise in working with clients who have a history of violent behavior — or to a more intensive, structured treatment setting such as a day treatment or inpatient program.

The APA Ethical Principles of Psychologists and Code of Conduct (“Ethics Code”) specifically allows for termination of therapy in potentially dangerous situations. Section 10.10(b) states: “Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.” Section 10.10(c) further states that the usual requirements for ethical termination, which include pre-termination counseling and suggesting alternative service providers as appropriate, would not apply “where precluded by the actions of clients/patients.”
Even in these difficult situations, however, the psychologist should keep in mind what is best for the client and can urge the client (e.g., by letter or voicemail) to obtain other appropriate services (see Campbell, Vasquez, Behnke & Kinsherff, 2010). In most cases, practitioners should provide a written communication with contact information for several alternative service providers if further treatment is needed.

In determining how best to respond to a potentially dangerous situation, it is useful to have knowledge of a variety of options. A survey of staff members affiliated with a psychiatric inpatient unit (Sandberg, McNeil & Binder, 2002) described various management strategies for handling stalking, threatening and harassing behavior by patients, as well as perceived effectiveness of these strategies. All staff members who used the following strategies rated them as effective for managing the situation:

- notifying the police or hospital security staff
- seeking consultation from an expert
- having the patient arrested
- obtaining a restraining order

About half of the staff members surveyed found it helpful to confront patients and tell them to stop, or to hospitalize the patients. Of course, the management strategies likely to be most effective in any particular situation will depend on a variety of factors, such as treatment setting and the client’s clinical characteristics.

**Ethical and legal considerations**

Responses that involve release of confidential information must take into account ethical and legal requirements. The APA Ethics Code provides a good initial framework for considering how to balance client confidentiality with therapist safety. Standard 4.01 states: “Psychologists have a primary obligation and take reasonable precautions to protect confidential information…” Standard 4.05(b), however, allows for disclosure of confidential information without the client’s consent in specific situations “where permitted by law for a valid purpose such as to...protect the client/patient, psychologist, or others from harm.” Ethics Code sections 3.10 and 4.02 on “Informed Consent” and “Discussing the Limits of Confidentiality” are also relevant. Informed consent procedures should include discussion of the potential for disclosure of confidential information if needed to protect the client or others from harm.

Many states have laws or regulations that permit disclosure of confidential information to protect the client or others from harm. The majority of states not only permit disclosure of confidential information when there is a threat of violence; they also mandate a “duty to protect” (also known as “duty to warn”) in certain situations, such as when there is a threat of suicide, violence, and victimization. Washington, DC: American Psychological Association.

How to Handle Subpoenas and Depositions

Learn answers to these frequent questions from psychologists related to providing information in a patient’s lawsuit.

This article focuses on the most common scenario in which questions about subpoenas arise: You provided treatment to a patient and subsequently received a subpoena to produce documents and/or testify at a deposition in a lawsuit between the patient and some third party. For ease of reference, we refer to a lawsuit or court case involving the patient, but the advice also generally applies to administrative proceedings and proceedings involving the parents or guardians of a minor patient. The latter half of this article addresses some questions that often arise when a psychologist is subpoenaed for a deposition in such a case.

Frequently Asked Questions About Subpoenas

Am I required to respond to a subpoena?

The basic rule is that while you must respond to a subpoena in some form you should not produce patient files or testify without appropriate consent from the patient or a court order. If you are covered by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, appropriate consent means a HIPAA-compliant authorization form. Many lawyers do not understand that consent requirements for mental health information are more stringent than for medical information.

Absent consent or a court order, your response to the subpoena will often be to explain why you cannot provide documents or testimony. But remember that you must provide some type of appropriate response or you could be held in contempt of court or fined.

How do I tell the difference between a subpoena and a court order?

A subpoena is a lawyer’s assertion that she/he is entitled to the requested information, while a court order determines that the lawyer is in fact entitled to it. A court order typically has “order” typed on it and is signed by a judge or magistrate. It will often have verbiage reflecting that one party has brought a motion to compel you to provide documents or testimony, the court has considered that motion and it is now ordering you to provide the requested information. If you are in a court hearing and the judge verbally orders you to divulge information, this demand also constitutes a court order that must be obeyed.

A subpoena typically has “subpoena” typed on it and is signed by an attorney instead of a judge. It may be issued by a clerk of the court.

If you are unsure whether the document is a subpoena or court order, you can contact the clerk of the court that issued the subpoena or, if a particular judge is identified on the document, you can ask to speak to that judge’s law clerk.

What is the difference between a subpoena for records and a subpoena to testify?

A subpoena may ask you to produce patient records and/or to testify at a deposition or hearing in your client’s case. If you have consent from your client, be sure that the consent covers what the subpoena is seeking. Consent to produce documents, for example, does not give you permission to testify at a deposition.

A subpoena seeking documents is often called a “subpoena duces tecum.” It will specify that certain documents are requested. A subpoena seeking only records may be written in a way that suggests you need to bring the patient record to the lawyer’s office or the court on a particular date, but often the lawyer just wants the records sent to him or her. Sometimes a subpoena will appear to ask you to bring your documents to the deposition or hearing, but lawyers often prefer to receive the documents in advance so they can review the patient records and formulate questions for you.

You can clarify both of these issues — whether to send or bring documents and the timing — by contacting the lawyer who sent the subpoena, assuming that you have a court order or consent from the client to release documents and talk with that lawyer.
What happens when the parents disagree about consenting to disclosure of a child’s records?

When a child’s treatment records are subpoenaed, the parent or guardian or other legal representative of the child is generally the person with the power to consent to releasing documents or testimony in response to a subpoena. When the two parents disagree, this is a complex situation with heightened risks.

This problem is most likely to arise in the context of a separation, divorce or child custody dispute. When parents are divorced or separated, the rights of custodial and non-custodial parents to access treatment records may be specified by court order or may be covered by state law. When the parents are still legally married and have no separation order or agreement, there won’t be a court order or agreement between the parties addressing this issue, so it will be necessary to look to any existing state law.

In these situations, you may want to contact the court for guidance, or contact your malpractice insurer or an attorney in your state.

Frequently Asked Questions About Depositions

Am I an “expert witness” or a “fact witness” in the case?

If you have been asked to provide deposition testimony in litigation brought by a patient whom you have treated, you are most likely being deposed as a fact witness. You will be asked to testify regarding the facts of your patient’s condition and treatment.

“If you have been asked to provide deposition testimony in litigation brought by a patient whom you have treated, you are most likely being deposed as a fact witness.”

A psychologist expert witness, by contrast, is typically retained by the patient’s lawyer or the court to provide an outside, expert view regarding treatment with which the expert was not involved. The expert witness is selected for his or her expertise and is usually subjected to specific court rules for expert witnesses. For example, the expert is formally designated by one party as its expert, prepares a report and can testify only if the court decides that the expert is qualified to provide the opinions listed in the report.

The expert witness is brought in to offer expert opinions on key issues in the case, such as the cause, extent or impact of the patient’s psychological state. By contrast, a treating psychologist will typically be allowed to provide only those opinions that he or she formed in treating the patient.

For example, in a child custody case the psychologist who treated one parent for depression might testify as to opinions regarding that parent’s condition and prognosis that were appropriately formed regarding the treatment for depression. But that psychologist would generally not be allowed to state opinions regarding the parent’s fitness as a parent. Rather, that opinion would typically come from a child custody evaluator (an expert hired by one side or by the court) who followed APA’s 2010 Guidelines for Child Custody Evaluations in Family Law Proceedings.

Psychologists generally do not serve both as the treating psychologist and as an expert witness in the patient’s case, in part due to ethical consideration regarding multiple roles. (See American Psychological Association’s Ethical Principles of Psychology and Code of Conduct, Section 3.05.)

If I am the treating psychologist testifying as a fact witness at the deposition, can I get paid for my time?

It is common for professionals to be compensated for the value of their time when being deposed as a fact witness, but this may vary from one jurisdiction to another. If you are uncertain whether and/or how much you will be compensated, you can ask the lawyer who has subpoenaed you, your client’s lawyer or the clerk of the court.

You can also check whether your therapist-patient agreement provides that your patient pay you a certain amount per hour for your time being deposed in the client’s case. This agreement basically is an expanded informed consent that also specifies certain payment obligations. For example, the therapist-patient agreement in the HIPAA for Psychologists Privacy Rule compliance product and the one given by the American Psychological Association Insurance Trust (The Trust) provide that your patient agrees to pay for your professional time if you are called to testify in his or her legal proceeding. Thus, if the attorney who has subpoenaed
Are You and Your Assets Protected?

Psychologists new to the profession often have a long professional priority list — obtaining licensure, starting and growing a practice, getting involved in the psychology community and paying down loans — before even considering the priorities of their non-professional lives. While focusing on building businesses, relationships and finances, early career psychologists need to consider how to secure and protect their assets.

In this article, Jana N. Martin, PhD, Chief Executive Officer (CEO) of the American Psychological Association Insurance Trust (The Trust), shares advice for newly minted psychologists. Before assuming her role as CEO, Dr. Martin managed a private practice in Long Beach, California for more than 20 years and served as a Trustee for The Trust.

We know some obvious ways psychologists seek protection for their businesses – professional liability insurance, for example – but is that all they need?

Certainly not! Professional liability is an obvious need for those who provide psychological services. But often psychologists don’t thoroughly evaluate their other risk exposures, or they think they cannot afford coverage. I understand that when money is limited, buying insurance to cover an event that has yet to happen isn’t very appealing. Another way of looking at it, however, is for psychologists to consider what they will be able to afford without coverage when something does happen — for example, they become seriously ill and can no longer support themselves, their dependents or their practice. It’s wise to look at all forms of business and personal finance protection and weigh the potential risks against the costs, particularly as families grow and assets expand.

Disability and term life insurance are good forms of financial protection at any age, but they can be essential for a practitioner with a lifetime of self-employment ahead or a family who depends on the psychologist. Business office coverage and office overhead coverage also work well to protect practice assets that auto and homeowner’s policies don’t cover. It’s important for early career psychologists to focus on building a successful practice, but it’s also important to focus on building a secure personal financial future.

If professional liability coverage for lawsuits is a given, are there other less obvious liability risks?

Yes. While lawsuits will continue to be a risk, we have seen a steady increase in licensing board complaints against psychologists as well as government investigations of alleged Medicare or Medicaid fraud. Health providers face risks associated with failure to comply with the Health Insurance Portability and Accountability Act (HIPAA) and/or meet Medicare and Medicaid requirements. Some government agencies have been particularly assertive lately with investigations of health care professionals, including psychologists, especially as more patients become eligible for Medicare and Medicaid.

The Trust advises psychologists to make sure they have sufficient protection. Most professional liability policies include basic protection for licensing board investigations, usually $5,000, but defense costs can often go much higher. Psychologists may want to spend slightly more to substantially upgrade coverage. I can give The Trust policy as an example: An additional $35 per year can increase the licensing board defense coverage limit to $25,000 and $45 can increase it to $50,000. The $35 or $45 upgrade also automatically increases coverage limits for Medicare, Medicaid and HIPAA investigations to $7,500 or $10,000, depending on which upgrade is chosen. Generally, we think the additional coverage is prudent.

You mention insurance and risk management. What is the difference?

Insurance is an important part of a sound financial security plan. It helps protect you against catastrophic financial losses resulting from lawsuits and other legal judgments, accidents and property damage. A risk management strategy helps you avoid catastrophes or at least mitigate the ones you cannot avoid. You may have heard these bits of advice: practice within your scope of training and competence; know and articulate your boundaries, particularly when a patient asks you to practice outside your area(s) of expertise; seek consultation when in doubt about practice or patient issues;
keep good records and back them up; and make sure you have adequate insurance coverage limits. There is an abundance of guidance available regarding the risks associated with practice — boundary issues, forensic and custody evaluations, and patient confidentiality, to name just a few. Sources of information include APA’s Ethical Principles and The Trust’s 800 Advocate Consultation Service. Psychologists spend so much time and energy preparing to provide good clinical care. Protecting themselves and their practice is equally important.

Do you see major emerging areas of concern for psychologists?

Any emerging opportunity will have corresponding risks. Good examples include rapidly developing electronic technologies and social media. We anticipate a revolution in the way psychologists provide psychological services, but we also see the emergence of all sorts of legal, ethical, privacy, confidentiality and security issues. Can we provide Internet-based therapy? To what extent can we use electronic communications? How can we back up and secure our records? Should we store them in “the cloud?” (For additional information about cloud computing, see the article at Practice Central, the APA Practice Organization website, found at apapracticecentral.org/update/2011/10-14/cloud-computing.aspx.) How much personal information should we reveal on a Facebook page? What should we say if a client tries to “friend” us? I know that many psychologists are asking these questions.

How can psychologists steer clear of trouble while using digital media?

While there is no clear direction from the courts and regulatory bodies, there is a growing body of guidance available from the practice and science communities. APA, The Trust and the Association of State and Provincial Psychology Boards have a joint task force developing guidelines on the use of technology in psychological services delivery. State psychological associations are disseminating information that may pertain more specifically to state and local laws. Some practitioners have developed and posted policies online related to electronic communications and social media. An example of a social media policy is provided for informational purposes on The Trust website at apait.org. Further, the Trust has workshops touring the US that focus on providing psychological services in the digital age. We are fortunate to have consultants working for our Advocate service who stand at the forefront of research and publishing in this area.

**Are there risks other than professional liability that are typically off the radar?**

Yes. Everyone who owns an automobile, a home or a boat and has experienced damage knows the value of having adequate insurance coverage. Less known is that standard liability limits in these policies may not adequately cover the larger legal judgments that can drain current assets and future earnings. Many insurers offer “umbrella” policies, which provide liability coverage above and beyond the standard limits on the primary policies. For example, if you carry an auto insurance policy with a $300,000 liability limit and a homeowner’s policy also with a $300,000 limit, purchasing a million-dollar umbrella brings both limits to $1,300,000. The cost will vary by risk, but coverage can be comparatively inexpensive because it usually kicks in after primary coverage has been exhausted. An umbrella may also cover events that occur outside the home or automobile, as well as some claims that are excluded from primary policies.

**You mention dependents. What’s the best way to protect them?**

Everyone immediately thinks of life insurance, and that’s an important part of seeing to it that dependents are taken care of in the event of death. But fewer of us understand the risk of becoming permanently disabled and no longer being able to earn a sufficient living. A disabling injury or illness occurs once every second in the United States, and such injuries or illnesses occur in every age group. A significant percentage of mortgage defaults are due to disability. Disability insurance, or what The Trust calls Income Protection, is designed to keep some money coming in until you can resolve the disability issue and get back to work. You have a number of options regarding amount and duration of benefits, and it’s important to confirm that the policy purchased has a “your own occupation” definition of disability. This is critical because you don’t want to be forced to take any job if you become disabled just because you can do it. You want to be covered if you can’t perform the material and substantial duties of your chosen occupation. Inflation is also a concern and it’s advisable to choose an option to increase the benefit amount over time to compensate for loss of purchasing power.

continued on page 19
Frank Ghinassi, PhD, has never had a problem discovering opportunities to serve in the role of leader. In the 1970s, he ran out of money after earning a master’s degree in clinical psychology, took a job as an entry-level certified alcohol counselor and eventually became the facility’s executive director — all while still in his 20s.

Now a full-fledged psychologist, Ghinassi has continued his interest in leadership. Today he is a member of the executive management group and vice president for quality and performance improvement at the Western Psychiatric Institute and Clinic (WPIC) at the University of Pittsburgh Medical Center (UPMC). WPIC is a 300-bed psychiatric teaching hospital, which, along with its 50 community-based ambulatory treatment programs, annually provides comprehensive behavioral health care to more than 40,000 children, adolescents, adults and older people.

“Many psychologists may not naturally think of themselves as organizational leaders,” Ghinassi says. But psychologists are uniquely qualified to take on leadership roles, whether in hospitals, universities or any other settings, he says. And he is committed to making sure that the next generation of psychologists fulfills that potential.

A history of leadership
Psychologists’ training is what makes them so well-suited for leadership, says Ghinassi. In their graduate programs, he explains, future psychologists gain expertise in how people interact, what motivates them and how diverse personalities and cultural backgrounds affect their lives.

“That puts psychologists in a good position to realize how to help teams work more effectively and how to lead them in achieving effective collaboration and constructive competition,” says Ghinassi. In addition to those qualitative skills, he adds, psychologists have the quantitative skills they need to assess how well their leadership is working: They’re grounded in test construction and measurement, research methods, and quantitative and qualitative analysis. “Psychologists are well-positioned to become architects of systems of care,” he says.

Ghinassi’s own professional history illustrates how he's put that kind of training to use in his own work as a senior administrator. After earning his doctorate in psychology from the University of Akron in 1991, and completing his predoctoral and postdoctoral internships at McLean Hospital in Boston, Ghinassi eventually served as director of mood and anxiety partial hospitalization and residential services at McLean Hospital/Harvard Medical School. Later he became clinical director of the mental health division of the city’s May Institute.

When Ghinassi first arrived as a new assistant professor in the Department of Psychiatry at the Western Psychiatric Institute and Clinic/University of Pittsburgh Medical Center in 1997, he served as the senior clinical administrator for ambulatory operations for a network of more than 50 treatment programs throughout the greater Pittsburgh region. His next position was chief of general adult psychiatry for both ambulatory and inpatient care. In what he calls “a natural evolution,” he moved into his current position in 2005.

As the facility’s first vice president for quality and performance improvement, Ghinassi now works to ensure that care is being delivered as efficiently and effectively as possible. He and his team assign metrics to the processes and outcomes of care and then use the results to provide feedback to help service providers monitor themselves and improve the quality and impact of their work.

Ghinassi also ensures that psychology interns, postdocs and psychiatry residents embrace quality improvement as an integral part of their professional identities. He strives to include trainees in each of the 50 to 70 quality improvement projects going on at any one time at WPIC and the UPMC Behavioral Health Network and encourages trainees to launch their own projects.

“I want to give them real-life experience in finding an area of...
potential improvement and then bring them up to speed on how you set up a typical quality improvement process: Pick some treatment delivery system in need of improvement or redesign, apply meaningful metrics, hypothesize a potential better way, pilot that solution and then measure changes in outcome as compared to baseline data,” he says. “That gives them a sense that they can make changes that will last beyond their short-lived educational rotations.”

Ghinassi isn’t just a quality improvement leader within his own institution, however. He’s also deeply involved with the Joint Commission, an independent nonprofit that accredits health-care programs.

About a decade ago, Ghinassi, along with a consortium from the National Association of Psychiatric Health Systems, the American Psychiatric Association and the National Research Institute, grew concerned that the Joint Commission didn’t have standard core measures for psychiatry but instead let each hospital choose areas to measure and report on. “It was cacophonous, because hundreds of hospitals were reporting on thousands of measures,” says Ghinassi. “There was little opportunity for benchmarking and true improvements in quality.”

Ghinassi and the consortium proposed the development of standard core measures, and Ghinassi was named chair of a Joint Commission-appointed technical advisory panel charged with doing just that. The resulting seven standard measures for hospital-based inpatient psychiatric services (HBIPS) are now being used as core measures by hundreds of hospitals across the country.

In addition, Ghanassi serves on technical expert panels for the National Quality Forum and the National Committee on Quality Assurance. Both organizations develop national performance measures and health care quality indicators.

Advice for would-be leaders

Ghinassi credits Philip G. Levendusky, PhD, senior vice president for business development at McLean Hospital/ Harvard Medical School, for opening his eyes to the possibilities of leadership as a psychologist. Ghinassi’s mentor during his years at McLean, Levendusky was also director of the inpatient cognitive behavioral unit when Ghinassi arrived as a predoctoral intern.

That was an unusual role for a psychologist back then, says Ghinassi. “It gave me the opportunity to see that not only could you enact traditional roles of providing good clinical care or being involved in research or teaching; another option was to become part of the leadership structure,” he says. Now Ghinassi is returning the favor by mentoring his own trainees in psychiatry and psychology.

Ghinassi’s advice to psychologists interested in becoming leaders? Learn from others. Keep an eye out for psychologists speaking at conventions or serving in various organizations, then reach out and ask for a half-hour phone appointment, he suggests. “Ask them what their path was like,” he says. “It opens the door.”

Start small as you take advantage of leadership opportunities, Ghinassi recommends. “Some of the skills that make you good as an individual performer aren’t the same as the skills that make you good at motivating others,” he says. “Going from being a good individual performer to spending more and more time mentoring and supervising others can be a big step psychologically and constitutionally.”

The process of learning leadership skills can begin as early as graduate school or internship, says Ghinassi, who recommends that trainees volunteer to chair committees or offer to direct research projects—activities that provide valuable training in working with teams and persuading people to align their goals. “There’s no shortage of opportunities,” he says.

Once they’re out of school, psychologists can try on leadership in any setting. In academia, for instance, psychologists could start small by chairing a sub-committee before working up to eventually chairing their department.

The same is true in clinical settings. “Someone will say, ‘We need to revamp the group programming at our outpatient clinic,’” says Ghinassi. “That’s an opportunity for a psychologist to say, ‘I’ve got training in that area; I’m willing to take that on and lead that effort.’”

Health care reform will offer many more opportunities for psychologists to take on leadership, especially in the area of quality improvement and performance measurement, says Ghinassi, pointing out that Medicaid and Medicare are moving toward pay-for-performance models.

And it’s crucial that psychologists take on those roles. Warns Ghinassi, “If psychologists don’t offer themselves for leadership positions, others will step in and fill the void.”
During the summer of 2011, the APA Practice Organization fielded an online survey of members to help understand and better serve the professional needs of the diverse psychology practice community. Members were selected at random from the APA database to receive the survey, and a total of 1,882 Practice Assessment (PA) payers responded. The margin of error for the findings, at a 95% confidence level, is ± 2%.

The 2011 survey built on surveys conducted in 2006 and 2008. The most recent survey included more questions about APAPO communications with members.

Selected highlights of survey responses from PA payers follow.

### Snapshots of the Practice Community

**View highlights of the summer 2011 survey of APA Practice Organization members.**

**Primary work setting**

- Independent solo practice: 46.1%
- Institution-based practice: 29.9%
- Independent group practice: 12.9%
- Academic: teaching and/or research: 5.4%
- Other: 5.7%

“Primary” refers to most income earned or most hours spent.

**Annual gross income from work as a psychologist**

- Less than $30,000: 4.9%
- $30,000 – $59,999: 12.8%
- $60,000 – $99,999: 36.7%
- $100,000 – $150,000: 28.5%
- More than $150,000: 11.8%
- I choose not to respond: 5.4%

**Top five practice issues of concern to respondents**

- Health care reform: 76.9%
- Managed care/private sector reimbursement: 70.5%
- Medicare reimbursement: 56.9%
- Electronic health record keeping: 43.4%
- Treatment guidelines (condition-specific): 42.5%
4 Five most important advocacy activities by APA Practice

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting reimbursement for psychological services</td>
<td>94.3%</td>
</tr>
<tr>
<td>Legislative advocacy efforts</td>
<td>90.0%</td>
</tr>
<tr>
<td>Positioning psychologists as experts in health and behavior</td>
<td>90.0%</td>
</tr>
<tr>
<td>Helping states protect the doctoral degree as the standard for psychologist licensure</td>
<td>88.2%</td>
</tr>
<tr>
<td>Educating the public about psychologists and psychological services</td>
<td>85.6%</td>
</tr>
</tbody>
</table>

APA Practice refers to APA Practice Organization and APA Practice Directorate. Percentages reflect combined responses of “important” and “extremely important.”

5 Five types of information from APA Practice of interest to members

<table>
<thead>
<tr>
<th>Information Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychology-related news</td>
<td>79.9%</td>
</tr>
<tr>
<td>Legal updates</td>
<td>79.9%</td>
</tr>
<tr>
<td>Information on the latest treatment procedures and models</td>
<td>79.0%</td>
</tr>
<tr>
<td>Regulatory compliance (HIPAA, other)</td>
<td>72.8%</td>
</tr>
<tr>
<td>Legislative updates</td>
<td>70.4%</td>
</tr>
</tbody>
</table>

Percentages reflect combined responses of “interested” and “extremely interested.”

6 Preferred methods of communication

- Postal mail: 29.7%
- E-newsletter: 73.8%
- Email about breaking news/specifc topics: 75.1%
- Practice Central website (apapracticecentral.org, NOT apa.org): 25.2%
- Social media tools such as Facebook and Twitter: 5.3%
- Other: 1.3%

Respondents were asked to select all methods that apply.

7 Professional use of social media tools

- Facebook: 12.1%
- LinkedIn: 28.4%
- Twitter: 3.6%
- None: 65.8%
- Other: 1.4%
Snapshots of the Practice Community

8 Rating of *Good Practice* magazine in terms of meeting professional needs

<table>
<thead>
<tr>
<th>Rating</th>
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</thead>
<tbody>
<tr>
<td>Excellent</td>
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<td>Good</td>
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<tr>
<td>Fair</td>
<td>19.2%</td>
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<tr>
<td>Poor</td>
<td>3.5%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>8.4%</td>
</tr>
</tbody>
</table>

The APA Practice Organization publishes Good Practice.

9 Rating of Practice Central website content in terms of meeting professional needs

<table>
<thead>
<tr>
<th>Rating</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
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<tr>
<td>Good</td>
<td>48.5%</td>
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<tr>
<td>Fair</td>
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<tr>
<td>Poor</td>
<td>3.1%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>19.4%</td>
</tr>
</tbody>
</table>

Practice Central is the APA Practice Organization website at apapracticecentral.org.

10 More Snapshots

How would you gauge the amount of information you receive from the APA Practice Organization?

- Too much 5.0%
- Too little 17.4%
- About right 77.6%

Have you ever contacted the APA Practice Directorate or APA Practice Organization?

- Yes 26.7%
- No 63.9%
- Not sure 9.4%

Overall, what is your impression of APA Practice?

- Positive 57.6%
- Neutral 38.9%
- Negative 3.5%
Dealing with Threatening Client Encounters continued from page 9

as when there is an identifiable victim and an imminent threat of serious injury. If you are concerned for your own safety, you should also evaluate the potential for your client to be violent toward others, which could trigger a duty to protect. It is important to know the law in your state regarding duty to protect and to be prepared to take appropriate action. Even if your state does not have a statute specifically addressing this topic, case law (prior court decisions) may have set a precedent for a duty to be imposed. For additional information on this topic, please see “A Matter of Law: Psychologists’ Duty to Protect,” available on Practice Central at www.apapracticecentral.org/business/legal/index.aspx.

In balancing confidentiality with actions needed to protect safety, the psychologist should consider what information needs to be released in order to accomplish the desired goals. The psychologist also needs to consider to whom the information should be released. For example, if a client leaves a threatening voicemail on your answering service and you believe that client may harm you, you could alert the police to the threat without providing details about the client’s treatment. Similar considerations will apply if a psychologist is being threatened or harassed by a former client, as confidentiality protections continue to apply after treatment has been discontinued.

In situations where you release confidential information for safety purposes, or have considered doing so but determined it was unnecessary, it is important to document your actions and rationale in your client records. By maintaining a thorough record, you can provide evidence that your decisions were based on reasonable professional judgment if questions arise at a later time.

You should feel safe interacting with your clients. If you are working in an institution, make sure you know the relevant resources, policies and procedures. If you are in independent practice, make sure you take adequate precautions. If you have concerns about a potentially dangerous client, take prompt action to address the situation. Confidentiality and clinical issues are very important, but your personal safety comes first.

Many mental health professionals do not receive extensive training in managing behavioral emergencies. To be better prepared for the future, further reading (see sidebar) or continuing education courses on evaluation and management of threatening or potentially violent patients may be helpful.

Note: Legal issues are complex and highly fact specific and require legal expertise that cannot be provided by any single article. In addition, laws change over time and vary by jurisdiction. The information in this article does not constitute legal advice and should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions regarding individual circumstances.

Are You and Your Assets Protected? continued from page 13

Why should people be thinking so much about the risks they face?
Practitioners need simply to prepare and not to worry. Professionally, psychologists are quite skilled at understanding the need to recognize and be prepared for risks. The goal is to explore options and take the appropriate steps not only to achieve some peace of mind, but also to have the confidence that if something does go awry, a plan is in place and an unprotected catastrophe can be avoided.

Is there anything else early career psychologists should know?
Yes. While we haven’t been able to give much detail here, I would recommend doing sufficient research before purchasing insurance or other financial services. I would not recommend purchasing insurance based on its price because the cheapest policy is not always the best. Consider the whole package and what you actually get for your hard-earned money. Know what coverage is included and what is not. Make sure you work with an experienced and licensed insurance agent. Also know that The Trust is a good source for insurance, financial security and risk management information.

Note: Insurance needs vary according to individual circumstances. The information in this article is for informational purposes only and does not constitute financial or legal advice. Talk to your attorney, financial advisor and/or insurance agent to ensure that you are adequately protected.

For more information about APA Insurance Trust products, visit apait.org or call 1-800-477-1200.
How to Handle Subpoenas and Depositions continued from page 11

you will not compensate you for your deposition time, you may be able to ask the patient to do so.

Should I retain a lawyer to represent me at the deposition?

In most cases, there is probably no need for you to have a lawyer represent you. Consider it, however, if you have reason to believe that your testimony is likely to result in your patient bringing a licensing board complaint or even a lawsuit against you. This may be a risk with very litigious patients, those with certain personality disorders or in cases where your testimony cannot legitimately support the client’s strong view of an important issue in the case.

While your client’s attorney will often have interests aligned with yours, remember that his or her primary loyalty is to your client and not to you.

You may also want to check whether your professional liability carrier is able to provide an attorney to represent your interests. For example, The Trust can provide an attorney to represent you if you are deposed in your client’s case. However, The Trust finds that most psychologists decide, after consultation with The Trust, that they don’t really need to bring in an attorney to represent them.

Are there any tips for how to approach my deposition testimony?

A helpful way to view a deposition is that it is in many ways the opposite of a normal conversation with a good friend. In a conversation, you help move the conversation along in various ways, such as assuming that you know what the other person is asking, talking as soon as the other person finishes and freely associating between topics. You can do these things because your friend understands what you are trying to say and will not later hold your statements against you. And your conversation is not being transcribed.

By contrast, your deposition testimony is being recorded, with lawyers intending to use it in support of or against your client. Playing by the rules of a normal conversation could result in your giving testimony that is confusing or that can be misconstrued. In deposition testimony it is the job of the lawyer questioning you to ask the right questions to elicit the information he or she seeks.

The following tips will make your deposition experience less stressful and lead to more accurate testimony:

• Take your time; this is not a test of speed.
• Make sure that you understand the question being asked. If you are not certain about what the lawyer is asking or the context or timeframe, ask the lawyer to clarify the question.
• Carefully think out what you want to say before you start speaking.
• Be precise and tell the truth.
• Answer only the question asked; do not volunteer additional information. For example if you are asked what diagnosis you provided, you should not go into an explanation of why or how you reached that diagnosis. It is the attorney’s job to ask those follow up questions if he or she is interested.
• Qualify your answers with the appropriate degree of uncertainty. If you are not sure of your recollection, you can couch your answer with phrases like “to the best of my recollection.” This will make things more comfortable for you if you realize you need to change your answer later in the deposition based on a document that you are shown or further questions about the client’s treatment.
• Do not be intimidated by pushy lawyers or fail to exercise caution when lawyers seem to be friendly and relaxed.

You will often have the opportunity to read and sign your deposition, which gives you the opportunity to note corrections to your testimony.

Note: Legal issues are complex and highly fact specific and require legal expertise that cannot be provided by any single article. In addition, laws change over time and vary by jurisdiction. The information in this article does not constitute legal advice and should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions regarding individual circumstances.

This question-and-answer guide is adapted from a November 2011 article in the PracticeUpdate e-newsletter from the APA Practice Organization. Members may contact the Practice Directorate’s Office of Legal & Regulatory Affairs at (202) 336-5886 or email their questions about this article to praclegal@apa.org.

Further information about responding to a subpoena is contained in the Fall 2008 Good Practice article, “How to Deal with a Subpoena: Pointers for Psychologists.”
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10/05/11   8:43 AM
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• Are You and Your Assets Protected?
• Leadership at a Teaching Hospital and Beyond
• Snapshots of the Practice Community