Transitions and Terminations: Legal and Ethical Issues When Discontinuing Treatment

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Transitions and Terminations: Legal and Ethical Issues When Discontinuing Treatment

Consider these important factors related to ending treatment.

The process of terminating psychotherapy often goes smoothly and offers an opportunity to review progress made in treatment, plan for managing any recurrence of symptoms and gain closure regarding the therapeutic relationship. Ideally, psychotherapy is discontinued when treatment goals are met, the psychologist and patient* agree that it’s time to stop, and the patient knows where to obtain follow-up services if needed in the future. Factors that may have a bearing on successful termination include length of therapy and clinical features such as quality of the therapeutic relationship and the patient’s personality traits.

Difficulties are most likely to arise when transitions are not mutually agreed upon by both patient and therapist. Sudden and unforeseen terminations can also be challenging.

Familiarity with legal and ethical duties, a thorough informed consent procedure and advance planning are all useful in promoting smooth and effective transitions.

In this article, the term “termination” refers to the discontinuation of treatment by a particular psychologist. The term “transition” is used more broadly to refer to all types of situations that involve discontinuation of treatment, including transfers to another mental health professional or setting.

Ethical and legal framework

The APA Ethical Principles of Psychologists and Code of Conduct (Ethics Code) provides both an excellent framework and specific guidance for handling treatment terminations. The Ethics Code Principle A (Beneficence and Nonmaleficence) requires psychologists to “strive to benefit those with whom they work and take care to do no harm.” This principle applies to the course of treatment as well as its ending. Ethics Standard 10.10 (Terminating Therapy) specifically addresses terminations as follows:

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

Section (a) implies that clinical judgment is involved in determining the benefits of continued services, a topic discussed in further detail later in this article. Section (b) clearly allows psychologists to unilaterally end therapy when they are threatened by a patient or someone connected to a patient. Section (c) addresses pretermination counseling and referrals.

Referral information is preferably given to the patient both verbally and in writing, with a copy included in the patient record. Even in circumstances that preclude pretermination counseling, such as when a patient suddenly stops attending therapy appointments, psychologists

*The terms “patient” and “client” may be used interchangeably in this article to refer to recipients of psychological services.
should typically provide patients who need additional treatment with contact information for several appropriate alternate service providers. A letter to the patient is generally an appropriate way to convey this information.

Many states have adopted the APA Ethics Code or similar ethical standards or rules for professional conduct for psychologists. Furthermore, some states have adopted specific statutes or regulations prohibiting abandonment of patients or have case law prohibiting abandonment. In other words, psychologists are both ethically and legally required to handle terminations in a way that does not constitute abandonment of a patient.

For example, the New York Rules of the Board of Regents § 29.2 states: “Unprofessional conduct [for psychologists and other listed health professionals] shall also include… abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, or abandoning a professional employment… without reasonable notice and under circumstances which seriously impair the delivery of professional care to patients or clients.”

According to Younggren & Gottlieb (2008), “Abandonment represents the failure of the psychologist to take the clinically indicated and ethically appropriate steps to terminate a professional relationship” (p. 500). Although psychologists may become concerned when they need to unilaterally terminate therapy, legal and/or state board actions against psychologists for abandonment appear to be rare (Younggren & Gottlieb, 2008). Usually, the real question is how to handle transitions in a way that best promotes the patient’s welfare – whether the transition is complicated or not.

To avoid allegations of abandonment, Knapp et al. (2013) offer the following advice: “The general risk management rule is not to terminate against the wishes of patients if they are in life-endangering crises. If therapists decide to terminate treatment, they should give adequate notice and provide referrals for other treatment opportunities if more treatment is needed” (p. 204). In addition, careful documentation, obtaining clinical and/or legal consultation as needed, and advance planning are all helpful in reducing risk. If you are concerned about a possible allegation of abandonment, however, you should consult with your malpractice insurer’s risk management service or a knowledgeable attorney.

Termination as a process
To handle termination as smoothly as possible, it helps to think of it as a process and begin planning for termination at the outset of treatment. Topics such as the expected course of

REFERENCES AND RESOURCES
treatment and policies regarding termination can be included as part of your informed consent. In fact, Ethics Standard 10.01 (Informed Consent to Therapy) requires that psychologists inform patients about the anticipated course of therapy. In addition, clear treatment goals should be established early.

Addressing these issues at the beginning of therapy helps patients to work in a collaborative manner toward achieving positive outcomes and to anticipate when therapy will end. It will also help patients better understand when termination is needed due to insufficient progress or inability to meet treatment goals.

**Termination by mutual agreement**

Typically treatment is terminated by mutual agreement of patient and therapist, which allows for effective pre-termination counseling to take place. Pretermination counseling should usually include the following: planning for an end date; reviewing progress made and goals achieved in treatment; discussing strategies for maintaining treatment gains; and clarifying how to access follow-up care if needed.

The specific issues that should be addressed and desirable length of pretermination counseling will depend on a number of factors, such as overall duration of therapy, clinical considerations and treatment approach. For example, a patient who has been in long-term psychodynamic psychotherapy for chronic depression will have a longer and more involved termination phase than a patient who has been in short-term treatment to cope with anxiety symptoms caused by transitioning to a stressful new job.

**Planned terminations**

Planned terminations that are initiated by either the patient or the therapist also generally allow for thorough pre-termination counseling and a smooth ending of the professional relationship. Planned transitions can occur for many reasons, such as relocation of either party or the psychologist taking a new job or retiring. Planned transitions can also occur when the patient’s insurance benefits change or run out.

From the outset of treatment, psychologists should strive to be aware of any financial limitations that could interfere with needed services and plan accordingly, with a focus on patient welfare. For example, if you are an out-of-network provider and the patient is under financial strain but will likely need long-term treatment, you should consider referral to an in-network provider.

**Termination is often more difficult when the decision to stop treatment is made unilaterally by either the patient or the therapist and is not triggered by a definitive event such as relocation.**

**Planning for the unexpected**

Ethics Code 3.12 (Interruption of Psychological Services) addresses both expected and unexpected reasons for termination as follows: “Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist’s illness, death, unavailability, relocation or retirement or by the client’s/patient’s relocation or financial limitations.”

Unless you are working for an organization with contracts in place that address continuity of care, advance planning is needed in case a psychologist is suddenly unable to provide services due to unforeseen circumstances such as an accident, serious illness or death. In addition to meeting ethical requirements, planning for the unexpected can facilitate your patients’ transition to a new mental health professional, simplify access to records, and prevent your family from being burdened by the complex task of figuring out how to handle your professional affairs if you are suddenly unable to do so yourself. To put an effective plan into place, see “Your Professional Will: Why and How to Create” on page 12.

**Other unilateral terminations**

Termination is often more difficult when the decision to stop treatment is made unilaterally by either the patient or the therapist and is not triggered by a definitive event such as relocation. For example, sometimes patients will simply stop paying for therapy or no longer attend scheduled appointments. Payment issues should be addressed promptly and referrals to lower-fee or in-network service providers offered if appropriate. Psychologists should keep in mind that failure to pay for services may at times reflect a patient’s dissatisfaction with treatment or other underlying clinical issues that need to be addressed.

If a patient stops attending sessions, it is usually appropriate to reach out to the patient by phone or mail to offer continued services or pre-termination counseling, clarify the status of your professional relationship and/or offer referrals to alternative service providers if needed. Further action may be required if you are concerned that your patient is in crisis or a danger to self or others. (For additional information on this topic, see “Duty to
Protect” in the Fall 2013 issue of Good Practice magazine at apapracticecentral.org/good-practice/secure/duty-to-protect.pdf.) If a patient or someone close to a patient threatens or harasses a psychologist, treatment should usually be discontinued immediately and appropriate steps taken to prevent harm (see “Dealing with Threatening Client Encounters” in the Winter 2012 issue of Good Practice magazine at apapracticecentral.org/good-practice/secure/client-encounters.pdf).

More complex reasons that psychologists may decide to unilaterally discontinue treatment or refer patients to alternative service providers include a lack of progress and/or a need for services beyond the psychologist’s professional skills and competence. If you think you may need to terminate treatment unilaterally, it is often useful to consult with colleagues about your concerns. Perhaps the treatment can be modified in order to be more helpful to your patient? In most cases, if you do decide to stop treatment, it is important to discuss the situation with the patient, give adequate notice, provide referrals as needed and keep careful documentation.

If you are unable to continue to provide needed care due to a lack of expertise or because treatment is not progressing, you should give patients the names and contact information for several mental health professionals or agencies that can provide appropriate services. Knapp et al. (2013) note that although giving patients three referrals is often recommended, doing so is not legally or ethically required. The goal is to provide some reasonable options for services (p. 203). If a patient is angry, he or she may at least initially object to any alternative service providers you suggest.

As mentioned earlier in this article, Knapp et al. (2013) recommend not terminating against the wishes of patients if they are in life-endangering crises. Terminating treatment of a patient with a chronic low level of suicidality can also be risky and should be handled with particular care. Ideally, the patient will understand your rationale and agree to a referral, for example to a more experienced therapist or to a more structured environment that provides urgent care services. If the patient is a potential risk to self or others, or if the patient is angry and disagrees with your decision to end treatment, you should consider consulting with a colleague. In addition, you may want to consult with an attorney or your malpractice insurer’s risk management service.

Although transitions can be difficult to manage when therapy is not progressing well, it is important to keep in mind that continuing treatment under these circumstances may be inadvisable. Knapp et al. (2013) recommend that psychologists stop treatment “if they are unable to provide a reasonable level of quality of care” (p. 206). This advice is consistent with Ethics Standard 10.10(a), as quoted earlier, which requires psychologists to terminate treatment when the patient no longer needs the service, is not likely to benefit or is being harmed by continued service. Of course, the transition itself must still be handled in an ethical and professional manner.

Vasquez, Bingham & Barnett (2008) offer a detailed discussion and a list of practice recommendations for ensuring clinically appropriate terminations consistent with professional standards and patients’ best interests. Their practice recommendations cover many of the key issues discussed in this article. In addition, they provide sample letters for use in the termination process.

**Promoting patient welfare**

Maintaining a focus on patient welfare is a good guiding principle when handling difficult transitions and other complex practice issues. Even in challenging circumstances, such as a unilateral termination due to a lack of expertise, the psychologist may be able to promote a positive outcome, for example by facilitating a transition to a provider who can better meet the patient’s needs.

If you have further questions about transitions and terminations, please contact the American Psychological Association Practice Directorate’s Legal and Regulatory Affairs Department at praclegal@apa.org or 800-374-2723. Please 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 should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions regarding individual circumstances.
Exploring Alternative Practice Models

Health care reform is prompting some psychologists to consider and make changes to their practice.

When Michael Goldberg, PhD, launched his psychology practice in 1994, he was a traditional solo practitioner. These days, he heads a practice that includes two freestanding outpatient clinics with 30 full-time-equivalent psychologists and other clinicians, additional practitioners embedded in several health care offices and day-to-day operations so complex “it makes my head spin,” says Goldberg, founder and director of Child and Family Psychological Services, Inc./Integrated Behavioral Associates in Massachusetts.

The practice’s ever-growing level of collaboration has been well worth it, says Goldberg. “More patients are getting care, and they’re getting better care,” he says. One key, he says, is to evolve slowly. “When I talk to other psychologists, I often hear, ‘I’m a small practice or a solo practitioner; I can’t do that,’” says Goldberg. “That’s absolutely incorrect and self-defeating thinking.”

The psychologists Goldberg encounters aren’t the only ones who are nervous, says Shirley Ann Higuchi, JD, associate executive director for legal and regulatory affairs in the American Psychological Association (APA) Practice Directorate. With the Affordable Care Act (ACA) pushing collaboration, she explains, APA and the APA Practice Organization have been fielding calls from solo practitioners wondering how they can compete in a rapidly changing health care environment. Fortunately, she says, practitioners don’t have to jump into full-fledged joint ventures. Instead, they can begin by taking easy, low-risk steps toward collaboration. “There’s a spectrum of models, from least to most risk,” says Higuchi.

A range of options

According to Kevin Ryan, JD, a member of Epstein, Becker & Green’s Health Care and Life Sciences practice in Chicago who advises health care clients on business and regulatory matters, those options include:

- **Referral system.** With the advent of the ACA and the Mental Health Parity and Addiction Equity Act, hospitals, primary care groups, home health agencies and others need help meeting patients’ behavioral health needs. Psychologists could contract with possible referral sources or simply approach them informally, saying “Here’s my card, keep me in [your contacts list] and when you need mental or behavioral health services, give me a call,” says Ryan, adding that a contract isn’t necessary. Although it takes time to identify potential referral sources, he adds, this is a low-cost, low-risk model. (Referral arrangements sometimes are more elaborate, as described in the next section of this article.)

- **Co-location.** “Instead of just contacting those referral sources, you could go where they are,” says Ryan, explaining that psychologists could rent space – either part- or full-time – in buildings where other health care providers are located. “This gets you right there so that when providers’ patients need someone, they can just walk across the hall,” says Ryan. Although this model is still fairly low-risk and easy to do, it will probably entail a lease or other contract.

- **Independent practice association (IPA).** In this model, independent practitioners come together to achieve common goals. Often one such goal is to contract with a managed care company or health system to provide services. The IPA, which is a legal entity apart from providers, gives payers access to providers they can contract with efficiently through the IPA. Providers are often free to negotiate individually with the payer, and they can also decide to opt out of the contract altogether. This model involves some legal risk, including antitrust concerns (see sidebar on page 8). You’ll also have to sign a “participating provider” agreement.

- **Management services organization (MSO).** “An IPA on steroids,” says Ryan, this model contracts not just with a single payer or health system but with multiple organizations over a broader geographical area. “This is much higher on the legal risk spectrum,” he says. For one thing, MSOs typically market themselves under a brand name. That can be good news or bad, depending on how well the brand fares, says Ryan. There are also potential antitrust issues if the MSO negotiates fees for providers.

- **Accountable care organization.** “I don’t see a group of psychologists putting together an accountable care organization (ACO),” says Ryan, explaining that this option is more geared toward physicians, primary care practices and hospitals. “That doesn’t mean psychologists can’t participate in ACOs,” he says. However, doing so requires
a huge amount of financial and clinical integration, such as risk-sharing and payments based on episodes of care.

• **Merger.** In a merger, two parties sign an agreement to become one, or one entity acquires the other. “This is the ultimate in clinical and financial integration and the highest legal risk,” says Ryan. Plus, he says, if things don’t work out, a merger is much harder to get out of than simply ending a contract.

**Models in action**
Psychologists are already developing innovative alternative practice models at all points on this spectrum, says Higuchi, and the APA Practice Organization is seeking to identify those models and provide guidance to foster that innovation.

In Rhode Island, for example, psychologists and other behavioral health practitioners have come together with the state’s largest independent practice association (IPA) of primary-care physicians to form a collaborative care network called the Rhode Island Primary Care Physicians Corporation Behavioral Health Network. “We have developed a statewide network of behavioral health clinicians and facilities,” explains Rhode Island Psychological Association President Peter Oppenheimer, PhD, adding that the growing network consists of about 100 behavioral health members as of early 2014.

The network allows the IPA’s 150 primary care physicians to search an online database for credentialed behavioral health professionals and facilities by specialty, location and what insurance they accept. Physicians will be able to provide patients with the clinician’s contact information on the spot, and they will securely transmit referral information to the clinician. Once the connection is made, the physician and behavioral health provider primarily use a secure email system to track referrals and patient care.

Goldberg’s co-location model is a step up the collaboration continuum. The model began in 2005, when Goldberg half-jokingly said to a physician who often referred patients to him and his fellow group members that she should rent them space in her office. “She said, ‘Done!’” remembers Goldberg. That was just the beginning: These days, practice members are also embedded in three more primary care offices, a neurology office and an obstetrics/gynecology office.

The next step was to develop a formal referral relationship with several medical practices. The contracts that undergird this model are simple, says Goldberg. There’s a base agreement that describes the two entities’ shared goals, such as increasing access to behavioral health services and delivering high-quality, coordinated, cost-effective care. The agreement also lays out expectations. Goldberg’s practice agrees to make a reasonable effort to participate in all health plan networks, for example. And while Goldberg’s practice agrees to see most of the other entity’s referrals, they’re not required to see all of them or turn down referrals from other sources. “I didn’t want to put all my eggs in one basket,” says Goldberg.

The second legal component is a lease for the shared office space. The third component is a series of agreements for the medical practice to pay for services not covered.
AVOIDING ANTITRUST PROBLEMS

Many psychologists in small independent practices have been seeking a “holy grail” of being able to legally join with other small practices to jointly negotiate fees with large insurance companies, says Alan Nessman, JD, senior special counsel in the APA Practice Directorate’s Office of Legal and Regulatory Affairs. These negotiations would change the balance of power with big payers. The problem is that joint negotiation requires the independent practices to agree upon a price they would accept, and “price fixing” is usually a clear antitrust violation.

“Price fixing is normally considered bad because it decreases competition, increases prices and brings higher costs to consumers,” says Nessman. Done properly, however, collaborations can improve quality, lower costs and promote cost-effectiveness. Plus, some collaborations need to be able to jointly negotiate to stay viable.

As a result, the antitrust enforcement agencies have issued various guidance on how collaborations can jointly negotiate without problems. This guidance has been synthesized by Patricia Wagner, an antitrust expert at the Epstein, Becker & Green law firm.

The key is sufficient financial or clinical integration. Examples of financial integration include capitated rate arrangements with health insurers or risk pools that withhold substantial portions of compensation unless the group as a whole meets cost-containment goals.

For most psychologists, clinical integration is a more attractive route, says Nessman, who adds that psychologists considering a collaboration that would jointly negotiate fees should consult with an antitrust attorney. In addition to achieving higher quality, lower costs and more efficient service delivery, clinical integration should include most, and ideally all, of the following elements:

- **Clinical protocols.** The collaboration must develop clinical protocols that apply to most of their patient population and reflect current developments in treatment.

- **Measurable quality and utilization goals.** The collaboration must develop goals for monitoring the quality of the treatment it provides and appropriate utilization of services.

- **Assistance in meeting goals.** The collaboration must develop procedures for actively educating, reviewing and helping providers achieve those quality and utilization goals.

- **Disciplinary procedures.** The collaboration must discipline or remove providers who can’t or won’t meet the goals the collaboration has established.

- **Case and disease management programs.** The collaboration must implement specific case and disease management programs.

- **Credentialing procedures.** The collaboration must implement credentialing procedures.

- **Integrated information technology system.** The collaboration must develop an integrated information technology system to disseminate practice standards and other communications and allow providers caring for the same patients to share clinical information more easily.

- **Nonexclusive network.** If the collaboration will have a significant market share, it should allow the various practices in the collaboration to contract separately with payers.

- **Performance monitoring.** The collaboration must adopt practice protocols, standards and performance monitoring procedures that would only be feasible with joint negotiation to ensure the participation of sufficient numbers of providers.

- **Collaboration.** The practice must facilitate cooperative interaction and collaboration among providers to help ensure they provide the right care at the right time.

- **Significant investment.** Providers must invest a significant amount of time and money in the infrastructure necessary to implement the program.

Although a small collaboration may be considered a less important target by enforcement agencies, don’t think you can ignore these rules just because your collaboration is small, warns Nessman. “Many antitrust rules apply the same way to two practices working together as they would to Apple and Microsoft collaborating.”

For more information, watch for additional guidance from the APA Practice Directorate. In addition, Div. 42 (Psychologists in Independent Practice) will conduct a panel presentation on antitrust issues during the American Psychological Association’s annual convention in August 2014 in Washington, D.C.
by the traditional, fee-for-service arrangement – such as participation in treatment team meetings, consultation and training, and on-call time.

“It’s a big system and a big model,” says Goldberg. “But in terms of the lawyers, it really wasn’t difficult at all. It’s something that can be done by solo practitioners and small groups alike.”

Higher up the spectrum of alternative practice models is the MSO that Keith A. Baird, PhD, and his colleagues are developing in Illinois. The goal of Behavioral Care Management, LLC, is to improve health care and lower costs by becoming the behavioral health care provider for many of the accountable care organizations being created in northern Illinois. Behavioral Care Management will negotiate contracts for consortium members – who include not just psychologists but psychiatrists, social workers, counselors and all other licensed mental health providers – with the accountable care organizations. Eventually, says Baird, the organization may even contract directly with the insurance companies behind the accountable care organizations.

“It is a company that will manage the behavioral care and manage the contracts, but it as an entity itself will not provide the services,” says Baird, a founding partner of Heritage Professional Associates as well as the new group. As a limited liability company or LLC, Behavioral Care Management has members – the equivalent of stockholders – who can be providers or just people who believe in what the company is doing.

One key cost-saving element is an online scheduling and referral system. Developed by consortium member Jeremy Bidwell, PhD, and a partner, the software allows providers to show their availability and primary care offices, emergency rooms and others to search for them by geographic and specialty area. “In our community, I’d guess that half of all psychiatric inpatient admissions could have been prevented if people had more real-time access to qualified outpatient providers,” says Baird.

Of course, says Baird, this practice model is still under development. “The biggest challenge is that we’re trying to form a company in a new kind of industry that doesn’t really exist yet,” he says, adding that the start-up costs are enormous. “We’re hoping that if this model works, people might be interested in replicating it.”

NOTE: This article is based on programs presented during the March 2014 State Leadership Conference in Washington, D.C., sponsored by the APA Practice Organization and APA. Future issues of this Good Practice magazine from the APA Practice Organization will include more information about alternative practice models.

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Dr. Smith left his laptop containing 400 client files on a table in his local café for only a few minutes while he purchased a beverage. When he returned to his table, the laptop had been stolen.

What happens next? If the information stored on his laptop was not properly encrypted, he will have to give “breach notifications” to all 400 patients and the U.S. Department of Health and Human Services (HHS). However, if the laptop was encrypted, he does not have to worry about breach notification and can focus on finding his backed-up files and getting a new laptop.

In today’s high-tech environment, there may be many threats to the confidentiality of personal information stored on computers, smart phones, flash drives and tablets. Many of these threats, such as accidentally sending a file to the wrong person, are unintentional. However, there are also intentional threats, such as actual theft of electronic devices or fraud, including identity theft.

The use of technology in health care is becoming commonplace with the advent of electronic health records and the increasing utilization of laptops, smart phones and tablets. Advances in technology allow providers, including psychologists, to better serve the needs of clients in different settings. Technology also enables psychologists to collaborate more effectively with primary care providers and other health professionals.

For those psychologists who are using technology or thinking about incorporating technology into their practice, it is important to have a basic understanding of the Health Insurance Portability and Accountability Act (HIPAA) Security Rule (see sidebar on page 11) as well as encryption.

What is encryption and how is it beneficial?
Encryption is the conversion of data into a systematically scrambled format that is very difficult for unauthorized persons to decode. For example, an unauthorized user may see symbols or numbers rather than letters.

It is possible to encrypt plain text as well as digital media such as scanned documents, photos and videos. Encryption also can protect you from threats such as computer viruses and other malware that can “steal” your client’s protected health information as well as your own personal data, although there are limitations to this protection as discussed later in this article. Encryption protects data until it is decrypted, or unscrambled, using the correct password.

For health care professionals, encryption is beneficial for protecting against unintended or unauthorized access to confidential patient information. Encryption makes it difficult for an unauthorized user to make sense of the encrypted material, thereby enhancing patient privacy.

How does encryption work?
Encryption uses a key, or mathematical algorithm, to scramble the data. The Advance Encryption Standard (AES) is the type of key that the federal government has adopted. There are three different key lengths: 128, 192 or 256-bit. These key lengths are considered strong and suitable for encryption. When looking at encryption products for your system, most vendors will list the level or strength of the algorithm used in AES terms. The largest-bit encryption is the most secure and is sometimes not significantly more expensive than smaller-bit encryption.

In order to access the information that has been encrypted, users must authenticate who they are to ensure that they have appropriate access. Different types of authentication methods include passwords and personal identification numbers (PIN). It is important to establish a strong password, change it regularly and make sure not to lose it.

Strong passwords combine capital and lowercase letters, numbers and symbols (such as *%&). A password should not be a single word found in the dictionary, but rather a word or phrase that you can modify with symbols and numbers. For example, “Th€ r@in In Sp@1n,” would be an appropriate passphrase (provided only as an example – please do not use this for your passphrase). A password or phrase that you can readily recall may be suitable. However, utilizing a phrase that you do not easily remember may provide more security and be more difficult for hackers to “crack.” Also, it is important that you do not use this same password/passphrase for anything else, such as an email password.

If the password is lost, it may not be possible to recover the encrypted data. Keep this information in a different place than on the device being encrypted and not in any easily accessed location, like taped to the monitor screen, as this may compromise security.
Types of storage encryption

Encryption can be implemented in many different ways. It is possible to encrypt an individual file that contains sensitive information or to encrypt all data stored on a computer. The appropriate level of encryption depends on the type of information you want to store, the amount of information to be stored and the different machines or devices on which the information will be stored. For example, if you are encrypting ePHI or financial information, consider using the strongest encryption option (AES 256-bit). If you are encrypting personal information such as photos, a lesser strength option may be appropriate.

Following is an explanation of three types of storage encryption. Keep in mind that, even if encryption is used, it is important to maintain backups of all information.

Full disk encryption, or whole disk encryption, is a process by which all the data on the hard drive of a computer is encrypted. Full disk encryption is generally only used on laptop or desktop computers, not tablets or smart phones. Access to any and all data on the computer is allowed only after successful authentication using a password or PIN. When users go to turn on this computer, they will be prompted to authenticate themselves. With successful authentication, the computer will start or “boot up.” An unauthorized person who attempts to turn on the computer without the key will not be able to access any information.

It is important to note that this type of encryption may not protect your computer against malware. Malware, short for malicious software, is software that can be used to gain unauthorized access to private computer systems or gather sensitive information. A common example is a computer virus. (It is possible to accidentally download a virus while you are searching the internet and click on a link, or when you open an email attachment. Do not click suspicious looking links in emails or open any attachments that come from someone you do not know.)

Full disk encryption may not be able to protect against malware attacks because it can only protect the data in encrypted form while the computer is not running. Once it is booted up the entire disc becomes decrypted and the malware can gain access to the information. This type of encryption may be best suited for protecting all the data on your device from loss or theft when the computer is not running. If you use full disk encryption, it is particularly important to set your computer to go into locked mode if it is not used for a few minutes in order to protect encrypted information from theft.

Virtual disk encryption is the process of encrypting a file, called a container, on your computer, which can hold many

HOW THE HIPAA SECURITY RULE RELATES TO ENCRYPTION

All psychologists who trigger the Health Insurance Portability and Accountability Act (HIPAA) must comply with HIPAA’s Security Rule requirements. This includes complying with the HIPAA breach notification rule that applies if unencrypted protected health information (PHI) is lost or stolen.

A psychologist triggers HIPAA through the electronic transmission of protected health information (which includes names, birthdates and other information specified in HIPAA) to an insurance company. The Security Rule outlines the steps that psychologists who have triggered HIPAA must take to manage the risk of unintended disclosures through security breaches (as well as accidental loss of PHI such as through computer crash, fire or flood).

The Security Rule applies only to electronically transmitted or stored protected health information (ePHI). The Security Rule requires you to: conduct a formal, structured risk analysis for your practice; determine what security measures are appropriate for your practice; and implement security measures along with security policies and procedures.

Examples of security measures are: setting strong passwords for devices and wi-fi; data backup; utilizing anti-virus software; and using encryption or secure transmission systems for transmitting data. Of these, encryption tends to be the most complicated.

Technically, the Security Rule does not require encryption; it only requires that you consider encryption in light of your risk assessment. Even so, with encryption becoming less expensive, easier to use and more widely adopted, it is increasingly viewed as a practical option for practitioners who want to protect ePHI.

Simply put, it makes sense to protect ePHI through encryption. If a breach occurs and ePHI is properly encrypted, you are spared the stress and difficulty of having to notify all the required parties, including affected patients and HHS.

The APA Practice Organization offers a Security Rule compliance product online at www.apapracticecentral.org/ce/courses/1370027.aspx that takes users through each of the required steps in the Security Rule compliance process. For more information on breach notification, review the 2013 HIPAA Privacy Rule primer from the APA Practice Organization at www.apapracticecentral.org/business/hipaa/hippa-privacy-primer.pdf.
After the unexpected death of a psychologist in independent practice, distraught family members, surviving colleagues or support staff face the process of closing the psychologist’s practice. Yet there is no clear written guidance to assist them.

Unfortunately, this scenario is not uncommon. The antidote is a professional will that protects practitioners, their estates, their clients and family members. A professional will designates a trusted colleague as “professional executor” and provide all the direction needed to manage relevant practice issues promptly and effectively in case of a psychologist’s death or incapacity.

Ethical and legal requirements

APA Ethical Principles of Psychologists and Code of Conduct (“Ethics Code”) Standard 3.12 addresses both expected and unexpected interruptions of treatment as follows: “Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist’s illness, death, unavailability, relocation or retirement or by the client’s/patient’s relocation or financial limitations.” In addition, Ethics Code 6.02(c) states: “Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists’ withdrawal from positions or practice.”

Many states have adopted the APA Ethics Code or similar ethical standards in laws or regulations governing the professional conduct of psychologists. In addition, most states have laws mandating the retention of patient medical records for a specified number of years, and such laws may apply to the estate of a deceased psychologist. Some states also specifically address the issue of professional wills in laws or other guidance.

Therefore, unless you work in a group practice or organization with policies in place that address issues such as continuity of care and transfer of records, some advance planning is needed. A professional will is a comprehensive way for independent practitioners to plan for unforeseen circumstances resulting in incapacity or death.

How to create a professional will

Professional wills can take a variety of formats, but all should identify a professional executor (usually a licensed psychologist or other licensed mental health provider) and give that person the authority to act on your behalf. A professional will should include all the basic instructions that an executor would need to notify clients, appropriately handle records, make referrals for continued treatment as needed, and wind down your practice.

A sample professional will, based on the work of the San Diego Psychological Association (SDPA) Committee on Psychologist Retirement, Incapacitation or Death is provided on pages 13 and 14. The APA Practice Organization (APAPO) gratefully acknowledges the work of the SDPA and has prepared this revised document with the association’s permission.

This material and additional APapo resources related to professional wills can be found in the Practice Management section of the Practice Central website at http://www.apapracticecentral.org/business/management/index.aspx. Those resources include:

- An online copy of the sample professional will for those who prefer to create the document electronically.
- An electronic template for the “Files, Passwords and Contacts List” document mentioned in the third section of the professional will template.
- Further instructions and considerations relating to the preparation of a professional will.

We recommend that you consult with an attorney with appropriate experience regarding preparation of a professional will.

If you have further questions about creating a professional will or the role of a professional executor, please contact the American Psychological Association Practice Directorate’s Legal and Regulatory Affairs Department at praclegal@apa.org or 800-374-2723.
Sample Professional Will *

NOTE: Italicized copy below appearing within brackets comprises notes and recommendations related to the sample will content.

I, ________________________________, do hereby declare this to be my Professional Will. This document supersedes prior Professional Wills [if any exist]. This is not a substitute for a Personal Last Will and Testament. It is intended to give authority and instructions to my Professional Executor regarding my psychology practice and records in the event of my incapacitation or death.

FIRST
I am a practicing psychologist licensed in ___________________________. My license # is ___________________.

My principal office address is_____________________________________________________________________________.

In the event of my death or incapacitation, I hereby appoint as my Professional Executor ________________________, who has agreed to serve in this role. His/her phone number and email and mail addresses are _____________________________________________. In the event that___________________ is unavailable or unable to perform this function, I hereby appoint as Secondary Professional Executor _______________________, who has agreed to serve in this role. His/her phone number and email and mail addresses are _____________________________________________.

I hereby grant my Professional Executors full authority to:

• Act on my behalf in making decisions about storing, releasing and/or disposing of my professional records, consistent with relevant laws, regulations and other professional requirements.
• Carry out any activities deemed necessary to properly administer this professional will.
• Delegate and authorize other persons determined by them to assist and carry out any activities deemed necessary to properly administer this professional will.

SECOND [If applicable]
My attorney for this Professional Will is___________________________, whose phone number and email and mail addresses are _________________________________. The executor of my current personal will is_________________________, whose phone number and email and mail addresses are _____________________________________________________.

THIRD
Copies of a separate “Files, Passwords, and Contacts List” are stored with copies of my Professional Will in the locations specified below in section FOURTH (B). This list is intended to be maintained and updated as needed to facilitate access to all relevant contacts, client records and other relevant documents, including all relevant hard copy and electronic files as well as back-up files. The list includes:

• Names and contact information for individuals who may be able to assist in locating/accessing my client records and other relevant professional documents (for example, colleagues, office staff, family)
• Location and/or how to access current client records
• Location and/or how to access past client records
• Location and/or how to access my psychological test materials [if applicable]
• Location and/or how to access my professional billing and financial records
• Location and/or how to access my appointment book and client phone numbers
• Location of the computer and other electronic devices used for my psychology practice
• Passwords for my computer and other electronic devices used for my psychology practice
• My professional e-mail and website addresses
• My office phone number and voicemail access code
• Location and/or how to access my professional liability insurance policy
• Location of any necessary keys you will need for access to my office, filing cabinets, storage facilities, etc.
FOURTH

My specific instructions for my Professional Executor are:

A. First of all, I would like to express my deep appreciation for your willingness to serve as my Professional Executor.

B. There are four copies of this Professional Will. They are located as follows: one is in your possession; one is in the possession of my attorney; one is with my personal will; and one is with my professional liability insurance policy.

C. Please use your clinical judgment and discretion in deciding how you want to notify current and past clients of my death or incapacity and whom to contact for further information, consistent with ethical and legal requirements. [Note: You may choose to provide more detailed instructions in this section. For example, you may wish to maintain a list of current and selected past clients who are to be notified of your death and/or any planned memorial services and to specify the location of such a list in this section.]

D. If clinically indicated, for example by their response to notification of my death, you may wish to offer a face-to-face meeting with some clients. You may also wish to provide several referrals sources for current and past clients. Referral sources can, of course, include yourself.

E. Please promptly notify my professional liability carrier of my death and arrange for any additional coverage that may be appropriate. Please also notify the state psychology licensing board.

F. Please arrange for clients’ records or copies of their records to go to their new psychologist or other mental health professional, if applicable, with the clients’ consent. All remaining records should be maintained according to the relevant, most recent APA Ethics Standards, state regulations and APA Record Keeping Guidelines. [Related recommendation: Include in the informed consent document signed by clients at the outset of treatment a notification that if you die or become incapacitated, your Professional Executor may take control of records and contact clients.]

G. You may bill my estate for your time and any other expenses that you may incur in executing these instructions. Unless otherwise ordered by the court, the hourly rate of [or specify total amount] ________ is acknowledged to be reasonable. [Notes: (1) You may wish to reinforce this commitment by also including it in your personal will. (2) If your practice is a corporation or LLC, you should consult with your attorney regarding whether your estate (instead of the corporation or LLC) should reimburse your professional executor.]

I declare that the foregoing is true and correct.

Executed at __________________________ on __________________________
[location] [date]

Signature

WITNESSES

Printed Name: __________________________ Signature: __________________________
Residing at: ________________________________________________________________

Printed Name: __________________________ Signature: __________________________
Residing at: ________________________________________________________________

*DISCLAIMER & ACKNOWLEDGMENT

This Sample Professional Will is for informational purposes only. It is not intended to provide legal advice and should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions regarding individual circumstances. Psychologists are advised to consult an experienced attorney in order to prepare a professional will. This document is based on the San Diego Psychological Association Committee on Psychologist Retirement, Incapacitation or Death (SDPA PRID) sample “Professional Will” which is available in its “Professional Will Packet” at bit.ly/1smnx7Z. APAPO gratefully acknowledges the work of the SDPA PRID and has prepared this revised document with the association’s permission.
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Snapshots of the Practitioner Community

Highlights from the November 2013 survey of APA Practice Organization members

Building off previous surveys, the APA Practice Organization (APAPO) conducted an online survey of members of members during the fall of 2013 to further understand and better serve the professional needs of the diverse psychology practice community. The 2013 survey included new questions such as about expected changes in practice professional activities and sources of professional information.

The survey was sent to all members, and 2,546 practitioners responded (13.7 percent response rate). The margin of error for the findings, at a 95% confidence level, is ± 2%.

Selected highlights of survey responses from APAPO members follow.

### Primary work setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>All respondents</th>
<th>Early career psychologists (ECPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent solo practice</td>
<td>54.3%</td>
<td>39%</td>
</tr>
<tr>
<td>Independent group practice</td>
<td>15.5%</td>
<td>15%</td>
</tr>
<tr>
<td>Non-federal hospital: General medical</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Mental health clinic</td>
<td>3.8%</td>
<td>9%</td>
</tr>
<tr>
<td>College/University counseling/Health center</td>
<td>3.6%</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>18.4%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**NOTE:** Respondents were allowed to select more than one option.

### Annual gross income from work as a psychologist

<table>
<thead>
<tr>
<th>Income Level</th>
<th>All respondents</th>
<th>Early career psychologists (ECPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $30,000</td>
<td>6.2%</td>
<td>8%</td>
</tr>
<tr>
<td>$30,000 – $59,999</td>
<td>13%</td>
<td>19%</td>
</tr>
<tr>
<td>$60,000 – $99,999</td>
<td>30.5%</td>
<td>49%</td>
</tr>
<tr>
<td>$100,000 – $150,000</td>
<td>29.6%</td>
<td>16%</td>
</tr>
<tr>
<td>More than $150,000</td>
<td>13.3%</td>
<td>3%</td>
</tr>
<tr>
<td>Chose not to respond</td>
<td>7.3%</td>
<td>5%</td>
</tr>
</tbody>
</table>

### Compared with two years ago, how has your annual gross income changed?

<table>
<thead>
<tr>
<th>Income Change</th>
<th>All respondents</th>
<th>Early career psychologists (ECPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less</td>
<td>33.6%</td>
<td>14%</td>
</tr>
<tr>
<td>About the same</td>
<td>40.5%</td>
<td>29%</td>
</tr>
<tr>
<td>More</td>
<td>24.3%</td>
<td>54%</td>
</tr>
<tr>
<td>Chose not to respond</td>
<td>1.5%</td>
<td>2%</td>
</tr>
</tbody>
</table>

### Top five practice issues of concern to respondents

<table>
<thead>
<tr>
<th>Issue</th>
<th>All respondents</th>
<th>Early career psychologists (ECPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private sector reimbursement</td>
<td>83.5%*</td>
<td>81%</td>
</tr>
<tr>
<td>Impact of health care reform on my practice</td>
<td>80.9%</td>
<td>81%</td>
</tr>
<tr>
<td>Confidentiality and security of patient information</td>
<td>71.4%</td>
<td>72%</td>
</tr>
<tr>
<td>Medicare reimbursement</td>
<td>65.9%</td>
<td>58%</td>
</tr>
<tr>
<td>Clinical practice guidelines (condition-specific, e.g. depression, obesity, PTSD)</td>
<td>65.5%</td>
<td>51%</td>
</tr>
</tbody>
</table>

*These percentages include respondents who indicated they were “extremely concerned” or “concerned” about the issue.
Five most important advocacy activities by APA Practice

<table>
<thead>
<tr>
<th>Activity</th>
<th>All respondents</th>
<th>Early career psychologists (ECPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting reimbursement for psychological services</td>
<td>98%*</td>
<td>98%</td>
</tr>
<tr>
<td>Legislative advocacy efforts</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>Educating the public about psychologists and psychological services</td>
<td>89.9%</td>
<td>85%</td>
</tr>
<tr>
<td>Raising psychology’s visibility in the marketplace</td>
<td>89.2%</td>
<td>89%</td>
</tr>
<tr>
<td>Helping states protect the doctoral degree as the standard for psychologist licensure</td>
<td>87.8%</td>
<td>88%</td>
</tr>
</tbody>
</table>

*These percentages include respondents who rated the activity “extremely important” or “important.”

Primary source for selected information topics – all respondents

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>APA Practice</th>
<th>APA division</th>
<th>State psych assoc.</th>
<th>Other organization</th>
<th>Online search</th>
<th>Conferences or other CE</th>
<th>Gov’t agency</th>
<th>Colleagues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Guidelines</td>
<td>63.3%</td>
<td>5%</td>
<td>12.5%</td>
<td>5.4%</td>
<td>3.3%</td>
<td>5%</td>
<td>1.5%</td>
<td>3.9%</td>
</tr>
<tr>
<td>HIPAA and regulatory compliance</td>
<td>56.7%</td>
<td>2.5%</td>
<td>15.5%</td>
<td>7.4%</td>
<td>2.3%</td>
<td>6.1%</td>
<td>4.5%</td>
<td>5%</td>
</tr>
<tr>
<td>Legal updates</td>
<td>48.5%</td>
<td>3.7%</td>
<td>27%</td>
<td>3.6%</td>
<td>2.3%</td>
<td>9.1%</td>
<td>1.5%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Psychology-related news</td>
<td>47.3%</td>
<td>10.9%</td>
<td>18.4%</td>
<td>7%</td>
<td>6.7%</td>
<td>5.3%</td>
<td>0.2%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Legislative updates</td>
<td>41.8%</td>
<td>3.2%</td>
<td>41%</td>
<td>4.7%</td>
<td>2.5%</td>
<td>1.9%</td>
<td>2.0%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

Top 5 changes anticipated in professional activities in the next three to five years

- I do not anticipate any significant changes.
- I will be more involved in integrated, multidisciplinary system of care.
- I will become more involved with professional activities outside of health/mental health service delivery.
- I will further diversify my practice activities and skills (for example, build a niche practice).
- I will increase my use of technology for professional purposes (such as electronic health records).

Through which of the following communication methods do you prefer to receive information from APA Practice?

<table>
<thead>
<tr>
<th>Method</th>
<th>All respondents</th>
<th>Early career psychologists (ECPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td>75%</td>
<td>84%</td>
</tr>
<tr>
<td>E-newsletter</td>
<td>62.4%</td>
<td>67%</td>
</tr>
<tr>
<td>Postal mail</td>
<td>41.5%</td>
<td>32%</td>
</tr>
<tr>
<td>Website (apapracticecentral.org)</td>
<td>31.2%</td>
<td>45%</td>
</tr>
<tr>
<td>Listservs</td>
<td>14.6%</td>
<td>26%</td>
</tr>
<tr>
<td>Social media</td>
<td>3.2%</td>
<td>7%</td>
</tr>
<tr>
<td>Text message</td>
<td>3.1%</td>
<td>5%</td>
</tr>
<tr>
<td>Blogs</td>
<td>2.6%</td>
<td>4%</td>
</tr>
</tbody>
</table>

NOTE: Respondents were allowed to select more than one option.
files and folders. This type of encryption allows for some flexibility in how your computer is set up and encrypted. It is possible to set up two containers on your computer system – with all client and business files within one container, and personal information in another. Access to a container is only allowed after proper authentication.

This type of encryption can be used on all types of electronics: computers/laptops, smart phones, tablets, flash drives and external hard drives. The files in virtual disk encryption are portable, meaning they can be copied from one medium to another with the encryption intact.

Virtual disk encryption offers better protection against threats posed by malware. Because this type of system requires a second authentication, separate from logging on to your computer, those files will be safe from any potential malware threats until the encrypted files are opened. Whereas full disk encryption can encrypt your whole computer, virtual disk only encrypts portions of the data that you choose. Virtual disk encryption allows for greater protection of PHI in the advent that malware is accidentally downloaded into your computer. With virtual disk encryption you are allowed time to discover and alleviate any malware issues before opening the “containers;” whereas with full disk encryption you are opening your computer up to a security threat when you log in because there is no second wall of protection.

File/Folder encryption is the process of encrypting individual files or folders within your computer. Each individual file or folder would be accessible after successful authentication by an authorized user. As with virtual disk encryption, this type of encryption is portable and can be used on all types of storage for computers, smart phones, tablets, etc. This type of encryption is also better protected against malware threats as explained above.

While virtual disk encryption and file/folder encryption sound similar, there is one major difference. The container used in virtual disk encryption is a single, opaque file. No one can see what files are inside that container until it is decrypted. File/folder encryption is transparent, so anyone with access to the file system may be able to view the names for encrypted files and folders (but not the information within those files).

Accordingly, practitioners generally should avoid putting patient names on encrypted files/folders. For example, you could assign a number or other code to each patient and not even identify them as patients so that an unauthorized user would only see that the device contained files 1 and 2 instead of patient files for James Jones and Mary Smith.

In summary, virtual disk encryption may offer the best option for many practitioners. While file/folder encryption may be suitable for some users, the need to save multiple single files or folders generally makes it a less efficient choice than virtual disk encryption. Sometimes a combination of storage encryption options is appropriate.

What to consider when choosing encryption software
Any independent practitioner, small group practice or organization will need to consider the following matters:

Identify your practice needs.
• Which devices need encryption? For example, your personal devices or just business computers? Your laptop, tablet or cell phone? A good rule of thumb is to encrypt those devices that you utilize in your practice and that may have ePHI on them.

• Who should be an authorized user? Who should be able to access the encrypted ePHI? Also consider whether employees and/or clinicians in your practice need access to different levels of information. For example, does your receptionist need access to the full client record or only the schedule file?

• Which type of encryption is best suited for your practice or organization? Multiple types of technology may be used concurrently to protect against different threats. For example, you may want to use full disk encryption to protect against data loss due to a computer crash or theft and virtual or file encryption to provide additional protection for client information that is more sensitive.

Do your research. Look into different encryption software vendors and ask questions. A simple online search – for example, using Google or Bing – will identify several products that may be suitable for your practice. It is in your best interest to research those companies by reviewing their websites and contacting customer service to ask questions. It is in a company’s best interest to make sure you understand the product and how well it is suited to your practice.

Consider cost. There are a lot of encryption product options ranging in price from free to several hundred dollars or more. You may wish to compare a free option like TrueCrypt (www.truecrypt.org) to a product available for purchase like BestCrypt Enterprise (www.jetico.com/data-protection-encryption-bestcrypt-enterprise/). (NOTE: Neither the American Psychological Association (APA) nor the APA Practice Organization endorses or recommends specific encryption products.) You will want to choose the encryption that is best suited to your practice – not necessarily the most expensive option.
How many times did you hit the snooze button this morning? We all crave sleep, but too many nights we fall short of the seven or eight hours we need to thrive. An estimated 50 to 70 million Americans suffer from a chronic sleep disorder, according to the Institute of Medicine.

In today’s overscheduled society, sleep may feel like a luxury, when in fact it’s a necessity. Sleep is vital to our health, safety and overall well-being. Sleep recharges the brain, allowing it to learn and make memories. Insufficient sleep has been linked to car crashes, poor work performance, and problems with mood and relationships. Sleep deprivation also raises the risk of high blood pressure, heart disease, diabetes, obesity, depression and stroke.

Seeing a Psychologist About Sleep Disorders

In many cases, people experience insomnia because they develop a pattern of behavior that interferes with good sleep habits. Sleeping difficulties are often connected to underlying problems such as stress, depression or anxiety.

It is a good idea to consult with a physician or another medical professional to learn if medical issues may be contributing to your sleep difficulties and treat related medical problems. Seeing a psychologist may also help you address sleep problems. Psychologists can help people change their behaviors and manage the thoughts, feelings and emotions that can interfere with a healthy night’s sleep. Licensed psychologists have the professional training and skills to treat individuals suffering from depression and anxiety, which have been linked to sleep problems like insomnia.

In working with a psychologist, you can expect to talk about your overall physical and emotional health, as well as your health beliefs and behaviors. A psychologist will help you identify any underlying stressors and behaviors that may be interfering with sleep.

A psychologist may ask you to keep a sleep diary with information about your routines and behaviors. This can help the psychologist identify patterns of behavior that might be interfering with sleep. For instance, if you have a habit of exercising at night or watching TV in bed, your psychologist can help you take a look at how your routines impair sleep, and help you find alternatives. The psychologist may also teach you relaxation techniques to help you learn to quiet your mind and unwind before bed.

Understanding Insomnia

Insomnia is a common sleep disorder that occurs in 30 million Americans, according to the Institute of Medicine. A person with insomnia has trouble falling or staying asleep. When sleepless nights persist for longer than a month, the problem is considered chronic. Often, people with chronic insomnia see the problem come and go, experiencing several days of good sleep followed by a stretch of poor sleep.

Studies show that people with insomnia who learn to recognize and change stressful thoughts sleep better than those who take sleeping pills to treat their insomnia.

Whatever the cause, you’re more likely to rest if you adopt healthy sleep behaviors. Much like diet and exercise, sleep is a basic building block to health.
Sleeping Better

Consider the following steps that can be helpful in changing unhealthy habits and improving your sleep.

Create a relaxing sleep environment. Keep your bedroom dark, cool and as quiet as possible and keep electronics such as a computer, TV and phones out of your bedroom. Exposure to stimulating objects and lights from computer and TV screens can affect levels of melatonin, a hormone that regulates your body’s internal clock.

Don’t discuss or deal with stressful or anxiety-inducing situations right before bedtime. Just as exercise can increase energy levels and body temperature, discussing difficult topics will increase tension and may provoke a racing heartbeat. Protect the quality of your sleep by dealing with any stressful topics long before bedtime.

Set a sleep schedule. Maintain a regular sleep routine. Go to bed and get up at the same times each day, even on the weekends. Don’t go to bed too early. If you hit the sack before you’re sleepy, you may lie in bed awake and start to feel anxious. That will only make it more difficult to drift off.

Limit naps. Late afternoon naps can interfere with nighttime slumber.

Maintain a regular exercise routine. Research shows that exercise increases total sleep time, particularly the slow-wave sleep that’s important for body repair and maintenance. However, don’t exercise too late in the day. Working out close to bedtime can boost energy levels and body temperature, making it harder to fall asleep.

Avoid late night meals and alcohol consumption. Skip heavy meals before bed and limit alcohol. Even if a cocktail seems to help you fall asleep, it can interfere with sleep quality and disrupt sleep later in the night.

Curb nicotine and caffeine use. These stimulants can make it harder to fall asleep and stay asleep, especially if consumed late in the day.

Schedule downtime before bed. Setting aside time to unwind and quiet your mind will help you get into a sleepy state of mind. Meditating, doing breathing exercises, taking a bath and listening to relaxing music are great ways to calm down at night.

Don’t check the clock. Tallying how much sleep you’re losing can create anxiety and make it harder to fall asleep.

Take notes. If you can’t stop your stream of thoughts, get up and write them down. Tell yourself you can check the list in the morning, so there’s no need to keep worrying tonight.

DEPRESSION AND SLEEP

Depression is one of the most common mental illnesses. More than 16 percent of Americans experience major depressive disorder during their lifetime, according to the National Institute of Mental Health. And depression and sleep problems often go hand in hand.

Many people with depression experience hypersomnia, a condition in which they sleep more than normal. On the other end of the sleep spectrum, insomnia is also common among people with depression. In fact, research suggests that people with insomnia are 10 times as likely to suffer from clinical depression.

Some people develop sleep problems first, and then go on to experience depression. In others, depression occurs before signs of sleep disorders. In either case, sleep difficulty is just one of many reasons to seek treatment for depression.

Depressed people typically feel hopeless and guilty. They often lose interest in routine activities and withdraw from family and friends. They may have thoughts of suicide. Treatment can address both depression and the sleep problems that go along with it.
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