

NEWSLETTER

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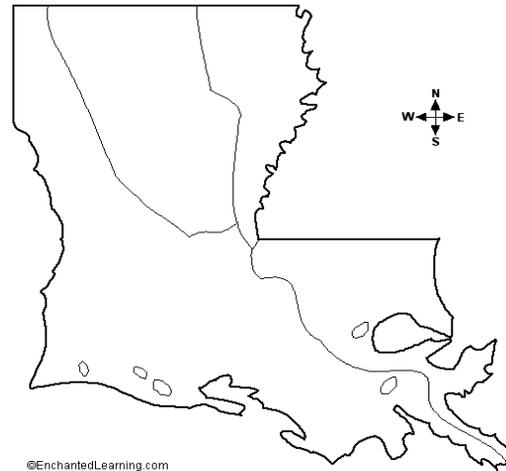
PRESIDENT'S MESSAGE DECEMBER 2008

BY CAROL MILES

What a remarkable year we had in 2008!

No matter where you stand on the presidential election, clearly President-Elect Obama has made history. Other amazing changes around us include, of course, the global financial crisis. Interestingly, this is also the year that mental health parity is finally a reality.

More than one-third of all Americans will soon receive better insurance coverage for mental health treatments because of a new law that, for the first time, requires equal coverage of mental and physical illnesses. The requirement, included in the economic bailout bill that President Bush signed in October, is the result of 12 years of passionate advocacy by friends and relatives of people with mental illness and addiction disorders. They described the new law as a mile-



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Our base is Louisiana—all the clinical social workers of the state

stone in the quest for civil rights, an effort to end insurance discrimination and to reduce the stigma of mental illness.

Mental health parity is just in time to handle the upturn in business in therapists' offices across the country, according to a recent article in USA Today. "People are pretty stressed out."

And just in time to help us as clinicians deal with our clients stress is a new resource offered by

one of our LACSW members, Peggy Brown.

Peggy Brown LCSW is offering Meditation Classes for Clinicians on Mondays 5-6 PM at 622 Pine Street NOLA. Call her for more information at 504-314-8030 or email at myrarbrown@yahoo.com.

Be sure to take care of yourself and have a Happy New Year.

Legal & Ethical Issues in Clinical Practice: Protecting Yourself and Your Clients

PART TWO:

Last month I introduced the subject of legal and ethical issues that may arise in clinical practice. I mentioned that the following month would discuss some tips for best practice to protect the therapist and the client, while attempting to avoid licensing board complaints or malpractice suits.

The following “tips” do not cover these broad topics, by any means, but are offered as a primer for further thought and discussion among colleagues. Additionally, they are offered in the hopes that one or two busy clinical social workers might have a ready response, or at least know where to turn for some consultation in the event that he or she receives a subpoena, board complaint, or petition for malpractice.

Some Tips to Avoid Licensing or Malpractice Problems:

1. Subpoenas

If you receive a subpoena for records or testimony, always attempt to gain the client’s written permission to release the records or to provide the testimony. Lawyers will tell you that you do not have to do so – that the subpoena is a court order. It is **not** a court order. The “court” refers to a judge and unless a judge orders you to release the records or your testimony, best practice procedure is that you must always invoke the privilege of confidentiality on the part of your client if the latter does not want to give you permission to release records or testify. This means that you **resist** releasing the subpoenaed records or testimony.

What does “resistance” entail? It can start with a letter to the attorney who sent the subpoena (better than making a telephone call – you want to have a paper trail of your efforts to protect client’s confidences) and continue with a court appearance or even an appeal of a trial court order to release records or testify, if you think that such divulging of client’s material is dangerous or if the client continues to deny permission for you to divulge. The point is this: confidentiality of client-therapist communications is the most highly prized tenet of our profession; it is what helps clients open their hearts and souls to us in an effort to reduce their suffering. My belief, which also happens to be enshrined in Louisiana (and most other states’) laws, is that despite the lawyers’ desire to obtain confidential information in the midst of litigation, our duty is to protect our clients’ confidences above all – if the client wants us to do so.

Keep in mind that most subpoenas are issued in furtherance of our clients’ goals, to some degree, and generally they want us to testify or release the requested records. But, imagine the nasty custody battle wherein one spouse wants to use the therapy information of the other spouse against him/her for the purpose of further disrupting the family. As you know, these cases can become horrible battlegrounds with everyone involved suffering greatly. Therapists can, unfortunately, become embroiled in these battles despite their wishes and it is these high-risk situations (as one example) that can result in licensing board complaints and/or malpractice actions against the well-meaning therapist.

In sum, do not ever ignore a subpoena, but also do not just immediately produce the requested information without thinking through the procedures – unless you have the client’s permission (those are

the typical situations and, obviously, the easy ones). Remember: it is always better to have a *written* release of information form to produce if you find yourself defending an alleged breach of client confidentiality lawsuit or complaint in court or before the licensing board.

2. Client Complaints or Malpractice Actions

If you receive a licensing board complaint from a former client, or a malpractice action, do not respond immediately. Most therapists whom I have represented in these matters feel so hurt and anxious that emotions run high and the universal tendency is to become defensive and, perhaps, overreact. Only being able to give general guidance in this brief article, the one constant piece of advice that seems to work across the board is to give the matter some time to settle before responding.

Also, consider consulting some trusted colleagues or a mental health attorney to review the allegations before sending in a response to the board or answering the petition. In general, I recommend to participants in my trainings that clinicians who practice in any high-risk areas (e.g., family, children, custody evaluations, borderline and other acting out personality disorders) should have an ongoing litigation consult group of other clinicians who also have high-risk clients. Staffing these cases can help protect the treating therapist when and if the stuff hits the fan. These colleagues must be willing to assist each other in testifying, if needed, concerning the treatment decisions, the group's advice and guidance, and the treating therapist's continued efforts to operate within a "best practice" framework; that is, treating the client within an ethical and clinically competent context.

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Deborah (Deb) Henson, LCSW, JD, LL.M., is a practicing clinical social worker and mental health/ethics lawyer. Deb just recently returned from Austin where she and her family had been living following Katrina. She is rebuilding both her clinical and law practices in New Orleans. Deb began private practice in 1981 (Tulane MSW-1977) and began practicing law in 1991 (Loyola JD; Univ. of California, Berkeley LL.M.). She has represented clinicians and lawyers in disciplinary matters since 2000. Deb lectures locally and nationally in the area of legal and ethical clinical practice. She is also available for consultation if needed. www.deborahmhenson.com or 504.232.8884

DSM psychiatry manual's secrecy criticized

The Diagnostic and Statistical Manual of Mental Disorders is being revised under a cloak of confidentiality. Critics say the process needs to be open, and cite potential conflicts of interest.

By Ron Grossman

December 29, 2008

Whether revisions to the bible of mental illness should be carried out in secret might seem like an academic question.

But the issue carries real weight for parents desperate to address children's difficult behavior or people in distress over their mental state. It also speaks to citizens' concerns over news accounts of an overmedicated America and of the troubling financial links between some psychiatric researchers and the pharmaceutical industry. An update is underway for the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, known as the DSM, which defines the emotional problems for which doctors prescribe drugs and insurance companies pay the treatment bills. Psychiatrists working on the new edition were required to sign a strict confidentiality agreement. Critics contend that the American Psychiatric Assn. should allow outside observers to review the scientific debate behind new and revised diagnoses.

Among the most prominent to speak out is the editor of the manual's third edition, Dr. Robert Spitzer, hailed by peers as the most influential psychiatrist of his generation. If the DSM is often called the profession's bible, then the DSM-III is the King James Version. Released in 1980, it set the standard by which others are measured. Recently, Spitzer broke ranks by publishing an open letter to the profession protesting the confidentiality mandate. "If you don't know what goes on at someone's meetings, they're suspect of having a conflict of interest," the Columbia University professor said in an interview.

The profession is already confronting that issue through revelations that academics in the field are earning tens of thousands of dollars in consulting fees from drug companies. The financial links between the drug industry and the psychiatric community have sparked a congressional investigation headed by Sen. Charles E. Grassley (R-Iowa). Officials with the APA counter that the psychiatrists working on the DSM revision are limited to \$10,000 annually in fees from drug companies. The association says "transparency" is the byword of those overseeing the process. Darrel Regier, who heads the APA's research arm, said the critics are failing to recognize progress in the field. "The field of psychiatry has gone from an ideology to a scientific pursuit," he said. The DSM grew out of a guidebook used by the military during World War II. Afterward, it was revised for general use and subsequently enlarged. When it first appeared in the 1950s, psychiatry was dominated by Freud's model of psychological suffering, one that was resolvable by talking out the conflict with a therapist. Yet even then, drugs were appearing for relief of psychotic symptoms, and leadership in the profession has since passed to psychiatrists with an alternative model: biology and genetics as the source of emotional problems. As the field has changed, the number of disorders in the DSM has tripled to 300, an increase paralleled by the rise in sales of drugs that pharmaceutical companies and psychiatrists tout as remedies for emotional suffering.

Some critics suspect that a quest for profits has encouraged the field to create mental illnesses out of personality quirks.

In his recent book, "Shyness: How Normal Behavior Became a Sickness," Christopher Lane traces how shyness morphed from a character trait into a pathological condition called "social phobia," which the DSM defines as "fears that he or she may do something or act in a way that will be humiliating or embarrassing." With disorders so broadly drawn, Lane wonders, who among us is sane? It's an apt criticism, says David Kupfer, who is shepherding the DSM's revision. "One of the raps against psychiatry is that you and I are the only two people in the U.S. without a psychiatric diagnosis," said Kupfer, head of the psychiatry department at the University of Pittsburgh. Kupfer said he hopes to reduce the number of diagnostic categories in the forthcoming edition of the DSM, scheduled to appear in 2012. He argues that scientific progress comes from formulating ideas, then seeing if others can shoot them down. If currently listed maladies fail that test, they'll be dropped, Kupfer said. Meanwhile, Lane – who has become something of a thorn in the side of the psychiatric community – has irked some by obtaining the working papers of psychiatrists who produced the DSM-III and making plans to post them on his website. Some of his finds read less like scientific discourse than like shtick from a Catskills comedian. One syndrome under discussion at the time was "chronic complaint disorder." Its supposed sufferers were largely "of Eastern European ancestry" and revealed their malady when asked how things are going. "In those cases," the psychiatrists wrote, "the pathognomonic expression becomes, 'Oy vey, don't ask.'"

LOUISIANA ASSOCIATION OF CLINICAL SOCIAL WORKERS

PROFESSIONAL MEMBERSHIP AND REFERRAL DIRECTORY INFORMATION

MEMBERSHIP YEAR: July 1, 2008 to June 30, 2009

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(Last, First, Middle Initial or Nickname) - Please Print

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Please list clinical specializations (Maximum 6): _____

Are you interested in participating in the Speaker's Bureau? _____ If yes, please list topics below:

Check with your C.P.A. for your particular tax situation regarding business expense deductions. Dues used for lobbying are not tax deductible. The LACSW uses the vast majority of dues every year for legislative lobbying expense in order to protect your vendorship law and the Licensed Clinical Social Work credential. We are an all volunteer organization here to protect your profession. Please join! Thank you!

Member Abroad-Laury A. Bourgeois, LCSW-BACS, RSW (GB-UK)



As I sit down to write the column for this newsletter scheduled to come out in December:

- It is the weekend before the Presidential Election
- I have absentee voted
- I have a consulting project in the hopper
- I will be offering another BACS Supervision Workshop for the LACSW on November 21 in New Orleans
- I'll have been to the states and gone again by the time you read this...

...and it's difficult to forget a question posed by one of my supervision workshop participants in France this past September:

"Is there anything you miss about the states?"

As I've shared with you in previous columns about working abroad, most of it is about working hard at working well at a distance. I work hard at my work. I work hard at keeping up with family and friendships that are important to me. I would do that no matter where I am because that is who I am. Prior to my departure, some friends expressed concern that I would be unhappy in France because I am such a "social" person. Interestingly enough, I have found that I can have as much or as little of people as I choose. I've made many friends from many cultures from all over the world. My language skills are exercised daily. I love the life we have here in France. I discovered recently that there is one thing I miss:

I miss the ability to look another American in the eye and have a conversation.

I am the lone American living in my village of 135 people full-time, maybe even in the valley as far as I know for sure. Language isn't the issue, culture is. As Americans, we inhabit a huge country. Other than the attacks of Pearl Harbour and 9/11, we have not experienced what it is like to have a war on our native soil. We are "leaders" of the world, yet many of us lead insulated lives. I have heard that only 10% of us actually have passports. By living abroad, I have become much more aware of what makes us special as "Americans". At times I feel like the local poster child for "America"! The experience is incredibly eye-opening and awesome.

We spend a lot of time within our profession talking about cultural diversity and the sensitivity required to work with so many people across so many cultures who have chosen "America". Have you ever stopped to think what unites us as from Americans within? Have you ever stopped to think that as a people, we have an image we project to the outside world and the world has an image of us?

When I first came to France, I spent a lot of time saying to my French neighbors: "Je ne suis pas une Américaine typique!" and to my English neighbors: "I am not a typical American!" I treasure my freedom to be myself and to be able to say that I am not a typical American. I loved that when I asked a range of friends and neighbors here to describe their view of a "typical" American, they used adjectives like: friendly, open, uninhibited, inclusive, good at accomplishing things and risk takers. Then there were those less comfortable adjectives: superior, racist, and not always genuine. I believe that there is much more that unites us as Americans than divides us. We share history, we share diverse experiences, we share freedom, we share the ability to be different if we choose...all of which leads to a feeling of unity and a bond among a people. Although I can visit daily with friends, family and colleagues on the phone from France if I choose, there is nothing like: having my friends from America come to visit me; having American colleagues here for workshops; or reconnecting face-to-face in the states. We are bound to a pride, a warmth, a glow in our heart that radiates to the rest of the world. Typical or not, here or there...I miss the opportunity to share what unites us and bask in that glow of our "group"! I am proud to be an American!

The Louisiana Association of Clinical Social Workers (LACSW) is a voluntary association of clinical social workers whose mission is
“to define, represent, promote, and protect clinical social work as a knowledge-based, client-centered profession which provides quality mental health services to the general public.”

LACSW offers its members the following benefits:

- A Board of Directors with state - wide representation to oversee the concerns of clinical social workers across the state of Louisiana.
- The only active presence in the Louisiana legislature through a full-time lobbyist who promotes clinical social work issues for the consumer and the social work practitioner.
- Discounts for workshops on clinical social work skills sponsored by the Continuing Education Committee within the Association.
- A clearinghouse for concerns of clinical social workers that are beyond the influence of the individual practitioner.
- Listing in a membership directory made available to health care companies and consumers to market the clinical social work services of the members.
- A Bi-monthly newsletter to keep members informed of the actions of the Association on their behalf.
- Staying abreast of national concerns via LACSW's membership in the Council of Social Work Organizations created in 2006 by the American Board of Examiners in Clinical Social Work.
- Representative interaction with managed care companies in Louisiana to assure high clinical practice standards and appropriate fee structures.

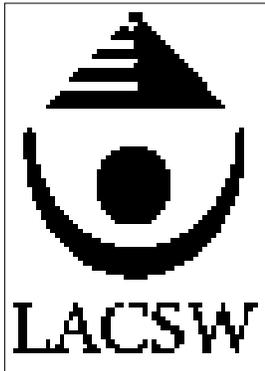
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TO BE ANNOUNCED
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