Dan's

Talking Points

Memo

Wilcoxon, Remley, & Gladding;
Chapter 7

Recent Update on Treating Minors

1. Any child age 12 or older may present on their own for psychotherapy.

2. The child may present an insurance card if valid and he/she is a named-insured on a family health plan. If there is a copayment, the child is responsible for the payment and the parents are not to be billed unless that is agreed upon.

3. Children from birth enjoy "Psychotherapist-Patient Privilege," therefore, parents may not waive any child's privilege just because they are the parent. Privilege also can not be waived by the child because they are not an adult. Privilege can only be waived if the court appoints a *guardian ad litem*, or a child's representative (attorney) to evaluate the merits of the waiver request. Even if a child wishes to waive privilege, they are not of age to do so, hence they may not waive "Psychotherapist-Patient Privilege."

4. If parents are involved with their child's treatment at all, the rules should be made clear "up front" to avoid confusion. Parents don't care for the notion that they have no authority to waive privilege on behalf of their child. Tell parents that you may elect to speak to them in generalities so as not to violate the child's rights, and you may seek their assistance to help on issues should it be warranted.

Consent to Treat Minors

1. Child from presently in-tact marriage (both biological parents are married at the time): **Either parent may consent.**
2. Child from un-married parents with no custody order: **Either parent may consent.**
3. Child from un-married parents with custody order: **See custody order.**
4. Child from divorced parents with no custody order: **NEVER HAPPENS IN CALIFORNIA!**
5. Child from divorced parents with custody order. Presenting parent has full custody: **See custody order to verify meaning of "full custody."**
6. Child from divorced parents with custody order. Presenting parent has joint legal custody and shared physical custody: **See custody order. There may be extenuating circumstances for elective medical procedures, e.g., counseling.**
7. Child from divorced parents with custody order. Presenting parent has joint legal custody and sole physical custody: **See custody order. There may be extenuating circumstances for elective medical procedures, e.g., counseling.**
8. Legally adoptive parents and/or divorced adoptive parents: **Same as for biological parents.**
9. Caretakers: Depending on the circumstance, e.g., foster parents due to absence of biological parents, inability to locate parents or they are incarcerated, etc.: **Caregiver's Affidavit (found on CAMFT web site).**

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1. Green and Hansen (p. 121) have noted that some ethical guidelines *prohibit* certain behaviors (e.g., sex with patient), others *obligate* certain behaviors (mandates, confidentiality), and still others imply *discretionary* behaviors (Should I take a refresher course on that new test that I'm using?). It's not all black and white. This is important.

2. Note the case of Aiko on pages 121-122. Here she clearly has a discretionary decision to make. What do you recommend? Why?

3. What do you think about Victor's "chain in purse" assignment to alleviate guilt for having an affair? (p. 123). What do you think about the author's commentary of Victors ignoring of the diversity issues that prevented the assignment from being successful?

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4. The authors note that one can retraumatize patients who are suffering trauma issues if the therapist is not sensitive to timing, depth, complexity, resistance, and patient vulnerability. Repeating a notion from Chapter 1, this is the "art" part of our work, knowing when to *do*, and when to *wait* (p. 123).

5. Let's talk about those four DSM-5 concerns for MFTs: 1) incompatibility of orientations, 2) the stigma of diagnosis, 3) misrepresentation of diagnoses, and 4) competence to diagnose … (beginning p. 124).

6. It is really true that the DSM and MFT are highly incompatible. DSM relates to diagnoses that are almost exclusively individual and relate to the "IP," etc.; MFT generally relates to systemic issues that may not have an individual emphasis at all. Yet, we are expected to utilize the DSM to justify our work and diagnose our clients for insurance payment purposes. How do we bridge the abyss? What are the ethics here? (pp. 124-125)

7. What about the stigma of diagnosis? Clients might find family pressures relieved by an accurate mental health diagnosis. Others may use their diagnosis as an excuse to justify their behaviors. (p. 126)

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8. I like the inset on pages 126 - 127 that says the health insurance was never intended to pay for non-medical problems such as "floundering marriages" and "trouble raising kids." But, isn't that what we deal with? We have an ethical (and legal) commitment to accurately represent a client's diagnosis.

9. Take a look at the Case of Meg and Kevin on page 127. It appears that LaMoya (the therapist) did the right thing by issuing a V62.89 - Phase of Life Problem DSM-IV-TR code (Now Z60.0 in the DSM-5), but the patient-couple was angry about her accurate diagnosis. Why? Can you see yourself being pressed to "fudge" a diagnosis for the reasons this couple presented? Be honest here …

10. Understand what Packer has termed the "insurance diagnosis" (which constitutes "insurance fraud").

11. We should chat about Christensen and Miller's notion that we are faced with the dilemma of "fudging on diagnosis at times" in order to resolve diagnostic vs. reimbursement quandaries (p. 128).

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12. Take a look at the entire section on Managed Mental Health Care (MMHC). Note the list of questions by Haas and Cummings for providers who are considering participation in an MMHC program (p. 129). We will discuss each of the areas in question:

    - Who takes the risk? (p. 129)
    - How much does the plan intrude into the relationship and the services provided? (p. 130)
    - Can clients get help if the client's needs exceed the plan's benefits? (p. 131)
    - Is there training for providers to be more efficient/effective? (per Zimet; "Most clinicians resent having their practices subject to external control," p. 132)
    - Do providers get a chance to have input? (p. 133)
    - Are policyholders clearly informed of the limits of their benefit? E.g., Informed consent. (p. 134)

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13. Carefully examine the little section on "Institutional Values and Legal Duty in Conflict with Professional Values" (pp. 136-137). There will very likely be times that you will be asked to do something that rubs you the wrong way per your perception of legal duty or your professional values. The little inset here is a good example regarding how the therapist was in conflict over new rules on institutional record keeping.

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The End