The Rosewood Institute

• Original Founders had a dream for the Rosewood Treatment Centers.....

• An Education and Training branch of The Rosewood Centers for Eating Disorders

• The dream unfolded.......

The Rosewood Institute

ARIZONA • CALIFORNIA
What Does TRI Do?

• Continuing Education training (Internal & External)
  – Approved Provider with: APA, NBCC, NAADAC, CBBS, and CDR

• Training professionals on the specifics of eating disorders/addictions and co-morbid complications
  1. West Coast Symposium for Addictive Disorders
  2. Cape Cod Symposium for Addictive Disorders

• Present/participate in eating disorder conferences
  – IAEDP, AED, NEDA, BEDA, BFI
TRI Initiatives and Goals:

- Invite Guest Speakers to share their specialties with our treatment staff
- Monthly Webinars and On-demand trainings
- Co-Sponsor Workshops/events and present locally and nationally with fellow field professionals
- Outreach & Education Projects for K-12 Grades & College
  - Operation Recover ED, Shannon Hershkowitz
- Internship program and Curriculum
  - Dr. Dena Cabrera, Clinical Director
2015 Webinars At-A-Glance

- **JAN 16**: After the Binge: Using the Mindful-based Strategies to Treat Binge Eating Disorders by Nancy Romanick, RDN, MBA, MAPC, LAC

- **FEB 27**: Treating Complex Trauma: A Sensorimotor Psychotherapy Approach by Holly Finley, LPC, CEDS

- **MAR 27**: Shaping Foundations: How Three Decades of Prevention Research has Transformed Education Outreach and Treatment of Eating Disorders by Dr. Michael Levine

- **APR 24**: Do no Harm-Ethics and Eating Disorder Treatment" / "The Implementation of Ethics and Eating Disorder Treatment by Dr. Jessica Rodriquez

- **MAY 22**: Nutrition Medicine: The Acute Care of Eating Disorders, Stabilization and Recovery by Megan Kniskern, RD, CEDRD

- **JUNE 19**: The Perfect Score: Treating Athletes with Eating Disorders by Dr. Ricky Menendez

- **JULY 24**: Tempe Program, by Debbie Richardson, RD, CEDRD

- **AUGUST 21**: Mirror, Mirror? Treating the Body Image Experience by Cheryl Musick, EAGALA Advanced Certified

- **SEPTEMBER 18**: Axis II: Treating the other 50% by Dr. Dena Cabrera

- **OCTOBER 16**: Being Whole Again: Keys to Families Gaining and Holding on to Recovery by Billie Church, MC, LPC

- **NOVEMBER 13**: The Diabetic Dilemma: Treating Eating Disorders in Diabetic Adolescents and Adults with Eating Disorders by Kim Vavrosky, MS, RD

- **DECEMBER 11**: Trends, Truths and Travesties: The Real Scoop on Food Allergies and Intolerances by Miriam Anand MD, FACP, FAAAI, FACAAI and Megan Kniskern MS, RD, CEDRD
Questions & Answers

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About Today’s Webinar

2 THINGS:

1. For Related Materials & FREE Ethics Book

2. Questions & Answers

Email Dr. J at drj@onsitestrategies.com or email TRI at TRI@rosewoodranch.com
“Do No Harm – Ethics and Eating Disorder Treatment: The Implementation of Ethics and Eating Disorder Treatment”

Dr. Jessica Rodriguez
Medical ethics is a system of moral principles that apply values and judgments to the practice of medicine. As a scholarly discipline, medical ethics encompasses its practical application in clinical settings as well as work on its history, philosophy, theology, and sociology.
Medical Ethics - Continued

- Medicine is the science or practice of the diagnosis, treatment and prevention of disease.
- Medicine encompasses a variety of health care practices evolved to maintain and restore health by the prevention and treatment of illness and treatment of illness.
- An Eating Disorder requires medical treatment as well as the co-occurring disorder and/or comorbidity.
The concept of non-maleficence comes from the Hippocratic Oath to “above all do no harm.” There are active and passive forms of potential harms. Eating disorder (ED) clients can be challenging and engender strong counter-transference responses. Though unintended, an active form of harm would be inappropriately terminating or abandoning a client who is stirring up feelings of rejection, incompetence, or powerlessness.
Non-maleficence requires professionals to work within areas of competence. Examples of passive harm include failure to appropriately refer a client either for diagnostic confirmation when the client requires interventions outside the skill range of the practitioner or when a more experienced level of care is needed based on the seriousness or complexity of the illness. Another example is failure to develop a bio-psychosocial or integrated approach instead of relying on single modalities that have proven insufficient by themselves.
When addiction treatment centers began to notice the epidemic rise in the number of clients/patients with co-occurring SUD/Eating Disorders, far too many Addiction treatment programs began acting unethically. For many treatment programs they began to capitalize on the new financial streams by admitting ED clients having unqualified medical and clinical staff, no nurse, no dietician or nutritionist or even for those requiring hospitalization, it was non-existent.
Criteria for determining capacity to consent to or refuse treatment include the ability to understand information, the ability to believe it, and the ability to weigh it in the balance in order to reach a decision. Competence is the clinical equivalent to the legal concept of capacity. In practice, mental health professionals use a wider working definition of competence in clients than the strict legal criteria of capacity and take into consideration other factors such as the client’s ability to apply the knowledge to his or her own situation, the consistency of decisions over time, and the value systems of the client (Grisso & Appelbaum, 1998).
It is also important to assess global versus specific competence. Global competence refers to overall competence whereas specific competence pertains only to a particular domain. ED clients may continue to have adequate or even highly functional insight and decision-making ability in other areas of their life yet be severely impaired in their capacity related to the eating disorder.
Two additional considerations in determining competence among clients with eating disorders pertain to the client’s lack of or fluctuating insight about the gravity of her disorder and health status as well as the presence of organic impairments that affect the client’s cognitive abilities (Webster, Schmidt, & Treasure, 2003). In particular, anorexic clients suffering from the effects of starvation may struggle with impaired reasoning and cognitive abilities (Werth et al., 2003).
In all starvation-related situations, a physical threshold may exist where a person can no longer think rationally as a result of chemical changes in the body related to the effects of starvation (Carney et al., 2006). Ideally, an agreement has been made at the start of treatment with the client and, if appropriate, their family, discussing possible medical risks and what course of action should be taken in that situation. It is important to discuss and define what symptom level is considered life threatening.
There are two types of autonomy relevant to assessing competency. Substantive autonomy is satisfied when the content of the person's action is deemed rational, that is, the majority of people would act similarly in similar circumstances. Formal or procedural autonomy is satisfied when the person's process of reasoning and deliberation is judged appropriate to her decision-making.
The person requires an assessment of her understanding and her ability to balance the costs and benefits of proposed alternatives (rather than the result of the choice). This capacity for decision-making is relative to the specific decision and to the time it has to be made—a disturbance of body image, a faulty awareness of signals of hunger and satiety, and cognitive distortions.
These are often in conflict with ED clients. A client does not want to be hospitalized, but she is at a dangerously low weight. Her parents remain ambivalent about a higher level of care despite feedback from the treatment team and physician. Resolving ethical dilemmas requires clinicians to identify the conflicting duties and rank the order of competing values. In the clients case, self-determination is in conflict with commitment to clients.
Determining how to balance autonomy and beneficence requires a thorough assessment of the client’s decision-making capacity. Autonomous decisions are contingent upon one’s ability to use rational deliberation and whether or not one is competent to make a particular choice (Kitchener, 1984).”
“Decisional capacity" is the ability to understand and appreciate the nature and consequences of a decision regarding medical treatment or forgoing life-sustaining treatment and the ability to reach and communicate an informed decision in the matter as determined by the attending physician and/or clinician.
Looking at the Law

- A rule established in a community by authority or custom
- Exists to remedy wrongs
- Based on Common Law
- Defines community standards
- Law and ethics can conflict
- Ignorance is not a defense
Let’s Discuss Ethics

- Determine morality
- Right or Wrong
- Are unchanging
- Every profession has it’s own code
- Peer and professional oversight
- Often incongruent with law
A decision by a court that sets precedent

Precedent is then the guide that other courts consider in making decisions

A precedent should be considered a word to the wise

Will not be arrested

Are vulnerable to suit
What a health care professional should do in any given situation

Not laws, ethics or court decisions but are often based on them

Vulnerable to ramifications if something goes wrong
Values

- An individual's driving force
- Values are used in individual decision making
- Are subject to change
Law and Ethics

- It is crucial for the health care professional to be aware of the role of law and ethics.
- Being educated about the law and ethics helps them to feel more confident and empowered.
- They have great anxiety over issues having to do with law and ethics.
- Many want to view these issues as black and white.
The Field of Law Plays a Role in Clinical Practice

- Law is adversarial
- Seeks truth by way of trial
- Law is concerned with individual rights
- Lawyer is trained to disregard emotional and affective responses
23 Areas Covered by Most Codes of Ethics

- Non-discrimination
- Objectivity
- Behavior
- Competence
- Reporting unethical conduct
- Professional Impairment
- Obeying the law/morals
- Public statements
- Publication credit
- Research
Client welfare
Treatment termination
Referral
Confidentiality
Client relationships
Professional relations
Ethical investigation
Remuneration
Commissions
Personal gain, societal obligations
Ethics vs Values vs Laws

- Ethics - determine morals
- What is wrong is always wrong and right is always right
- Usually has professional penalties and censure attached
- Values help individuals make decisions relates to beliefs
- Help prioritize goals
- Change as the person’s situation changes
- Can have consequences
Health care professionals must not discriminate against any individual. They should put aside conflicting professional or personal issues and display empathy when possible, especially towards those with disabilities.
Because of the nature of the relationship between a health care professional and his/her client, the potential for self-serving behavior always exists. For this reason, she must refrain from any professional involvement that could be construed as a conflict of interest. She may not be involved with former or current clients personally, socially or for any business reasons, especially related to any sexual behavior. She shall not accept significant monetary or material gifts from providers, treatment facilities, or clients.
Health care professionals must maintain principles of privacy and confidentiality regarding clients, unless the client poses a danger to herself or others. They must encourage, not enable. The counselor must provide appropriate services without consideration of the fees received. Each client has a right to make informed decisions with an awareness of all the ramifications the counselor communicates.
Another issue that may come up is when sensitive issues are discussed in clinical supervision; the same confidentiality laws apply, meaning a supervisor cannot disclose information about a case discussed in supervision unless it meets criteria for the four exceptions.

Finally, looking at it from the perspective of the person being supervised, it is imperative that during the informed-consent process with a client (the explanation of confidentiality), it is openly discussed that the clinician/counselor/practitioner is supervised and to provide the contact information for the supervisor.
The health care professional's goal is to prevent harm to the client, and even further, to benefit the client. Manipulative behavior is not tolerated. The client must derive a clear benefit from the treatment relationship or it should be terminated.
Clients may hold differing spiritual, moral, or personal view and beliefs from those of the counselor. Health care professionals should continue education in the field to upgrade skills and knowledge when interacting with clients.
In the 1970s, the U.S. Congress enacted confidentiality laws to protect people entering substance abuse and alcoholism treatment centers. The Confidentiality Of Alcohol And Drug Abuse Patient Records Regulation, also known as "42 CFR Part 2" or just "Part 2," mandates that substance abuse programs receiving federal assistance cannot disclose a patient's participation in the program—revealing that he has sought treatment for alcohol or drug abuse—nor any of his health information without that patient's consent. The regulation makes some exceptions that include medical emergencies, instances of child abuse, criminal activity on the center's premises, medical research, audits or evaluation activities.
Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996 to standardize the privacy rights for patients throughout the health care system. In accordance with this legislation, the Department of Health and Human Services issued the Privacy Rule in 2000. Though the Privacy Rule is similar to Part 2, it allows substance abuse programs to release patient information for the purposes of "treatment, payment and health care operations"---allowances Part 2 does not make.
Both Part 2 and the Privacy Rule allow substance abuse programs to release information about patients without their consent if it does not identify the patient as a substance abuser or alcoholic. Treatment centers that are part of a larger hospital may report to public health departments about serious diseases such as tuberculosis, as long as the center identifies itself by the larger hospital's name so that the patient isn't revealed to be receiving substance abuse treatment.
The Privacy Rule permits treatment and mental health agencies to disclose information to the parents of a patient who is a minor, unless such disclosures conflict with other federal laws or state laws. Part 2 mandates that substance abuse centers must obtain written consent before releasing any information to a parent or legal guardian and such treatment programs are therefore bound to abide by the Part 2 law.
Part 2 prohibits treatments centers from releasing a patient's information under a subpoena without consent, unless the subpoena is backed by a court order that meets Part 2 requirements. The Privacy Rule doesn't require a court order to release information under subpoena without consent, as long as there is evidence that the lawyer has made reasonable attempts to secure a qualified protective order or give the patient prior notice. The Substance Abuse and Mental Health Services Administration recommends that, in such cases, treatment centers defer to Part 2 rules regarding court orders.
Attempt to anticipate the consequences of each of the possible courses of action and the implication for each

Decide on what appears to be the best possible course of action given all the variables involved

Once the decision has been implemented, determine if any further follow-up or other action is necessary
To Minimize Risk

- Set healthy boundaries
- Consult with other health care professionals
- Work under strict supervision
- Self-monitor constantly
- ALWAYS protect the well-being of the client
What is to be Strictly Adhered To

- No sexual contact with current or former clients ever
- Avoid personal relationships with clients
- Try to avoid business relationships with clients
- Use caution in giving or receiving of significant gifts
- No physical contact
3 Types of Transference

- Classical
- Interactional
- Counter-transference
3 Classes of Legal Wrongs

- Crime
- Breach of contract
- Tort

THREE BOARD CATEGORIES OF TORTS

- Intentional torts
- Strict liability tort
- Negligence
4 Elements in the Establishment of Negligence

- Dereliction of
- Duty
- Directly Causing
- Damages
To Prevail in a Negligence Case

- Must prove all of the following points
- The worker was legally obligated to provide treatment in accord with a standard of care
- The care given falls below the standard
- The workers fail to provide proper care and the client suffers a compensable injury
- The worker’s care was the cause in face of the injuries suffered by the client
Legal Exceptions to Confidentiality

- When a client is a danger to self
- When a client is a danger or has threatened harm to others
- When a client is gravely disabled and unable to make a rational decision as to his/her need for treatment
- When a client is suspected of elder abuse
- When a client is in a medical crisis and unable to grant permission
- When the client information is used for quality reviews
- For record keeping or statistical purposes
- For review by accrediting and licensure bodies
Types of Records Covered

- Oral records
- General medicine records
- Pre-treatment records
- Records of former client / patients
- Records of non-clients
- Insurance records
Disclosures Without Consent

- QSOA
- Court ordered information
- Emergency situations - medical psychiatric
- Mandatory reportable situations
- Releases for research or audit
- Blood borned pathogens - needle sticks
- Tarasoff situations
Disclosures to the Client Themselves is Possible if

- Unless the consent was not given freely, voluntarily or without coercion
- Granting the release would not harm the treatment effort
- Granting the release would not be harmful to the client
The duty to warn and protect


The California Supreme Court ruled: When a therapist determines, or pursuant to the standards of the profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended victim of the danger, to notify the police or to take whatever other steps are reasonably necessary under the circumstances.
Duty to Warn

- Rests with licensed mental health providers and administrators

1. A duty to warn exists when the clinician has direct knowledge of potential harm to an individual group, or property.

Direct knowledge consists of 3 elements:

a) The client’s propensity to commit violence,

b) The client has the intention to inflict physical injury, and

c) The client has named a specific person or group of persons who are to be victims
2. Duty to warn includes reasonable and timely efforts to:
   a) Seeking commitment of the client
   b) Or take treatment action designed to eliminate the carrying out of threat
   c) Or inform the police or identified victims
3. The warning given the intended victim should include:
   a) A description of the threat
   b) Identification of the person making the threat
   c) Identification of the intended victim or victims

4. Duty to warn usually has an exemption from confidentiality statues for the clinician
Reverse Tarasoff

- Bellah vs Greenson 1978
- Tarasoff does apply if someone with HIV or AIDS is having unprotected sex

Emancipation

- Means literally to become free from the control or restraint of another
- A legal procedure whereby children become legally responsible for themselves
- Under most emancipated minor statues a minor is emancipated if: Married, In Military, Receive a declaration of emancipation
Extended the constitutional right to privacy to a minor’s decision to obtain contraceptives or to terminate an unwanted pregnancy

Preferable to have parents involved but many would not seek treatment if they had to tell their parents

Not all states concur-many will not allow use of state funds for such purposes
Hippa Privacy Guidance for Parents and Minors

- A parent is generally a “personal representative” of his or her minor child under Privacy Rule and has the right to obtain access to health information about his or her minor child.

Legal citations:
Meirer vs Ross General Hospital-1968
Abille vs United States 1980; and
Pisel vs Stamford Hospital 1980
-Dilemma-can only hospitalize when acute harm Imminent-liable if you don’t /Meds can exacerbate suicide i.e., SSRI’s
No Harm Suicide Contracts

- 3 elements to be legal contract
- An offer
- An acceptance
- An exchange
- Not sufficient to prevent self harm
- Creates liability for the clinician
- If used should be part of a larger intervention
Negligence

- Occurs when a clinician deviates from the standard of practice
- Courts usually require negligence to award compensatory damages
- Negligence is: “doing something which should not have been done (commission), or omitting to do something that should have been done (omission)”
Failure to evaluate for meds
Failure to justify hospitalization
Dual relationships
Sexual improprieties
Failure to supervise client
Failure to evaluate suicide risk
Failure to monitor changes in suicide risk
Continued

- Failure to conduct a mental status exam
- Failure to diagnose correctly
- Failure to develop necessary treatment plan
- Failure to document interventions
- Failure to safeguard outside environment
- Failure to ensure safety
8 Inpatient Allegations for Malpractice

- Failure to predict the suicide
- Failure to control, supervise or restrain
- Failure to take proper tests and evaluations of the patient to establish suicide intent
- Failure to medicate properly
- Failure to observe the patient continuously (24 hours) or on a frequent enough basis (e.g., every 15 minutes)
- Failure to take an adequate inventory
- Inadequate supervision and failure to remove belt or other dangerous objects
- Failure to place the client in a secure room
Most states have some form of involuntary outpatient commitment statute

One of the following criteria are necessary:

- Danger to self
- Danger to others
- Unable to care for basic needs

4 forms of Outpatient Civil Commitment – An alternative to hospitalization

- Initial commitment, conditional release, combination order, a stay of the commitment
Case Law Regarding Managed Care

- Wickline vs State 1986
- Wilson vs Blue Cross of Southern California 1990
- New Jersey Psychological Association vs MCC Behavioral Health Care
Clients Can Request Their Data Be Amended if it is Inaccurate

- If you agree with the request, you must notify others who have parts of the record to amend their records as well.
- Client has the right to request a means of getting information, address or phone etc.
- Clients have the right to know where their information was disclosed for up to the past 6 years.
- You must have a privacy officer no matter size.
- You must mitigate harmful effects caused by disclosures.
de·co·rum

/dɪˈkɔrəm, -ˈkoʊr-/ Show Spelled [dih-kawr-uhm, -kohr-] Show IPA

noun 1. dignified propriety of behavior, speech, dress, etc.

2. the quality or state of being decorous; orderliness; regularity.

3. Usually, decorums. an observance or requirement of polite society.
In summary, the following are essential guidelines in addressing ethical dilemmas with ED clients:

- Be aware of your own values, beliefs, and potential biases.
- Be honest and humble about your own level of professional expertise. Make referrals and collaborate with other professional as indicated.
- Discuss and document limitations of confidentiality and plans in the case of medically dangerous or life-threatening situations at the start of treatment.
Clearly define the competing values, codes, laws, or policies relevant to the dilemma.

Document all discussions relevant to the ethical dilemma including any discussions of confidentiality or informed consent (with client, family, team members, etc.).

Do a thorough assessment of the client’s decision-making capacity and document findings. Update this assessment as needed.

Utilize and document clinical, ethical and, if necessary, legal consultation.

Be conscious of personal needs and potential compassion fatigue. Take proactive self-care steps.
Merriam-Webster Dictionary


Association of Social Workers, Ethical Dilemmas, 2012

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