2014

Understanding Counselor Liability Risk

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HPSO

Healthcare Providers Service Organization

PART ONE

Overview

Introduction

In July 2003, the American Counseling Association Insurance Trust (ACAIT) partnered with Healthcare Providers Service Organization (HPSO) to offer insurance solutions and risk control services to its members through the HPSO Professional Liability Insurance Program. The CNA / HPSO affiliation offers a unique, market-leading insurance product, which combines professional liability coverage with an array of other insurance policy extensions and services.

HPSO has been the endorsed partner of the ACAIT and the American Counseling Association (ACA) for the past 10 years. Through HPSO, CNA serves as a leading underwriter of professional liability insurance coverage for counselors, with more than 74,000 policies in force. Although counselors purchase professional liability insurance policies primarily to defend themselves against allegations of medical malpractice, the CNA / HPSO Professional Liability Insurance Program also includes several important additional features, such as license protection, deposition assistance and record request reimbursement. For purposes of this report, liability risks include professional liability claims, license protection claims, and legal expense reimbursement when counselors are required to respond to subpoenas demanding client records and / or deposition appearance under oath.

This report examines claims paid by CNA / HPSO on behalf of insured counselors that closed over the 10-year period from January 1, 2003 through December 31, 2012.

Purpose

The primary purpose of this resource is to utilize the CNA database of counselor closed professional liability and license protection claims to identify risk and loss patterns and trends. It also analyzes expenses related to additional benefits provided to insureds, such as assistance with managing subpoenas for records and depositions.

Part Two of the report is limited to professional liability closed claims that resulted in financial loss, in order to highlight the types of situations that produced serious adverse consequences for clients. Parts Three and Four focus, respectively, on deposition assistance / record request matters and counselor license protection closed claims. Part Five of the report presents selected highlights from the qualitative counselor work profile survey. Using this information, counselors can examine and benchmark their own current practices in relation to claims and losses experienced by their peers. We believe that this information will lead to a better understanding of the risks and challenges counselors encounter on a daily basis, and provide motivation for constructive change.

The report also contains case studies and high-level risk control recommendations in Part Six which, if implemented, can help prevent incidents and increase client satisfaction, while minimizing exposure to liability and licensure / certification actions. In addition, a self-assessment checklist is included in Part Six to further aid counselors in enhancing their risk awareness and risk control practices.

Database and Methodology

For this analysis, we reviewed and analyzed only those professional liability closed claims that met the following criteria:

- The claim involved a counselor or a counseling group practice owned by a counselor.
- The claim closed between January 1, 2003 and December 31, 2012.
- The claim resulted in an expense and / or payment of one dollar or more.

These inclusion criteria were applied to 3,614 reported adverse incidents and claims that closed during the designated time period. The final data set comprised 1,043 counselor closed claims, which were subsequently reviewed and analyzed as shown in Figure 1.

In collaboration with the ACA, CNA / HPSO identified specific counselor professional designations. Each claim involved a CNA-insured counselor practicing within one of the following ACA-approved professional categories:

- alcohol / drug counselor
- career / vocational counselor
- counselor educator
- forensic counselor
- licensed professional clinical counselor (LPCC) / licensed clinical professional counselor (LCPC)*
- licensed professional counselor (LPC)
- marriage / family counselor
- mental health counselor
- pastoral counselor
- psychological counselor
- rehabilitation counselor
- school counselor

* Note that specialty titles and designations are defined by individual states and may vary across jurisdictions.

Figure 1 reflects the total costs (i.e., indemnity and / or expense, as noted in the column headings) for professional liability claims with indemnity payment, professional liability claims with expense only, deposition and record requests, and license protection claims. These 1,043 closed claims are categorized by the type of coverage. While professional liability claims with indemnity payments constitute a relatively small percentage of the total number of claims, they involve more than two-thirds of the aggregate loss, as noted in Figure 1 and delineated in Part Two of this report.

As illustrated in Figure 1, the most severe (i.e., most costly) actions were professional liability claims with indemnity payments, incurring $11.1 million in total cost. Please note that professional liability claims typically resolve over a period of several years. For the purposes of this report, all indemnity and expense amounts are attributed to the year the claim closed, regardless of when the claim was first reported or initiated.

During the report period, 400 professional liability claims incurred expenses and closed without indemnity payment. These professional liability expense-only claims totaled $3.1 million. There are many reasons why a claim may incur expenses without an indemnity payment, including the following scenarios:

- The claim was successfully defended on behalf of the counselor.
- A third party, such as an employer or employer's insurer, may have paid an indemnity payment on behalf of the counselor.
- The claim may have been abandoned or forgotten and / or the statute of limitations period passed without legal activity by the complainant.
- The court may have determined that the named counselor should be removed or dismissed from the lawsuit.
- The adverse event was investigated and a claim file opened, but the counselor was never named in the lawsuit and the claim was closed.

The expense payments took the form of attorney, investigation and expert witness fees, as well as, record-copying charges and other administrative costs.

1 TOTAL PAYMENTS BY COVERAGE CATEGORY

Coverage category	Number of closed claims	Percentage of closed claims	Total paid indemnity	Total paid expense	Total
Professional liability with indemnity payment	63	6.0%	$8,077,841	$3,055,015	$11,132,856
Professional liability expense only	400	38.4%	—	$3,060,595	$3,060,595
Deposition and record requests	185	17.7%	—	$343,587	$343,587
License protection	395	37.9%	—	$1,472,360	$1,472,360
Total	**1,043**	**100%**	**$8,077,841**	**$7,931,557**	**$16,009,398**

Deposition assistance, record requests and license protection actions accounted for a combined total of 55.6 percent of closed claims. This substantial proportion may be due to the sensitive nature of the counselor / client relationship. Counselors often work with clients experiencing difficult personal, familial, occupational and sometimes legal problems, and may become privy to highly confidential and private information. Counselors may thus be subpoenaed to present clinical records and / or to appear for depositions under oath related to protected client information.

Executive Summary

Analysis of CNA-insured counselor claims reveals that the most frequent professional liability allegations asserted against counselors involve inappropriate sexual / romantic relationships with clients, or the partners or family members of clients. (Because of the prevalence of these claims, they are discussed in greater depth in Part Two.) Child custody matters have the highest percentage of deposition and record requests of all closed claim underlying matters and client types. These claims are discussed in Part Three. The most frequent license / certification actions result from complaints / allegations of sexual misconduct, followed by breach of confidentiality and scope of practice issues. These claims are discussed in Part Four.

Some of the most salient findings regarding counselor professional liability claims and license protection actions are summarized below:

- Approximately half the counselors (50.8 percent) experiencing professional liability claims worked in an office-based setting. (Figure 6)
- Most professional liability claims (66.7 percent) involved face-to-face counseling of an individual client. (Figure 7)
- Professional liability claims primarily involved adult clients (92.1 percent), but claims involving child clients through age 17 (7.9 percent) resulted in an average indemnity payment almost three times higher than the average indemnity payment for an adult, and nearly two-and-a-half times higher than the overall average indemnity payment. (Figure 8)
- Clients most often sought counseling for marital discord (31.7 percent), family discord (9.4 percent), depression (7.9 percent) and alcohol abuse / addiction (7.9 percent). (Figure 9)
- The most frequent allegation was inappropriate sexual / romantic relationship with the client, a client's spouse / partner or family member (39.7 percent). (Figure 11) The review of license protection claims in Part Four focuses on situations where counselors engaged in inappropriate sexual / romantic relationships with colleagues and employers.
- Payments for all license protection defense paid claims totaled $1,472,360, with an average payment of $3,727 for defense of a board complaint. This does not include fines, penalties, additional education or reimbursement of board investigative costs. (Figure 19)
- Counselors who acted outside their state-defined scope of practice accounted for 10.1 percent of license protection closed claims. (Figure 23)

Terms

The following definitions are valid within the context of this report:

- **Client** – Any person receiving treatment or professional services from a CNA-insured counselor.
- **Expense payment** – Monies utilized in the investigation, management and / or defense of a claim, including but not limited to expert witness expenses, attorney fees, court costs and record duplication expenditures.
- **Incurred** – The costs or financial obligations, including indemnity and expenses, resulting from resolution of a claim.
- **Indemnity payment** – Monies disbursed on behalf of an insured counselor in the settlement or judgment of a claim.
- **Severity** – The average paid amount for those counselor claims that closed with a payment of one dollar or greater.

In addition, note that any mention in this report of the *ACA Code of Ethics* refers to the 2005 edition. If and when a newer version of the *ACA Code of Ethics* is published, please refer to the newer publication.

The most frequent professional liability allegation asserted against counselors involved inappropriate sexual / romantic relationships with clients, or the partners or family members of clients.

PART TWO

Analysis of Professional Liability Claims

Analysis of Claims by Insurance Type

Almost all insureds (95.2 percent) who had a professional liability claim that closed during the stated period received coverage through an individual professional liability policy. Only 4.8 percent of insureds who had a professional liability claim that closed during the stated period were insured through a CNA-insured employer or corporate entity.

2 CLOSED CLAIMS BY INSURANCE TYPE FOR ALL COUNSELORS

Insurance type	Percentage of closed claims	Total paid indemnity	Total paid expense	Average paid indemnity	Average paid expense	Average total incurred
Counselor, individually insured	95.2%	$7,796,341	$2,815,280	$129,939	$46,921	$176,860
Counselor employed by a CNA-insured private practice	4.8%	$281,500	$239,735	$93,833	$79,912	$173,745
Overall	**100%**	**$8,077,841**	**$3,055,015**	**$128,220**	**$48,492**	**$176,712**

Analysis of Severity by Year

- In 2003, the CNA / HPSO Program for counseling professionals began. While claims were reported during that first year of the Program, no claim closed with an indemnity payment in 2003, as professional liability claims generally require more than one year to resolve.
- While severity dipped and rose during the earlier years, the severity trend line in Figure 3 indicates that the general movement is toward higher indemnity payments over a period of years.
- Between 2010 and 2012, the average paid indemnity increased significantly. This increase was partially attributed to the following three large claims that closed in 2011 and 2012:
  - A counselor educator with no client counseling responsibilities entered into multiple relationships with a student. He failed to refer the student to another professional for treatment, instead providing counseling services that were outside his role. On one occasion, he failed to report the student as being a danger to herself or others after the student presented while drinking alcohol and carrying a loaded gun. Instead of calling 911, the counselor improperly called his wife to assist him, and then decided to take the student to his family home, in order to provide support. The student subsequently had a sexual relationship with the counselor's spouse, resulting in dissolution of the counselor's marriage. The adult child of the counselor resented the breakup of the family and notified the police of the prior unreported incident when the student had a gun, resulting in the student being fired from her job. After her relationship with the counselor's wife ended, the student sued the counselor for the loss of her job and severe emotional distress. Given the counselor's failure to report the episode with the student having a gun and his lack of professional judgment, experts could not support the counselor's actions and the claim was resolved at policy limits.

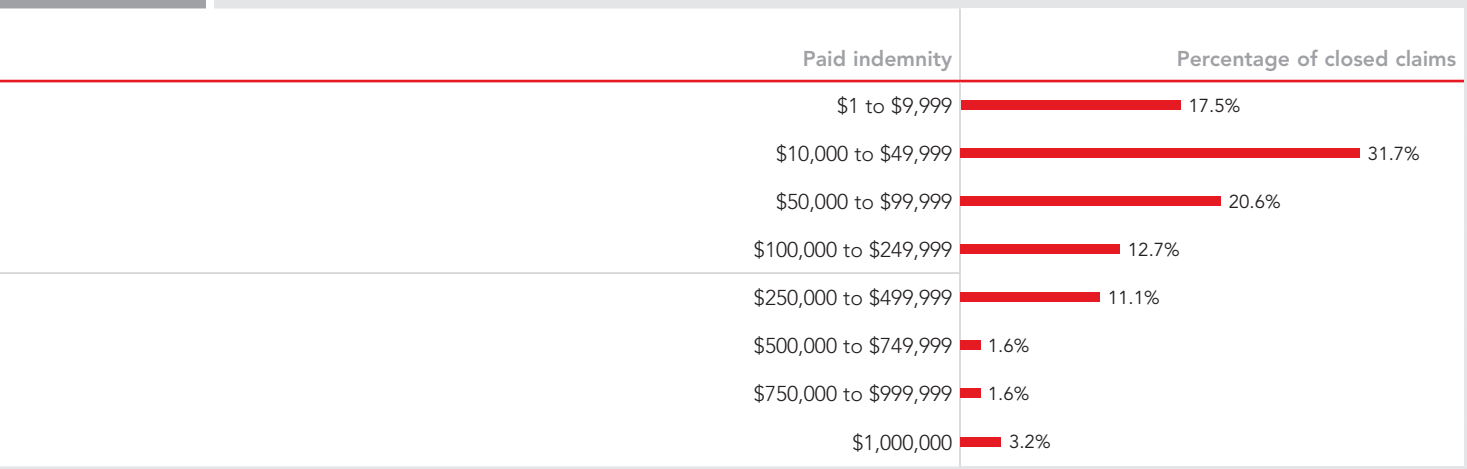
- A counselor was engaged to interview a couple for their appropriateness as adoptive parents. After meeting with the couple both together and separately, the counselor approved the couple as appropriate to adopt children. Over several years, the couple adopted a number of children. Many years after the counselor's assessment and approval, both parents were found guilty of grave child abuse and neglect, and at least one of the children subsequently died from the effects of the abuse. There were multiple parties to the claim, and amounts paid on behalf of the co-defendants are unknown. The CNA-insured counselor's role was limited to the initial assessment of the couple and the resulting finding that the couple would be acceptable for adoption. The counselor never met any of the children and never provided counseling to any member of the family. The claim against the counselor was resolved in the high six-figure range.
- A counselor entered into an allegedly consensual sexual relationship, including cohabitation, with a client in active treatment. The client came to believe that she was being victimized and abused by the counselor. The client surreptitiously videotaped a session where the counselor was clearly seen striking her. The client contacted law enforcement authorities, who conducted surveillance of the counselor and videotaped the counselor stealing funds from the client's bank account, resulting in the filing of criminal charges. The professional liability claim was resolved with a mid-six-figure settlement.

3 **PROFESSIONAL LIABILITY CLOSED CLAIMS WITH PAID INDEMNITY, WITH TREND LINES**

Distribution of Closed Claims

- Claims that closed with indemnity payments between $1 and $99,999 collectively represented 69.8 percent of all claims.
- The largest subset of claims (31.7 percent) closed with indemnity payments between $10,000 and $49,999.
- Almost one quarter (23.8 percent) of claims closed with indemnity payments between $100,000 and $499,999.
- Only 6.4 percent of claims closed with indemnity payments between $500,000 and policy limits of $1 million, including two claims that were resolved at $1 million each.

4 DISTRIBUTION OF SEVERITY OF CLOSED CLAIMS WITH INDEMNITY PAYMENT



CASE STUDY 1: Example of a Counselor Claim with a Severe Outcome

As noted in Figure 4, 3.2 percent of claims closed at full policy limits. One of these serious claims, involving a certified alcohol / drug counselor, is described below:

Case Summary:
The client was a 52-year-old woman who had been admitted to a private alcohol and drug rehabilitation inpatient facility with diagnoses of long-term depression, fibromyalgia and chronic pain. She was treated with pain medication and antidepressants. The facility required full payment at the time of admission and asserted that it was capable of caring for and treating her multiple problems and symptoms.

The counselor assessed the client shortly after her admission. He determined that while the client had a long-past history of alcohol use and required medication for pain management, she did not have a current substance abuse disorder. Within his scope of practice, he was unable to make a determination of mental illness. Nevertheless, he believed that an alcohol and drug program was not appropriate for the client, who needed psychiatric inpatient treatment. On at least two occasions, he reported his findings and concerns to his supervisor, the client's psychologist and the facility owner. In response to the counselor, the facility owner (who was not a healthcare professional) indicated that the client's diagnosis was the responsibility of the clinical staff and would be managed by them. The owner further stated that the client was in the correct treatment setting.

The counselor was an experienced, state-certified alcohol / drug counselor who was working as an independently contracted (i.e., non-employed) counselor for the co-defendant facility. The counselor was neither qualified nor was asked to evaluate any other aspect of the client's mental or physical health, and his professional conduct remained within his scope of practice. He demonstrated appropriate concern for the client and reported his findings regarding her past and current use of narcotic pain drugs to all relevant caregivers.

Following a family visit, the client attempted suicide, wounding herself in the neck. She survived the attempt, but suffered severe anoxia and permanent brain damage. The counselor was not working on the day of the suicide attempt.

The client's permanent condition dictates that she cannot be left alone and requires full-time assistance with all aspects of her personal care. Plaintiff's experts valued her future care at $4-6 million. Defense experts placed the value at $2.7 million. The plaintiff sought economic, noneconomic and punitive damages, as well as plaintiff's attorney fees.

Claim Analysis:
Defense experts and the defense attorneys judged the counselor's actions to be appropriate and within the standard of care, deeming his potential liability in the matter to be 2 percent or less. The relevant state law imposes a limitation on noneconomic damage awards in medical malpractice claims for psychologists and psychiatrists, and limits attorney fees. However, this law does not extend to certified counselors. Defense counsel vigorously contended to the court that the counselor should be included within the statutory framework, as he was being supervised by a covered professional. However, these arguments were rejected. All co-defendants to whom the damage caps applied settled or were dismissed from the case, with the CNA / HPSO-insured counselor as the sole remaining defendant. Attempts were made to offer a reasonable settlement, but the plaintiff's demands greatly exceeded the counselor's policy limits.

Notwithstanding his minor role in the care of the client, as well as the fact that there were positive expert opinions regarding the care he provided, the plaintiff's attorney was unwilling to release the counselor from the case or even to offer a reasonable settlement demand. Due to state joint and several liability laws, if the counselor were found personally responsible for as little as 1 percent of the client's damages, he could theoretically be held personally liable for the entire amount of any jury verdict. Given the counselor's positive expert reviews and the plaintiff's unreasonable settlement demand, the decision was made to vigorously defend this case, and the trial commenced.

Resolution:

Notwithstanding expert opinions and a vigorous defense, the jury found the counselor to be 8 percent liable for the client's injuries. The judgment amount could have been in excess of $4 million. Counsel determined that there were several appealable matters related to the trial and the judge's rulings. As a result, discussion ensued about appealing the jury's decision, given the counselor's adherence to the standard of care. However, re-trying any of those matters would not necessarily change the result, in light of the plaintiff's obvious mistreatment and grievous injuries. Moreover, the counselor suffered emotional distress and anxiety from the entire matter and was eager to settle the claim without further legal action.

Post-verdict jury interviews included juror comments that the counselor should have notified the client or her family that she should not have been admitted to an alcohol and drug treatment facility, or taken more aggressive steps to have her transferred to an appropriate setting. Defense counsel leveraged the possibility of an appeal to obtain a post-judgment settlement that included a total dismissal of the claim against the counselor. As a result of the defense's counsel's strategy, the claim was resolved at policy limits. The settlement monies were paid toward the client's lifetime care needs and attorney fees.

Risk Management Recommendations:

- *Know and understand state medical malpractice laws as they pertain to potential professional liability exposures.* Review the state practice act, speak with representatives of professional associations, and discuss potential liability risks with a broker or the insurer.
- *Before accepting employment, investigate the facility's suitability* by reviewing its website and asking direct questions during hiring interviews regarding the facility's client or patient population, relevant policies, commitment to quality and scope of care.
- *Contact regulatory and professional licensing agencies* if questions arise regarding the competence of facility management and / or the level of clinical care provided by the licensed professional staff.
- *Document assessment findings clearly and factually,* including how results were arrived at, who was notified of the findings and what recommendations were made for additional diagnostic evaluation.
- *Notify regulatory bodies when the chain of command fails to address concerns relating to client care, treatment and safety within the facility.* Most states offer anonymous complaint hotlines. However, even if reporting protocols require self-identification, it may be necessary to make such a statement to protect clients who are clearly in jeopardy. In this case study, the counselor had notified all possible parties within the facility, to no avail. Reporting his concerns to an external regulatory body would have been the only remaining option within his scope of practice.

Before accepting employment, investigate the facility by reviewing its website and asking direct questions during hiring interviews regarding the facility's client or patient population, relevant policies, commitment to quality and scope of care.

Counselor Specialty

- Counselor educators represent the highest severity of any counselor specialty, due to one claim involving multiple relationships with a student (described on page 12). The claim noted at the top of Figure 5 was resolved for policy limits.
- Marriage / family counselors accounted for the largest percentage of closed claims (27.0 percent), with an average paid indemnity higher than the overall average paid indemnity.
- Mental health counselors comprised 17.5 percent of closed claims, with an average paid indemnity lower than the overall average paid indemnity.
- Licensed professional clinical counselors (LPCCs) accounted for 15.9 percent of the closed claims, with an average paid indemnity lower than the overall average paid indemnity.
- Alcohol / drug counselor claims constituted 11.1 percent of closed claims, with an average paid indemnity nearly $70,000 higher than the overall average paid indemnity. The high severity of average paid claims in this specialty is skewed by the $1 million claim detailed on page 15.

5 **SEVERITY BY COUNSELOR SPECIALTY***

** Specialty titles and designations are defined by individual states, and may vary across jurisdictions.*

Counselor specialty	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Counselor educator	1.6%	$1,000,000	$1,000,000
Alcohol / drug counselor	11.1%	$1,365,625	$195,089
Marriage / family counselor	27.0%	$2,366,081	$139,181
Mental health counselor	17.5%	$1,334,960	$121,360
Licensed professional counselor (LPC)	19.0%	$1,126,475	$93,873
Licensed professional clinical counselor (LPCC)	15.9%	$672,700	$67,270
Pastoral counselor	6.3%	$192,500	$48,125
Rehabilitation counselor	1.6%	$19,500	$19,500
Overall	**100%**	**$8,077,841**	**$128,220**

Counselor Practice Location

Counselors work in a variety of locations and settings, with approximately half of the counselors who experienced a closed claim working in an office-based setting.

Counselors may lease space or time in an established counseling center or clinic. In these types of arrangements, they must be especially vigilant regarding issues such as ensuring client privacy, protecting clinical records, and maintaining a clean, safe and accessible environment.

- One of the two most severe closed claims occurred in an alcohol and drug treatment center. The alcohol / drug counselor was alleged to have failed to identify the client as suicidal. The client then stabbed herself, resulting in anoxia and severe, permanent brain damage. (Refer to Case Study 1 on page 15).
- The second most severe closed claim involved a counselor educator working in a school setting who entered into multiple relationships with a student, as noted on page 12. This claim was resolved at policy limits.
- Incidents occurring in the client's home accounted for 6.3 percent of closed claims, but had an average paid indemnity significantly higher than the overall average paid indemnity. This high average paid indemnity was affected by a closed claim involving a couple's adoption of multiple children, based on the counselor's approval of them as adoptive parents, as noted on page 13.
- Only 3.2 percent of closed claims occurred in a government-controlled setting, but the location reflects a higher-than-average indemnity payment, due to one closed claim where the counselor failed to properly monitor a juvenile sex offender in a government-run sex offender program, who subsequently raped and killed a sibling. The claim was resolved in the low six-figure range.
- The majority of closed claims involved private-practice counselors working in an office setting. These closed claims had an average paid indemnity lower than the overall average paid indemnity.
- Mental health / counseling outpatient clinics unaffiliated with a hospital comprised 14.2 percent of closed claims, with an average paid indemnity lower than the overall average paid indemnity.

6 SEVERITY BY WORK LOCATION

Location	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Alcohol / drug treatment center	1.6%	$1,000,000	$1,000,000
Academic institution (faculty only-no clinical)	1.6%	$1,000,000	$1,000,000
Client's home	6.3%	$952,460	$238,115
Government healthcare facility / service	3.2%	$392,500	$196,250
Counselor office-based setting	50.8%	$3,353,475	$104,796
School counseling service	1.6%	$90,000	$90,000
Mental health / counseling outpatient clinic (not affiliated with a hospital)	14.2%	$804,100	$89,344
Religious institution, facility or event	3.2%	$140,000	$70,000
Mental health / psychiatric hospital (inpatient)	1.6%	$61,081	$61,081
Rehabilitation hospital (inpatient)	3.2%	$102,500	$51,250
Correctional facility, jail or prison	1.6%	$50,000	$50,000
Telecounseling (i.e., remote consultation)	3.2%	$57,500	$28,750
Vocational rehabilitation facility / service (inpatient and / or outpatient)	1.6%	$19,500	$19,500
Private group practice setting	4.7%	$46,625	$15,542
Freestanding fertility clinic	1.6%	$8,100	$8,100
Overall	**100%**	**$8,077,841**	**$128,220**

Counseling Mode

- The majority of closed claims (66.7 percent) involved face-to-face counseling between the counselor and the client, with an average paid indemnity slightly greater than the overall average paid indemnity.
- One closed claim involved the failure to identify a child's risk for danger to self or others during a transfer to another mental health facility. Because no danger was noted by the counselor, the child was transferred with a single staff member in attendance. The child obtained a knife and tried to stab the staff member, who is now permanently emotionally disabled. This claim was resolved with a settlement that was more than double the overall average paid indemnity.
- Another closed claim involved a counselor erroneously informing a student counselor that a child had been sexually abused by a family member. The student then repeated this information in a report. The family lost wages and spent significant funds denying the accusation, which was ultimately found false. The claim was resolved at $250,000.
- Several closed claims (11.1 percent) involved couples counseling, with both partners also engaging in face-to-face individual counseling. This category was affected by a claim described on page 13, where the counselor approved a couple for adoptive and / or foster parenthood, and the couple went on to adopt and abuse multiple children over a period of years. This claim was resolved in the high six-figure range, resulting in an average paid indemnity higher than the overall average paid indemnity.
- Telecounseling closed claims comprised 3.2 percent of the closed claims by counseling mode. As computer and telecommunications technology improves, remote consulting is expected to increase, especially in areas of the country where counselors are in short supply.

7 SEVERITY BY COUNSELING MODE

Counseling mode	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Supervision during transfer of client to another facility	1.6%	$275,000	$275,000
Supervision session with student (face-to-face)	1.6%	$250,000	$250,000
Couples counseling (both partners seen individually and as a couple)	11.1%	$1,005,000	$143,571
Individual counseling (face-to-face)	66.7%	$5,853,141	$139,360
Family counseling (members seen together and in individual sessions)	9.4%	$496,600	$82,767
Couples counseling (one partner seen individually and both as a couple)	1.6%	$70,000	$70,000
Family counseling (some members seen only in individual sessions)	3.2%	$62,500	$31,250
Individual telecounseling (i.e., remote consultation)	3.2%	$57,500	$28,750
Couples counseling (together, with no individual sessions)	1.6%	$8,100	$8,100
Overall	**100%**	**$8,077,841**	**$128,220**

Client Age

- The vast majority of clients asserting claims against insured counselors were adults (92.1 percent).
- While claims involving child clients accounted for only 7.9 percent of closed claims, they had an average paid indemnity nearly three times higher than claims involving adult clients.

8 SEVERITY OF CLOSED CLAIMS BY CLIENT AGE

Age range	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Child (0-17)	7.9%	$1,566,875	$313,375
Adult (18-64)	92.1%	$6,510,966	$112,258
Overall	**100%**	**$8,077,841**	**$128,220**

The majority of closed claims (66.7 percent) involved face-to-face counseling between the counselor and the client, with an average paid indemnity slightly higher than the overall average paid indemnity.

Client Reason for Seeking Counseling

Clients sought counseling for a wide range of personal and mental health issues, including the following:

- Marital discord / problems was the most cited (31.7 percent) reason for seeking counseling. These closed claims had an average paid indemnity lower than the average for all closed claims.
- Depression (7.9 percent) and depression with anxiety (6.3 percent) together comprised 14.2 percent of closed claims, each having an average paid indemnity higher than the overall average.
- Family discord was the reason for clients seeking counseling in 9.4 percent of closed claims, with an average paid indemnity lower than the overall average paid indemnity.
- Alcohol abuse and / or addiction was the reason for seeking counseling in 7.9 percent of closed claims, with an average paid indemnity significantly lower than the overall average paid indemnity.
- Bipolar disorder accounted for 4.8 percent of closed claims, with an average paid indemnity higher than the overall average paid indemnity.

Other significant reasons for seeking counseling had single claims with high indemnity payments, including the following:

- A previously cited closed claim (see page 13) involved a couple seeking approval for adoption of children. The counselor found them acceptable, but they later severely abused several of their adopted children.
- One claim involved a child who attacked a mental health worker during transfer to another facility (see page 20). The worker alleged that the counselor had not adequately assessed the child's risk for violence, and the claim was resolved for a low six-figure amount, which was higher than the overall average paid indemnity.
- A child was ordered by the court to attend a government-sponsored monitoring program for sex offenders (see page 18). The assigned counselor failed to report the child for partial non-compliance with the stated program requirements. The child subsequently raped and killed a sibling. The claim was resolved in the low six-figure range.
- A client with severe dissociative disorder entered treatment with the insured counselor, who elected to utilize a controversial form of therapy involving sexual talking and touching. While the counselor had discussed the use of the selected therapy with his supervisor, the counselor made no therapy notes documenting the sessions. The client alleged that the treatment caused severe emotional distress. The claim was resolved in the low six-figure range.

9 CLIENT PRIMARY REASON FOR SEEKING COUNSELING

Primary reason for seeking counseling	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Assessment for adoption / foster parenting suitability	1.6%	$800,000	$800,000
Depression	7.9%	$1,696,875	$339,375
Depression with anxiety	6.3%	$1,157,500	$289,375
Disruptive behavior (preventing client from remaining in the home)	1.6%	$275,000	$275,000
Sex offender (via courts)	1.6%	$250,000	$250,000
Multiple personality / severe dissociative disorder	1.6%	$200,000	$200,000
Bipolar disorder	4.8%	$553,000	$184,333
Relationship issues (other than marriage)	3.2%	$192,500	$96,250
Aggressive behavior	1.6%	$90,000	$90,000
Marital discord / problems	31.7%	$1,724,960	$86,248
Court-ordered counseling	4.8%	$252,100	$84,033
Borderline personality	1.6%	$80,000	$80,000
Family discord / dysfunction	9.4%	$468,500	$78,083
Suicidal ideation (includes parasuicidal ideation)	1.6%	$61,081	$61,081
Eating disorder	3.2%	$102,500	$51,250
Suicide attempt	1.6%	$50,000	$50,000
Trauma history (sexual)	1.6%	$25,000	$25,000
Drug abuse / addiction (legal or illegal drugs)	1.6%	$19,500	$19,500
Alcohol abuse / addiction	7.9%	$60,625	$12,125
Post-traumatic stress disorder (PTSD)	1.6%	$10,000	$10,000
Counseling through embryo adoption process	1.6%	$8,100	$8,100
No reason for counseling was provided in claim file	1.6%	$600	$600
Overall	**100%**	**$8,077,841**	**$128,220**

Professional Liability Allegations

In order to clarify and organize the wide variety of allegations asserted against counselors, it was useful to categorize them in terms of the eight sections of the 2005 Edition of the *ACA Code of Ethics*, comprising

- Section A – The Counseling Relationship
- Section B – Confidentiality, Privileged Communication and Privacy
- Section C – Professional Responsibility
- Section D – Relationships with Other Professionals
- Section E – Evaluation, Assessment and Interpretation
- Section F – Supervision, Training and Teaching
- Section G – Research and Publication
- Section H – Resolving Ethical Issues

- Counseling Relationship (Section A) encompassed 58.7 percent of the closed claims, with an average paid indemnity lower than the overall average paid indemnity. Included in this group are allegations of inappropriate sexual / romantic and multiple relationships between counselors and clients. Inappropriate sexual / romantic relationship claims were frequent and are examined in greater detail in this report on page 27.
- Professional Responsibility (Section C) represented 20.6 percent of the closed claims, with an average paid indemnity nearly twice that of the overall average paid indemnity. Included in this group are claims alleging
  - failure to practice within the boundaries of competence based on education, training and supervised experience, state and national professional credentials, and appropriate professional experience
  - use of inaccurate, lapsed or deceptive licenses or certifications
  - failure to obtain appropriate referrals and / or consultations
  - failure to implement a counseling plan with a reasonable likelihood of success
  - improper management of an embryo adoption
  - misdiagnosis leading to client harm or the need for additional or extended treatment
- Supervision, Training and Teaching (Section F) included only 3.2 percent of closed claims, but reflected the highest average paid indemnity. This category was affected by a previously described closed claim (see page 12) where the counselor educator engaged in an improper counseling relationship with a student, failed to report a situation when the student was a danger to herself and others, and allowed the student to become involved in personal relationships with his own family members. The claim was resolved at policy limits.

10 SEVERITY OF ALLEGATIONS BY THE 2005 EDITION OF THE *ACA CODE OF ETHICS* SECTION CODE

Allegation class	*ACA Code of Ethics* section	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Supervision, training and teaching	F	3.2%	$1,275,000	$637,500
Professional responsibility	C	20.6%	$2,922,181	$224,783
The counseling relationship	A	58.7%	$3,525,435	$95,282
Confidentiality, privileged communication and privacy	B	17.5%	$355,225	$32,293
Overall		**100%**	**$8,077,841**	**$128,220**

Primary Allegations

A closed claim may involve multiple allegations against a counselor. For purposes of this report, the allegation with the greatest adverse effect or causing the most harm to the client was selected as the primary allegation. For the reader's convenience, each allegation in Figure 11 displays the letter corresponding to the relevant section heading in the 2005 edition of the *ACA Code of Ethics*.

There was significant variation among the primary allegations made by claimants against the insured counselors. However, three allegations had the highest percentage of claims:

- Inappropriate sexual / romantic relationship with a client, client's partner or client's family member comprised 39.7 percent of the closed claims. These closed claims had an average paid indemnity lower than the overall average paid indemnity. Closed claims involving allegations of improper counselor sexual / romantic relationships are discussed in greater detail on page 27.
- The allegation that the counselor failed to practice within expected boundaries of competence accounted for 15.8 percent of closed claims, with an average paid indemnity greater than twice the overall average.
- Several closed claims (12.7 percent) involved sharing of confidential / private client information without appropriate authorization, thus violating a major tenet of the client-counselor relationship, as well as potentially breaching legal and regulatory requirements.

These closed claims had an average paid indemnity lower than the overall average. Confidentiality and privacy issues are discussed in Part Three in relation to subpoenaed counselor records or depositions, and in Part Four in connection with license protection actions.

11 SEVERITY BY PRIMARY ALLEGATION

Allegation	*ACA Code of Ethics* section	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Improper counseling relationship with current student	F	1.6%	$1,000,000	$1,000,000
Multiple relationships with client despite potential for client harm	A	1.6%	$500,000	$500,000
Failure to monitor services provided by other counselors / counselors-in-training	F	1.6%	$275,000	$275,000
Counseling plan failed to provide reasonable likelihood of success	A	1.6%	$275,000	$275,000
Failure to practice within boundaries of competence	C	15.8%	$2,649,681	$264,968
Failure to obtain consultation for questions of ethics or professional practice	C	1.6%	$250,000	$250,000
Failure to clarify, adjust or withdraw from potentially conflicting roles among multiple clients	A	1.6%	$142,500	$142,500
Sexual / romantic interactions / relationships with current clients, client's partners or client's family members	A	39.7%	$2,229,435	$89,177
Failure to identify and resolve adverse consequences of treatment	A	3.2%	$140,000	$70,000
Failure to clarify the relationship of counselor with couples or family clients	A	1.6%	$70,000	$70,000
Failure to consult with other professionals if unclear regarding reporting responsibility	B	1.6%	$50,000	$50,000
Improper acceptance / requesting of fees from clients	A	4.6%	$127,500	$42,500
Improper sharing of confidential information without client consent and / or without legal justification	B	12.7%	$303,500	$37,938
Failure to provide client with pre-termination counseling referral recommendations	A	3.2%	$31,500	$15,750
Use of inaccurate, lapsed or deceptive licenses or certifications	C	1.6%	$15,000	$15,000
Sexual relationships with former clients, their partners or family members prior to end of five-year waiting period	A	1.6%	$9,500	$9,500
Defamation / slander / libel	C	1.6%	$7,500	$7,500
Failure to initially and continually inform client regarding limitations of confidentiality	B	1.6%	$1,125	$1,125
Failure to explain confidential nature and parameters of all group work to all members	B	1.6%	$600	$600
Overall		**100%**	**$8,077,841**	**$128,220**

Additional Analysis: Closed Claims Alleging Inappropriate Sexual / Romantic Relationships Between Counselors and Clients

Current Clients

One of the most significant findings revealed by the data was the frequency of claims involving counselors who enter into inappropriate sexual / romantic relationships with clients, client partners or client family members. The 2005 edition of the *ACA Code of Ethics* (A.5.a.) states that "… sexual or romantic counselor-client interactions or relationships with current clients, their romantic partners or their family members are prohibited." Notwithstanding this ethical guidance, approximately 40 percent of the professional liability claims in the report involved the counselor engaging in an inappropriate sexual / romantic relationship. These claims resulted in indemnity payments of $2.2 million.

Counselors assume a position of trust and frequently assist clients with the most intimate and private aspects of their lives. To engage in an inappropriate relationship is to abuse that trust. Even if the client attempts to initiate or consents to a sexual / romantic liaison, counselors are responsible for maintaining professional boundaries as defined by the *ACA Code of Ethics*, state-specific practice acts, state licensing / certification boards and applicable employer policies. For additional guidance, refer to the risk control recommendations in Part Six.

From a clinical perspective, the emotions associated with the development of transference and / or counter-transference between the counselor and client are an inherent element of the counseling process, to be resolved through appropriate counseling techniques that do not include engaging in sexual / romantic behaviors. When such emotions cannot be successfully resolved with appropriate counseling approaches and techniques, the counselor should discuss this issue with the client, seek supervision and assistance, and – if necessary – transfer the client to another counselor.

Former Clients

The *ACA Code of Ethics* also addresses sexual / romantic relationships with former clients, their partners or family members. The *ACA Code of Ethics* states that five years should elapse from the last counseling session to the initial consideration of whether an intimate relationship with a former client – or with a one-time romantic partner or family member of the client – may be harmful.

Simply terminating a client from ongoing counseling in order to enter into a closer relationship does not meet ACA ethical criteria. Such conduct can be highly damaging to the client and others, may lead to claims against the counselor and are injurious to public perception of the profession.

Figures 12 through 14 provide additional data and information regarding some of the inappropriate relationships identified in the analysis of counselor professional liability closed claims, as well as the outcomes for both the involved clients and counselors. Licensure / certification / disciplinary board actions related to inappropriate counselor-client sexual / romantic relationships are analyzed in Part Four.

- Of those counselors engaging in sexual relationships with clients, 28.6 percent were treating only the client and did not have another family member or significant other in treatment at the same time.
- In 6.3 percent of the closed claims in this category, the counselor was treating both spouses and entered into a sexual relationship with one of the spouses.
- The highest paid indemnity in this category ($300,000) involved a counselor treating both spouses and their children, while also having a sexual relationship with one of the spouses.
- One claim involved a sexual relationship between the counselor and the mother of a child being treated by the counselor. This claim involved a second allegation of improper bartering, as the client's mother was a massage therapist who traded massage sessions in lieu of payment for her child's counseling sessions. It was further asserted that the counselor became involved with the child's entire family, and engaged in multiple inappropriate personal relationships and behaviors with the child client.
- In one case, the counselor was treating a client while also engaging in an inappropriate sexual relationship with her adult son.

Counselor-client sexual / romantic relationships were initiated by both counselors and clients, but more often by counselors, with 30.1 percent of closed claims involving inappropriate relationships initiated by the counselor while the client was in active treatment.

The counselor has the responsibility to appropriately manage signs of transference and / or counter-transference, utilizing sound clinical counseling techniques. If necessary, counselors in such a situation should seek the assistance of a supervising counselor. Other potential sources of assistance and direction include the ACA, local professional associations, licensure / certification / disciplinary boards, relevant state statutes / regulations, and employer policies and procedures. *When more than one ethical, clinical and / or legal requirement or regulation is identified, adherence to the most stringent applicable standard is recommended.*

As previously noted, the subject of counselors engaging in sexual relationships with former clients is addressed in the *ACA Code of Ethics* (A.5.a.). The Code indicates that the possibility of a sexual relationship with a former client should not be entertained until a minimum of five years has elapsed following the date of the last treatment. At that juncture, scrupulous consideration should be given to whether the relationship would be deemed exploitive or otherwise potentially harmful for the client. The same five-year waiting period also is indicated before engaging in a sexual relationship with a client's one-time significant other or family member.

- The most frequently alleged injuries / adverse outcomes from counselor-client sexual relationships were sexual abuse / assault and emotional / psychological harm or distress.
- Other injuries included loss of the client's marriage or intimate relationship(s) and exacerbation of existing or additional diagnoses. In one claim, a client who had been in a sexual relationship with the counselor was unable to resume her prior lifestyle, could no longer attend school or work, and became permanently disabled.

12 INDIVIDUALS INVOLVED WITH THE COUNSELOR IN INAPPROPRIATE SEXUAL / ROMANTIC RELATIONSHIPS

Individual involved in inappropriate relationship	Individual(s) in treatment	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Client	Client, spouse and children	1.6%	$300,000	$300,000
Client	Client and spouse	6.3%	$510,000	$127,500
Client	Client	28.6%	$1,349,435	$74,969
Mother of client	Minor client	1.6%	$50,000	$50,000
Mother of client	Adult client	1.6%	$20,000	$20,000
Overall		**39.7%**	**$2,229,435**	**$89,177**

13 SEVERITY BY ALLEGED INITIATOR OF SEXUAL / ROMANTIC RELATIONSHIP AND RELATED TREATMENT STATUS

Individual initiating relationship	Status of treatment during relationship	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Client	Active	4.8%	$345,000	$115,000
Counselor	Active	30.1%	$1,831,335	$96,386
Counselor	After terminating client from treatment	1.6%	$42,500	$42,500
Mutual agreement	Active	3.2%	$10,600	$5,300
Overall		**39.7%**	**$2,229,435**	**$89,177**

14 INJURY / ADVERSE OUTCOME ALLEGED TO RESULT FROM COUNSELOR-CLIENT SEXUAL / ROMANTIC RELATIONSHIPS

Primary injury or adverse outcome	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Emotional disability (client unable to attend school or work)	1.6%	$300,000	$300,000
Sexual harassment by counselor	1.6%	$176,875	$176,875
Sexual abuse / assault by counselor	15.8%	$929,500	$92,950
Emotional / psychological harm or distress	12.7%	$553,060	$69,133
Depression	3.2%	$137,500	$68,750
Loss of marriage or significant intimate relationship	3.2%	$110,000	$55,000
Exacerbation of diagnosis / additional diagnosis	1.6%	$22,500	$22,500
Overall	**39.7%**	**$2,229,435**	**$89,177**

Multiple Nonprofessional Relationships with Clients, Former Clients, their Partners and / or their Family Member(s)

According to the 2005 edition of the *ACA Code of Ethics* (Section A.5.c.), "Counselor-client nonprofessional relationships with clients, former clients, their romantic partners or their family members should be avoided, except when the interaction is potentially beneficial to the client."

This broad statement leaves significant room for interpretation. Some examples of potentially beneficial interactions might include attending a formal ceremony such as a client's wedding, graduation or public appearance, or mutual membership in a professional association or community organization. These interactions must always be initiated with the full consent of the client.

If uncertain regarding the appropriateness of a relationship, review your state practice act, contact the ACA or local professional association, consult with a clinical supervisor or request an opinion from the state licensure / certification / disciplinary board. Remember that uncertainty may be a sign that the relationship will not benefit the client. For an example of a counselor engaging in multiple nonprofessional relationships with severe outcomes for all parties, see Case Study 2 on page 31.

If uncertain regarding the appropriateness of a relationship, review your state practice act, contact the ACA or local professional association, consult with a clinical supervisor or request an opinion from the state licensure / certification / disciplinary board.

CASE STUDY 2: Inappropriate Sexual Relationship

Medical malpractice claims alleging inappropriate sexual behavior may be asserted against any healthcare provider, including counselors. This following case study involves a mental health counselor.

Case Summary:
The client and her husband sought treatment for marital difficulties, while the client also suffered from trauma and codependency issues related to having been raised in an alcoholic home. The counselor treated the husband and wife both together and as individuals.

The counselor believed that the wife suffered from post-traumatic stress disorder and dissociative disorder resulting from childhood abuse. A specific therapy, known as eye movement desensitizing and reprocessing, was employed to assist the client in recalling and processing her traumatic experiences. The counselor encouraged the client to "recall" past episodes of sexual abuse and rape, notwithstanding the client's belief that such abuse had never occurred. While comforting the client, the counselor initiated a sexual relationship with her, after which the counselor and client either began or ended nearly every session with sexual relations. The counselor encouraged her to meet with him outside of the treatment environment for personal and social activities and led her to believe that they were in a "special" relationship.

The client's marriage ended during this period, and the husband (who was not aware of the relationship between the counselor and his wife) no longer sought treatment with the counselor. After approximately two years, the counselor abruptly terminated the client from treatment without giving any reason, yet continued to request that she see him personally, which she found very troubling. The client retained several intimate email messages that she and the counselor had exchanged during this period, which supported her allegations.

The client subsequently learned that she was not the only female client with whom the counselor had been sexually involved. She experienced severe anxiety, guilt and shame regarding the relationship and suffered physical and emotional symptoms significantly more severe than when she had entered treatment. Finally, she began treatment with a new counselor, who encouraged her to report the insured counselor to the Department of Health.

The insured counselor refused to provide any specific information regarding his relationship with the client. His session notes were inadequate or absent for most of the client's treatment. Without specifically admitting to sexual relations with the client, he offered to surrender his license to settle the matter with the Department of Health. The offer was rejected, and his license to practice was revoked.

The client filed suit alleging multiple boundary violations of a sexual and non-sexual nature, as well as improper treatment of the client's transference phenomenon and incorrect diagnosis.

Claim Analysis:
The defense expert met with the client and administered psychological testing. The testing determined that the client suffered from an anxiety disorder related to the relationship with the counselor. The expert noted that the counselor was solely responsible for maintaining proper boundaries in a therapeutic relationship, and that the client's consent to sexual and personal intimacy did not absolve the counselor of that responsibility. It was determined that by engaging in the following conduct, the counselor had violated the standard of care:

- *He encouraged the client to believe she was in a state of denial and had repressed memories of paternal sexual abuse as a child.* The counselor further encouraged the client to believe she had "recovered" memories of that abuse. (The client's siblings were interviewed and there was no evidence or corroboration of sexual abuse within the family.)
- *He led the client to believe they were in a "special" relationship,* as well as arranging and engaging in meetings with the client outside of the treatment setting for personal and social activities.
- *He physically comforted the client in response to her expressions of sadness,* using that process to initiate and engage in sexual activity with the client.
- *He abruptly terminated the client's treatment,* without explanation, appropriate referral or assistance in obtaining continuing counseling elsewhere.
- *He attempted to continue his personal and sexual relationship with the client* after terminating treatment.

Resolution:
The counselor had breached professional, clinical and ethical boundaries in engaging in multiple relationships with the client throughout her treatment. In addition, the counselor's clinical treatment did not meet acceptable standards of care. Due to the expert's findings of counselor negligence, the client's credibility (including email evidence) and the counselor's refusal to actively participate in his defense, the professional liability aspects of the claim were settled. (Note that criminal acts are not covered under the professional liability insurance policy and were not part of the settlement discussions.)

The parties entered into mediation and eventually reached a settlement related to the professional liability claim with dismissal. Settlement was in the low six-figure range.

Risk Management Recommendations:
Law, ethics, scope of practice and established standards of care all govern the practice of licensed counselors. Counselors can maintain appropriate boundaries and minimize risk by understanding and adhering to the following requirements:

1. *Know and practice within the counselor's state-specific scope of practice,* and in compliance with the standard of care and state licensing / certifying board requirements. If more than one standard, law or regulation is involved, the counselor should adhere to the most stringent applicable standard.
2. *Utilize proven therapeutic techniques* that are appropriate to the client's clinical needs, within the counselor's competence and representative of the accepted standard of care.
3. *Maintain appropriate boundaries with clients* and know and comply with the *ACA Code of Ethics* (visit **www.counseling.org**). In addition, follow state-specific laws and regulations related to professional conduct, applicable ethics codes of state and / or local professional organizations, and requirements of the relevant licensure / certification / disciplinary board.
4. *Remember that the counselor is solely responsible for maintaining appropriate boundaries in the counseling relationship,* and that client consent for sexual, personal and / or social relationships does not exempt the counselor from this professional duty.
5. *Prohibit and prevent sexual intimacies of any kind from occurring with a client* or with a client's relative or significant other.
6. *Manage client transference and / or counter-transference with appropriate counseling techniques, obtaining clinical supervision or assistance as needed.* If transference and / or counter-transference cannot be appropriately managed within the counseling relationship and becomes an obstacle to achieving treatment goals, cease treatment and encourage the client to seek counseling with another professional.
7. *Thoroughly document all client discussions related to transference and boundary issues,* the clinical decision-making process, actions to obtain clinical supervision or assistance, and assistance provided to the client in obtaining alternative treatment.
8. *Refrain from contact with clients who are no longer in treatment.* If unintentional contact occurs, maintain proper professional boundaries.

PART THREE

Deposition Assistance and Record Request Matters

Introduction

Counselors may be subpoenaed to provide a deposition or court testimony in matters where they are not a defendant, but are or were involved in the assessment and / or treatment of a client who is involved in a legal action. Similarly, they may receive subpoenas or requests for clinical records.

As noted in Figure 15, various counselor specialties are subject to receipt of deposition and subpoena requests. Many of these requests are related to children, including parental fitness assessments, child custody or support matters, child abuse / neglect allegations, or demands for visitation and / or records from noncustodial parents. Such subpoenas and requests also may arise from adult situations where the counselor has assessed or treated one or more of the involved parties. Examples include divorce actions; alcohol or drug use / addiction; mental illness; and adult physical, emotional and / or sexual abuse.

15 ANALYSIS OF DEPOSITION AND SUBPOENA REQUESTS WITH EXPENSE REIMBURSEMENT BY COUNSELOR TYPE

Counselor specialty	Percentage of deposition and subpoena request closed claims	Total paid expense	Average paid expense
Counselor practice / firm	1.1%	$24,529	$12,264
Pastoral counselor	1.1%	$8,453	$4,226
Alcohol / drug counselor	3.2%	$15,451	$2,575
Licensed professional clinical counselor (LPCC)	32.0%	$113,502	$1,924
Rehabilitation counselor	1.1%	$3,412	$1,706
Marriage / family counselor	9.7%	$30,620	$1,701
Mental health counselor	13.0%	$38,131	$1,589
Licensed professional counselor (LPC)	37.8%	$107,155	$1,531
School counselor	0.5%	$1,278	$1,278
Counselor educator	0.5%	$1,056	$1,056
Overall	**100.0%**	**$343,587**	**$1,857**

CASE STUDY 3: Custody Dispute

Client record and deposition requests often present a range of legal and ethical challenges. Failure to respond to a legal subpoena could result in the imposition of sanctions, including issuance of a warrant from the court for the counselor's arrest. Yet, provision of confidential records to individuals or even courts can produce complex and challenging situations for counselors, in which they require immediate legal assistance to protect their clients and themselves.

Case Summary:
One claim involved a child custody dispute between a divorced couple, based upon allegations by the father that his daughter had been sexually abused by a relative of the child's mother. A counselor was appointed by the court to make a report of her findings and recommendations, and gave a deposition three months later. The child also was examined by a physician, an investigator from the Department of Human Services and a separate counselor retained by the mother. The physician concluded it was very likely the child had been sexually abused.

Claim Analysis and Resolution:
As a result of this diagnosis, a criminal investigation of the relative was initiated. Shortly thereafter, the mother filed a motion requesting that the court disqualify the counselor from serving as the court's appointed expert. The court disagreed and ordered that the child be placed with the father. In addition, the court ordered that all future visits by the mother be directed by the counselor.

The mother then filed a board complaint and a lawsuit against the counselor, contending that the counselor had overstepped the boundaries set by the court in making her recommendations. The mother also alleged the counselor was not qualified to testify as an expert and that the counselor's unqualified testimony had resulted in custodial loss of her child. Nearly a year later, counsel succeeded in having the claim dismissed.

Risk Management Recommendations:
Counselors must take seriously their responsibility to protect their clients' private and confidential information. They also should be cognizant of and comply with evolving and expanding state and federal confidentiality and privacy laws and regulations. In addition, the counselor must understand and recognize situations that may require disclosure of sensitive client information, e.g., when a client appears to present a danger to self or others, or when there is evidence of child abuse / neglect.

Counselors must obtain client authorization prior to releasing confidential and private information, where federal and state laws and regulations permit such release pursuant to client authorization. Consult an attorney conversant with applicable guidelines, including the required content of the authorization. In some jurisdictions, counselors also may be responsible for informing clients of possible situations where confidential information may be released without client authorization. Discuss privacy issues at the outset of counseling and periodically thereafter and clearly document these discussions in the client's clinical record, including the client's acknowledgment and signature when possible.

CNA and HPSO have also developed tools to assist their insured healthcare professionals, including counselors, in deposition preparation and demeanor. Visit the risk management section of the **hpso.com** site for access to the video titled "Preparing for a Deposition."

Subpoenas for Counselor Clinical Records and / or Counselor Depositions Under Oath

Figure 16 reveals that counselors working with any type of client may encounter a subpoena to deliver clients' clinical records and / or present themselves for deposition under oath. Often these subpoenas are unexpected and provide little preparation time.

- Counselors who worked with adults in matters related to child custody, divorce and child abuse were more likely to receive a subpoena for deposition.
- Other matters resulting in subpoenas for deposition involved adult clients dealing with employment issues and adult abuse.

Experience with CNA / HPSO insureds has demonstrated the importance of scrupulous preparation for a deposition under oath. The claimant's attorney may use complex or aggressive questioning techniques, and the counselor must be able to answer all questions truthfully, without divulging additional or extraneous information.

During depositions, the claimant's attorney may use complex or aggressive questioning techniques, and the counselor must be able to answer all questions truthfully, without divulging additional or extraneous information.

16 ANALYSIS OF DEPOSITION REQUEST BY CLIENT TYPE, UNDERLYING MATTER WITH EXPENSE REIMBURSEMENT

Client type	Underlying matter	Percentage of deposition request closed claims	Total paid expense	Average paid expense
Adult	Monitoring court-ordered alcohol / drug treatment	1.4%	$27,711	$13,856
Adult	Personal relationship	0.7%	$4,673	$4,673
Adult	Counselor license	0.7%	$4,373	$4,373
Child	Child neglect	0.7%	$4,097	$4,097
Adult	Assessment for suicide risk	0.7%	$2,074	$2,074
Adult	Child custody	2.7%	$8,094	$2,024
Child	Child abuse	9.5%	$25,038	$1,788
Child	Child custody	34.9%	$90,070	$1,766
Adult	Grief counseling	1.4%	$3,411	$1,706
Adult	Employment	5.4%	$13,444	$1,681
Adult	Emotional matters related to physical injury / condition	4.1%	$9,802	$1,634
Adult	Adult abuse	4.1%	$9,351	$1,559
Child	Child abuse and custody	2.7%	$6,049	$1,512
Adult	Compliance with court-ordered monitoring	0.7%	$1,365	$1,365
Adult	Assessment for potential adoption of a minor	0.7%	$1,305	$1,305
Adult and child	Child custody	3.4%	$6,389	$1,278
Adult	Divorce	11.0%	$20,291	$1,268
Adult	Child abuse	1.4%	$2,465	$1,233
Adult or child	No information regarding underlying matter	5.4%	$9,584	$1,198
Adult	Mental health	1.4%	$2,264	$1,132
Adult	Post-hospitalization assessment	0.7%	$916	$916
Adult and child	Child support	1.4%	$1,325	$663
Adult	Abandonment by another counselor	1.4%	$1,217	$609
Child	Child criminal assault	0.7%	$600	$600
Adult	Divorce and child custody	1.4%	$1,116	$558
Adult	Workers' compensation	1.4%	$853	$427
Overall		**100%**	**$257,877**	**$1,766**

Figure 17 shows the wide variety of issues – ranging from family matters to probation noncompliance – that may result in a request to counselors to produce client records.

- The expenses in Figure 17 reflect the amounts paid to attorneys to respond to requests for client records from insured counselors. The average cost is $2,198.
- Records are subpoenaed most frequently for child custody matters.

17 ANALYSIS OF RECORD REQUESTS BY CLIENT TYPE, UNDERLYING MATTER WITH EXPENSE REIMBURSEMENT

Client type	Underlying matter	Percentage of record request closed claims	Total paid expense	Average paid expense
Adult	Assessment prior to criminal trial	2.6%	$10,064	$10,064
Adult	Child abuse	2.6%	$5,596	$5,596
Adult	Substance abuse	2.6%	$4,884	$4,884
Child	Child custody	38.4%	$41,962	$2,797
Adult	Child custody	2.6%	$2,272	$2,272
Adult	Mental health	5.0%	$3,881	$1,941
Adult	Employment	2.6%	$1,887	$1,887
Adult	Adult abuse	2.6%	$1,584	$1,584
Adult	Grief counseling	2.6%	$1,294	$1,294
Child	Emotional matters related to physical injury / condition	2.6%	$1,212	$1,212
Child	Child abuse	2.6%	$1,188	$1,188
Adult	Emotional matters related to physical injury / condition	10.2%	$4,044	$1,011
Adult	Child neglect	2.6%	$816	$816
Adult	Counselor did not treat the client	2.6%	$814	$814
Adult or child	No information regarding underlying matter	10.2%	$2,716	$679
Adult	Divorce	5.0%	$1,065	$532
Adult	Probation noncompliance	2.6%	$432	$432
Overall		**100%**	**$85,711**	**$2,198**

Figure 18 lists the most common resolutions to deposition-related and record-related legal situations, and reveals average covered expenses associated with each.

- In more than one-third of the claims in this category, the counselor was prepared by an attorney and completed the deposition.
- In 16.8 percent of the claims in this category, the counselor was requested to prepare and appear for deposition, but never did so because the underlying dispute was resolved.
- In 5.4 percent of the claims, the deposition was canceled once the records were provided.
- In 3.8 percent of the claims, the matter was closed once the subpoenaed records were compiled and provided.

18 **EXPENSES BY RESOLUTION OF DEPOSITION-RELATED OR RECORD-RELATED CLOSED CLAIMS**

Figure 18 represents the five most frequent resolutions to deposition-related matters and record requests.

Matter	Resolution achieved	Percentage of deposition / records closed claims	Total paid expense	Average paid expense
Deposition	Records provided and deposition canceled	5.4%	$42,701	$4,270
Records subpoenaed	Counselor complied and records provided	3.8%	$14,552	$2,079
Deposition	Counselor prepared and deposition completed	35.7%	$124,288	$1,883
Deposition	Records provided and deposition completed	5.4%	$16,038	$1,604
Deposition	Canceled, as underlying matter settled prior to deposition date	16.8%	$34,253	$1,105

CASE STUDY 4: Example of a Counselor Claim with a Successful Outcome

Medical malpractice claims alleging breach of privacy may be asserted against any healthcare provider, including counselors. The following case study involves a licensed professional counselor.

Case Summary:
The insured licensed professional counselor provided services to a married couple, both together and individually, for approximately one month. The sessions revealed multiple episodes of emotional abuse by the husband, who also made physical threats against his wife and their children, and admitted to holding a loaded gun during marital discussions. In addition, the husband placed security cameras throughout their home and required his wife to wear a recording device, in order to hear her conversations when she was not in his presence. He further attempted (unsuccessfully) to have a friend engage his wife in an affair to prove his belief that she was unfaithful.

The counselor believed that the wife and children were at risk, recommending to the wife that she leave the marital home to live with her parents who were located several hours away. The counselor reported the husband's behavior as child abuse, in compliance with state child protection regulations. The wife left the marital home with the children and subsequently filed for divorce and sole custody of the children, due to the husband's emotional and physical abuse.

The counselor was ordered by the court to provide records relating to the client and was subsequently required to testify under oath during the divorce and child custody proceedings. The counselor had maintained meticulous entries in the clinical records for both the husband and wife during treatment. Included in each file were signed statements from both parties that they understood that their personal information would not be released without their authorization unless the counselor determined they were a danger to themselves or others, evidence of child abuse existed or a court order had been issued.

Claims Analysis and Resolution:
The husband sued the counselor for breach of privacy and fiduciary duty, emotional distress, the loss of his marriage and family, and an incorrect diagnosis of his mental state.

Fortunately, the counselor had carefully reviewed with the husband and wife the conditions under which she would release the clients' personal information. Both spouses had signed their agreement to those conditions. Further, the counselor maintained client records supporting her clinical decision-making process, the husband's diagnosis and her actions in reporting the husband for child abuse.

Defense experts fully supported the counselor's assessment of the husband, her actions in reporting the abuse, as well as her advice to the wife to leave the marital home with her children for safety reasons. They further noted that the husband lacked awareness of the seriousness of his problems. The defense filed a motion for summary judgment. The expert witnesses retained by the husband's attorney were unable to support the allegations against the counselor, and the judge granted the motions for summary judgment and dismissal of the claim. The presence of strong documentation had provided the defense experts and defense counsel with the information needed to successfully defend the counselor in this lawsuit.

Risk Management Recommendations:

When determining whether or not to release confidential information, consider the following guidelines:

1. *Know and practice within the state scope of practice act,* and in compliance with the standard of care and state licensing / certifying board requirements.
2. *Review state and federal laws, regulations and requirements,* as well as employer policies regarding client healthcare information confidentiality and privacy, and act accordingly. When multiple requirements exist, comply with the most stringent of those that apply.
3. *Preserve client confidentiality with spouses and / or family members,* and explain and consistently maintain practice boundaries (including privacy) with every client.
4. *Follow state and federal requirements and exemptions regarding unauthorized release of private healthcare information,* including the duty to warn if clients are a danger to themselves or others, as well as the requirements for reporting known or suspected child abuse.
5. *Review with each client all applicable confidentiality / privacy regulations and protections,* as well as any exceptions to those protections. Explain practice policies when initiating treatment, and obtain a written acknowledgment from each client confirming the understanding and acceptance of these conditions.
6. *Understand and comply with the* ACA Code of Ethics (**www.counseling.org**) and other relevant ethics codes from other professional organizations or licensure / certification boards related to client confidentiality and privacy.
7. *Never ignore a subpoena,* whether it involves releasing clinical records, appearing for a deposition or testifying in court. Consult with an attorney knowledgeable about health law and request guidance about potential conflicts between legal mandates and client privacy rights when responding to a subpoena.
8. *Engage a healthcare attorney to prepare for any deposition or testimony under oath.* The preparation should minimally include a scrupulous review of clinical records, as well as practice in responding to questions truthfully and accurately, without providing unasked-for information.
9. *Maintain complete and accurate documentation in the client's clinical record* regarding the clinical decision-making process, the client's response to treatment, discussions with clients about confidentiality / privacy regulations and exceptions, and any client-related correspondence.

PART FOUR

Analysis of Counselor License Protection Defense Paid Claims

Review of License Protection Defense Paid Claims

An action taken against a counselor's license or certification to practice differs from a professional liability claim in that it may extend beyond matters of professional negligence and involve allegations of a personal, nonclinical nature, such as substance abuse. Another difference is that amounts paid for license protection claims represent only the cost of providing legal defense for the counselor, rather than indemnity or settlement payments to a plaintiff.

A complaint can be filed against a counselor by a client, colleague, employer or regulatory agency, such as the Department of Human Services. By highlighting the most common types of license protection claims, this section can assist counselors in identifying where they may be vulnerable and implementing effective strategies to minimize risk.

- Almost a third (32.3 percent) of the 1,224 reported license protection incidents resulted in a payment.
- The total expenditure for license protection defense paid claims was approximately $1.5 million, with an average paid claim amount of $3,727. This average payment reflects the legal expenses and associated travel, food, lodging and wage loss costs reimbursable under the insurance policy.
- The average payment amount may not be reflective of the total expense paid by the counselor for his or her license protection defense. Fines, penalties, mandated continuing education and reimbursement to the regulatory body for investigative expenses are all potential expenses that are not reimbursable under the CNA / HPSO policy.

19 LICENSE PROTECTION DEFENSE CLAIMS

License protection defense detail	Percentage of total reported incidents	Total paid expense	Average paid expense
Paid claims	32.3%	$1,472,360	$3,727
Closed without payment	67.7%		
Total	**100%**		

License Protection Defense Paid Claims

All but seven license-protection defense-paid claims involved counselors who were individually insured by the CNA / HPSO program. In the remaining seven paid claims, the counselor owned the small group practice insured by CNA / HPSO. There was no difference in average payment between individual counselors and counselors working in a CNA / HPSO-insured counseling group.

- Counselors with a license protection defense paid claim most often provided counseling services in an office-based setting (93.9 percent), followed by a client's home (2.2 percent) and inpatient facility (2.0 percent).
- The average payment for an office location was slightly lower ($3,681) than the overall average payment ($3,727).
- Claim payments involving schools, correctional facilities and inpatient settings were higher than the overall average payment for license protection defense. However, practice location did not appear to influence the type of allegation filed against the counselor.

20 AVERAGE PAID EXPENSE BY YEAR, WITH TREND LINE

21 SEVERITY BY PRACTICE LOCATION

Location	Percentage of paid claims	Total paid expense	Average paid expense
School	0.8%	$19,655	$6,552
Correctional facility	0.8%	$16,087	$5,362
Inpatient facility	2.0%	$42,212	$5,277
Counselor's office	93.9%	$1,365,640	$3,681
Client's home	2.2%	$27,991	$3,110
Group home	0.3%	$775	$775
Overall	**100%**	**$1,472,360**	**$3,727**

Paid Claims by Specialty

Categories were based on self-identified specialty / licensure when the counselor applied for professional liability insurance coverage through CNA / HPSO.

22 SEVERITY BY SPECIALTY

Specialty	Percentage of paid claims	Total paid expense	Average paid expense
Pastoral counselor	1.5%	$27,026	$4,504
Mental health counselor	15.4%	$233,048	$3,820
Alcohol / drug counselor	6.1%	$90,915	$3,788
Licensed professional counselor (LPC) / licensed professional clinical counselor (LPCC)	66.6%	$977,392	$3,716
Marriage / family counselor	10.1%	$141,633	$3,541
Counselor educator	0.3%	$2,346	$2,346
Overall	**100%**	**$1,472,360**	**$3,727**

Claim payments involving schools, correctional facilities and inpatient settings were higher than the overall average payment for license protection defense. However, practice locations did not appear to influence the type of allegation filed against the counselor.

Analysis of Allegations

This section examines the specific allegations identified in the license protection defense paid claims, extending beyond the classification system of the various state and regulatory bodies that oversee counselors. The primary allegation categories include misconduct, unprofessional conduct, incompetent practice and sexual misconduct. Often, this schema does not provide sufficient insight into the specific circumstances that led to the allegation. Therefore, this report classifies allegations in a more detailed manner, based upon the primary reason for the complaint.

Complaints were filed by current and former clients, members of the client's family or social circle (e.g., spouses, parents, grandparents, foster parents, significant others), present and past employers, colleagues, and staff of regulatory agencies or facilities.

The most frequent board complaints related to sexual misconduct (14.4 percent), breach of confidentiality (13.6 percent) and beyond scope of practice (10.0 percent). These allegation classes represented 38.0 percent of the total. A detailed analysis of these three classes is provided on pages 49 and 50. Note that the top 10 allegation classes represented 79.1 percent of the total complaints where payment was made for legal defense. Basic risk control recommendations will be highlighted throughout this section, in order to assist counselors in minimizing risk and assisting defense counsel in license protection matters before a regulatory board.

Multiple allegation classes were found in all counseling specialties. The range and number of complaints indicate the importance of knowing and following the expectations of professional behavior delineated in the *ACA Code of Ethics* and other codes of professional conduct.

Counselors were often faced with complaints of personal bias against the noncustodial parent, grandparent, foster parent or social service agency when making official recommendations to a court or agency regarding custodial issues. Typical complaints included personal bias, breach of confidentiality for disclosing information to the noncustodial parent, failure to treat, failure to release records, and failure to properly assess in cases where abuse was suspected and reported, but no evidence was found.

Consistency of documentation throughout the counseling relationship is essential to a successful defense. Be vigilant about documenting any changes to treatment plans, as well as recording such basic information as dates, times, places and people seen. Telephone calls and in-person conferences should be documented and, if necessary, the documentation reviewed with the client. Ensure that the treatment plan is reviewed and updated at regular intervals, and signed off by oneself and the client, or by the parent when the client is a minor.

Beyond scope of practice claims (10.0 percent) included several allegations that the counselor lacked proper supervisory skills. Other complaints included providing counseling services without supervision, sending an email message without approval while under supervision, lacking appropriate license for the counseling services provided, teaching without appropriate credentials and performing psychological testing without proper licensing.

23 FREQUENCY BY PRIMARY ALLEGATION CLASS

Allegation class	Percentage of paid claims
Sexual misconduct	14.4%
Breach of confidentiality	13.6%
Beyond scope of practice	10.0%
Failure to properly assess	8.5%
Failure to treat	6.8%
Failure to release records	6.3%
Billing	6.1%
Multiple relationships	4.8%
Verbal abuse	4.3%
Failure to obtain consent before treatment	4.3%
False advertising	3.3%
Failure to report suspected abuse	3.0%
Personal (non-sexual) relationship with client	2.8%
Substance abuse	2.5%
Abandonment	1.8%
Unethical behavior (all other)	1.5%
Documentation	1.0%
Multiple clients (i.e., providing services to two or more clients who have a relationship with each other)	1.0%
Recruiting	0.8%
Physical abuse	0.5%
Accepted gifts from client	0.3%
Clients served by others (i.e., counseling clients who have a professional relationship with another counselor)	0.3%
Criminal infraction	0.3%
Impairment	0.3%
Inappropriate delegation	0.3%
Lack of knowledge of standards	0.3%
Imposing personal values	0.3%
Release of information without consent	0.3%
Termination of practice (e.g., retirement, leaving a practice, etc.)	0.3%
Total	**100%**

Maintaining boundaries at all times is of paramount importance, and therefore counselors should seek assistance whenever confronted with a questionable situation. One complaint involving the acceptance of gifts resulted in a defense payment of $5,202, and the counselor's license was revoked. The alleged criminal infraction was related to negligent handling of an animal, and did not appear to be connected to a counseling relationship. This case demonstrates that seemingly private actions can have profound impact on a counselor's professional status.

Certain allegation classes, such as substance abuse, were not related to professional conduct. Instead, they involved driving under the influence, use of illegal drugs and, in one case, giving a controlled substance to a friend.

24 SEVERITY BY PRIMARY ALLEGATION CLASS

Allegation class	Percentage of paid claims	Total paid expense	Average paid expense
Lack of knowledge of standards	0.3%	$10,000	$10,000
Sexual misconduct	14.4%	$309,439	$5,428
Accepted gifts from clients	0.3%	$5,202	$5,202
Multiple relationships	4.8%	$88,730	$4,670
Criminal infraction	0.3%	$4,632	$4,632
Billing	6.1%	$108,228	$4,509
Multiple clients (i.e., providing services to two or more clients who have a relationship with each other)	1.0%	$17,667	$4,416
Failure to treat	6.8%	$108,298	$4,011
Documentation	1.0%	$15,744	$3,936
Failure to properly assess	8.5%	$130,888	$3,849
Release of information without consent	0.3%	$3,825	$3,825
Beyond scope of practice	10.0%	$136,883	$3,422
Personal (non-sexual) relationship with client	2.8%	$37,488	$3,408
Unethical behavior (all other)	1.5%	$20,176	$3,362
Failure to report suspected abuse	3.0%	$39,325	$3,277
Breach of confidentiality	13.6%	$171,497	$3,175
False advertising	3.3%	$39,941	$3,072
Verbal abuse	4.3%	$50,365	$2,962
Failure to release records	6.3%	$71,629	$2,865
Termination of practice (i.e. retirement, leaving a practice, etc.)	0.3%	$2,675	$2,675
Abandonment	1.8%	$18,601	$2,657
Substance abuse	2.5%	$24,722	$2,472
Failure to obtain consent before treatment	4.3%	$39,737	$2,337
Impairment	0.3%	$2,310	$2,310
Physical abuse	0.5%	$4,309	$2,154
Clients served by others (i.e., counseling clients who already have a professional relationship with another counselor)	0.3%	$2,125	$2,125
Recruiting	0.8%	$5,812	$1,937
Imposing personal values	0.3%	$1,903	$1,903
Inappropriate delegation	0.3%	$210	$210
Overall	**100%**	**$1,472,360**	**$3,727**

A Detailed View of Major Allegations

This section highlights the top three license-protection allegations – sexual misconduct, breach of confidentiality and beyond scope of practice.

The most frequent allegation class was sexual misconduct. The most frequent allegation was having relationships with current clients (78.9 percent), followed by relationships with former clients (17.5 percent). Relationships with colleagues, employers and employees had one claim, as did relationships with supervisors. Allegations related to relationships with colleagues, employers and employees ($3,698) were close to the overall average payment ($3,727), while the three other categories had a higher average payment.

Prudent judgment and vigilance must characterize the counseling relationship. The counselor should recognize warning signs and expeditiously implement measures to establish appropriate boundaries with all clients, current and former. It is also advisable in certain circumstances to seek the support and counsel of other professionals. In some cases, it may be necessary to terminate the counseling relationship to avoid the reality or appearance of a breach of professional ethics.

25

DETAILED VIEW OF ALLEGATION CLASS – SEXUAL MISCONDUCT

(14.4 percent of total license protection defense paid claims)*

**The percentage of this allegation class is calculated in Figure 23.*

Allegation detail	*ACA Code of Ethics* section	Percentage of sexual misconduct paid claims*	Total paid expense	Average paid expense
Roles and relationships – current clients	A	78.9%	$244,189	$5,426
Roles and relationships – former clients	A	17.5%	$52,616	$5,262
Relationships with colleagues employers and employees	D	1.8%	$3,698	$3,698
Supervisory relationships	F	1.8%	$8,936	$8,936
Overall		**100%**	**$309,439**	**$5,428**

Breach of confidentiality allegations represented 13.6 percent of the total license protection defense paid claims. Allegations included sharing information with a client's former spouse(s), speaking to clients in front of other clients in the waiting area, failure to obtain a waiver to discuss client issues with another counseling professional and making inappropriate comments during a group session.

The nature of the counseling relationship requires a high level of trust and confidentiality. Counselors must secure the proper releases before discussing any case details with a client's family member. Also, counselors must be aware of privacy considerations dictated by governing laws and regulations, as well as ethical guidelines, when speaking to clients in waiting rooms and other open settings.

Counselors must ensure that they have the appropriate education, training, experience and credentials to provide counseling services. If a question arises, they should check with their state licensing board or professional organization. Maintaining proper competence and boundaries as a supervisor is imperative. Counselors-in-training rely upon the supervising counselor to guide and monitor their activities. In some instances, claims were filed because the supervising counselor appeared to lack the proper credentials.

Supervising counselors always must prioritize the client's well-being. Moreover, they must ensure that counselors-in-training understand their training plan, relevant rules and policies, when to seek supervisory approval and how to conduct themselves in a professional manner.

26 **DETAILED VIEW OF ALLEGATION CLASS – BREACH OF CONFIDENTIALITY**

(13.6 percent of total license protection defense paid claims)*
**Total percentage of this allegation class is calculated in Figure 23.*

Allegation detail	*ACA Code of Ethics* section	Percentage of breach of confidentiality paid claims*	Total paid expense	Average paid expense
Respecting client rights	B	100%	$171,497	$3,175

27 **DETAILED VIEW OF ALLEGATION CLASS – BEYOND SCOPE OF PRACTICE**

(10.0 percent of total license protection defense paid claims)*
**Total percentage of this allegation class is calculated in Figure 23.*

Allegation detail	*ACA Code of Ethics* section	Percentage of beyond scope of practice paid claims*	Total paid expense	Average paid expense
Relationship boundaries with supervisee	C	67.5%	$110,056	$4,076
Counselor supervision competence	F	7.5%	$2,816	$939
Relationship boundaries with supervisees	F	2.5%	$8,489	$8,489
Standards for students	F	22.5%	$15,522	$1,725
Overall		**100%**	**$136,883**	**$3,422**

Licensing Board Actions: The Impact on a Counselor's Career

The following explanation of terms pertains to license protection matters addressed in this report:

- **Civil penalty** – A monetary fine for each violation of the state practice act.
- **Consent or stipulated agreement** – A condition or conditions that must be met for the counselor to continue to practice professionally.
- **Dismiss with prejudice** – A judgment rendered by a court that prevents further legal action.
- **Letter of concern / guidance / caution** – A communication from the board noting that the counselor may have engaged in questionable conduct, and warning the recipient to avoid future infractions.
- **Letter of reprimand** – A communication stating that probable cause of an infraction has been found, and that disciplinary action will be implemented if any future problems arise. A letter of reprimand is more serious than a letter of concern.
- **Revocation of license** – A decision by a regulatory body prohibiting the individual from practicing.
- **Surrender of license** – A decision by the individual to cease professional practice.

More than half (56.7 percent) of board complaints were successfully defended on behalf of the counselor, with the board rendering no action. Counselors' licenses were surrendered in 2.3 percent and revoked in 4.3 percent of the cases, effectively ending the counselors' professional careers.

28 FREQUENCY OF BOARD OUTCOMES FOR PAID CLAIMS

Board outcome	Percentage of paid claims
Case closed (no action)	56.7%
Probation	9.1%
Letter of caution / guidance / concern	8.1%
Continuing education (CE) / monetary fine / supervision	7.5%
Revocation	4.3%
Suspension	4.1%
Consent or stipulated agreement	3.3%
Letter of reprimand	3.0%
Surrender of license	2.3%
Dismissed with prejudice	0.8%
Civil penalty	0.5%
Notice to cease and desist	0.3%
Total	100%

Eight of the 12 board outcomes for license protection defense paid claims exceeded the overall average payment of $3,727. Higher-than-average defense payments typically represent outcomes with more serious consequences for the counselor, specifically surrender, suspension, continuing education / fine / supervision, revocation, civil penalty, probation, or consent or stipulated agreement.

Ethical infractions can cause significant harm to clients and others, and also have long-term consequences for a counselor's career. Counselors must know and comply with their professional association's code of conduct, as well as guidelines set forth by the relevant state practice act. The self-assessment checklist on pages 74-76 is designed to help counselors review their adherence to professional standards and make appropriate modifications to their practice.

29 SEVERITY BY BOARD OUTCOME

Board outcome	Average paid expense
Dismissed with prejudice	$10,000
Surrender of license	$7,665
Suspension	$7,227
Continuing education (CE) / monetary fine / supervision	$5,399
Revocation	$5,037
Civil penalty	$5,000
Probation	$4,211
Consent or stipulated agreement	$4,198
Letter of caution / guidance / concern	$3,016
Case closed (no action)	$2,965
Letter of reprimand	$2,658
Notice to cease and desist	$1,408
Overall	**$3,727**

PART FIVE

Highlights from the 2013 Qualitative Counselor Work Profile Survey

Introduction

In 2013, CNA and HPSO conducted a four-part study of counselor liability. Part Five differs significantly from the closed claims analyses in Parts Two, Three and Four, as it presents selected highlights from the 2013 Qualitative Counselor Work Profile Survey. (The complete results of the survey may be accessed on the HPSO website at **www.hpso.com/CounselorClaimReport**.) The survey reflects direct feedback from two subsets of our insured counselors: one group of insured counselors who had a claim filed against them and a demographically similar group of insured counselors with no claims filed against them. Both groups of respondents electively opted to complete the 2013 survey tool. In this survey, the term *respondent* refers to those HPSO-insured counselors who voluntarily replied to the HPSO survey.

This survey was performed at the request of counselors and others seeking information about issues not addressed by the analysis of closed claims. It should be noted that the findings in Part Five are derived only from those counselors who responded to the 2013 counselor survey and do not reflect all HPSO-insured counselors or all counselors in general.

The survey approach permitted comparison of several variables that may influence professional liability exposure, including

- age, education and experience as a counselor
- annual CE requirements
- participation in supervision / peer review
- type of treatment
- presence of a disclosure policy

HPSO engaged Wolters Kluwer Health, Lippincott Williams & Wilkins to survey counselors on these and associated issues. The survey participants included counselors who participated in the CNA / HPSO insurance program between January 1, 2003 and December 31, 2012.

Survey Background and Methodology

The purpose of this survey was to examine the relationship between professional liability exposure and a variety of demographic and workplace factors. The responding counselors were divided into two groups: those who had experienced a professional liability claim resulting in loss that had closed between 2003 and 2012, and those who had never experienced a claim.

The sample for the group who experienced claims consisted of 912 counselors who had submitted a professional liability claim within the past 10 years. This claim group sample comprised two subgroups: 567 respondents with a professional liability claim payment made on their behalf and 345 with a license protection claim payment. The nonclaims sample was produced from a randomized sample of 10,000 current CNA / HPSO-insured counselors that approximately matched the geographic distribution of the claims group.

A hybrid methodology was used, consisting of a printed mail survey and an emailed invitation to complete an online version of the survey. Each participant was sent the print version and, if an email address was available, the online invitation as well. Those receiving the print version were invited to take the online survey via a generic link. Each survey was labeled with a unique identifier to guard against duplicate respondents. To encourage participation, respondents were eligible to receive a prize.

Within this section, results reflect overall responses for both the claims and nonclaims segments, as well as professional liability (PL) and license protection (LP) groups within the claims portion. The margin of error at the 95 percent confidence level for the claims portion of the study was ±3.9 percent. The corresponding margin of error for the nonclaims version was ±1.8 percent. This confidence level means that there is a probability that the result is reliable at least 95 percent of the time.

Please note that the survey findings are based upon self-reported answers and thus may be skewed due to the respondents' personal perceptions and recollections of the requested information. It should be noted that the qualitative survey results are not comparable to the quantitative counselor closed claims data in Parts Two, Three and Four.

SURVEY RESPONSE RATES

	Claims version		Nonclaims version
	Print	Online	Total
Initial deployment	July 8, 2013	July 8, 2013	—
Reminder #1 sent		August 21, 2013	—
Field closed			September 23, 2013
Initial sample size		912	10,000
Undeliverable / opt out		14	134
Usable sample		898	9,866
Number of respondents		378	2,745
Response rate		**42.1%**	**27.8%**

Summary of Findings

- A majority of claims and nonclaims counselors have completed a Council for Accreditation of Counseling & Related Educational Programs (CACREP®) accredited program, and participation in such a program appears to make no difference in terms of claims distribution. (Table 9)
- While most claims and nonclaims counselors have participated in a residency program, this participation appears to have minimal effect on distribution of claims. (Table 10)
- A majority of the counselors surveyed reported needing continuing education credit, with most (56 percent) needing at least 16 credits per year. Those who reported needing 15 or fewer credits have a lower percentage in the claims group than in the nonclaims group. (Table 14)
- Most counselors said they routinely participate in a supervision / peer review process. However, nonclaims respondents were more likely to participate in regular review than respondents with claims. (Table 22)
- Only a small proportion of claims were related to a breach of confidentiality, and the proportion of nonclaims respondents who admitted to having ever breached privacy rules was relatively low. (Table 31)
- Survey respondents who reported seeing between three and five clients per day tended to have a higher percentage of claims than those who saw six to 10, 11-15 and 16 or more clients per day. (Table 43)
- The majority of counselors who experienced a claim did not have a policy regarding error disclosure. This group reported a higher percentage of claims, compared to respondents who had such a policy. (Table 51)
- Although sole reliance on handwritten (as opposed to electronic) medical records appears to result in a higher percentage of claims, the majority of respondents rely on handwritten records. (Table 52)
- Seventy-four percent of respondents who experienced a claim reported that they were "very satisfied" with the claim resolution, while 69 percent were "very satisfied" with the claim consultant and 73 percent were "very satisfied" with the claim experience. (Table 53)
- Fully 99.1 percent of respondents indicated they were thankful they had purchased a professional liability policy. (Table 55)

Topic 1: Respondent Demographics

Current License

The majority of respondents who experienced claims self-reported as a licensed professional counselor (LPC), which also represented the largest percentage of nonclaims respondents. From the data, it appears that specialized counseling professionals are less likely to experience a claim.

1 LICENSE

Q: Please confirm your current license.	Claims	Nonclaims
Licensed professional counselor (LPC)	45.1%	32.0%
Mental health counselor	15.7%	19.8%
Licensed professional clinical counselor (LPCC)	15.1%	8.9%
Marriage / family counselor	6.9%	4.7%
Alcohol / drug counselor	5.8%	5.5%
School counselor	1.1%	4.7%
Forensics counselor	0.8%	0.3%
Psychological counselor	0.8%	1.1%
Bodywork counselor	0.5%	0.1%
Life coach counselor	0.5%	0.6%
Rehabilitation counselor	0.5%	1.3%
Pastoral counselor	0.3%	1.5%
Career counselor	0.0%	0.8%
Counselor educator	0.0%	1.9%
Genetic counselor	0.0%	0.1%
Other	6.9%	16.7%

Gender

Most respondents who experienced a claim were female, as were most of the nonclaims respondents. According to the U.S. Bureau of Labor Statistics (2012), the breakdown of counselors by gender is 69.3 percent female to 30.7 percent male.

2 GENDER

Q: What is your gender?	Claims	Nonclaims
Female	77.1%	80.3%
Male	22.9%	19.7%

Age

The majority of respondents who experienced a claim were over the age of 50, with 39.4 percent falling between ages 51 and 60 years. The statistic contrasts with the nonclaims survey, which had a more even mix of counselors across all age brackets. Older counselors are more likely to experience a claim than their younger counterparts.

3 AGE

Q: What is your age?	Claims	Nonclaims
25 years or younger	0.0%	3.6%
26 to 30 years	0.8%	13.2%
31 to 35 years	5.2%	13.9%
36 to 40 years	6.9%	12.0%
41 to 45 years	10.8%	12.1%
46 to 50 years	4.4%	8.0%
51 to 60 years	39.4%	22.6%
61 years or older	32.5%	14.6%

Highest Level of Education

The overall distribution of education level was consistent between the claims and nonclaims groups. A large percentage of all survey respondents have a graduate degree.

4 HIGHEST LEVEL OF EDUCATION

Q: What is your highest level of education in counseling completed?	Claims	Nonclaims
High school or equivalent	0.6%	0.4%
Bachelor's degree	0.6%	5.7%
Master's degree	83.3%	78.5%
Doctorate degree	14.7%	14.8%
Postdoctorate degree	0.8%	0.6%

Location of Practice

The claims and nonclaims groups had a similar distribution of practice locations. Counselors practicing in a suburban setting (52.1 percent) had the highest percentage of claims, while rural-based counselors tended to have the lowest likelihood of experiencing a claim.

7 LOCATION

Q: Which of the following best describes the location where you provide services as a counselor?	Claims	Nonclaims
Rural	17.5%	17.9%
Suburban	52.1%	44.5%
Urban	30.4%	37.6%

Employment Status

While most respondents without claims were full-time employees, owners / partners were more likely to experience a claim than their nonclaim counterparts. (Note: The "Other" employment status refers to counselors working for a temporary agency.)

27 EMPLOYMENT STATUS

Q: At the time of the incident, what was your employment status? (Claims) Q. What is your current employment status? (Nonclaims)	Claims	Nonclaims
Owner / partner	42.2%	17.6%
Independent contractor, self-insured	27.7%	21.6%
Employed, full-time	21.8%	37.1%
Employed, part-time	6.8%	11.7%
Student	0.0%	5.4%
Other	1.5%	6.6%

Years as a Counselor

Respondents with less than two years of counseling experience accounted for 9.2 percent of total claims. Those in practice six to 10 years had the highest percentage of claims. Most respondents from the nonclaims group tended to be relatively new to counseling practice.

28 YEARS AS A COUNSELOR

Q: At the time of the incident, how many years had you been a licensed / certified counselor? (Claims) Q: How many years have you been practicing as a licensed or certified counselor? (Nonclaims)	Claims	Nonclaims
Less than 2 years	9.2%	28.0%
2-5 years	16.3%	21.4%
6-10 years	30.0%	18.5%
11-15 years	18.4%	12.9%
More than 15 years	26.1%	19.2%

Topic 2: About Licensure / Certification in Counseling

Completing a CACREP® Accredited Program

A majority of both claims and nonclaims counselors have completed a CACREP accredited program. The proportions of respondents who completed and did not complete such programs did not differ between the two groups.

9 HAVING COMPLETED A CACREP PROGRAM

Q: Did you complete a CACREP accredited program?	Claims	Nonclaims
Yes	57.8%	57.6%
No	42.2%	42.4%

Completing a Residency Program

Most claims and nonclaims counselors have participated in a residency program. Participation in residency programs did not appear to affect claims status.

10 HAVING COMPLETED A RESIDENCY

Q: Did you complete an internship / residency program?	Claims	Nonclaims
Yes	87.2%	84.5%
No	12.8%	15.5%

Number of Annual CE Credits Required

A majority of the counselors surveyed reported needing CE credits, with most (56.0 percent) needing at least 16 credits per year. The percentage of those who reported needing 15 or fewer credits is lower in the claims group than in the nonclaims group.

14 NUMBER OF ANNUAL CE CREDITS REQUIRED

Q: According to your state, how many continuing education credits are you annually required to complete to maintain your counselor license / certification?	Claims	Nonclaims
None	2.5%	9.6%
1-15	18.5%	23.5%
16-30	56.0%	48.5%
31-60	23.0%	18.4%

Topic 3: Setting Where Primary Services Are Provided

Regular Supervision / Peer Review

A majority of counselors said they routinely participate in a supervisory and / or a peer review process. Doing so appeared to have a beneficial effect on exposure to claims.

22 PARTICIPATION IN REGULAR REVIEW

Q: Do you participate in regular supervision and / or peer review?	Claims	Nonclaims
Yes	77.0%	81.8%
No	23.0%	18.2%

A majority of counselors said they routinely participate in a supervisory and / or a peer review process. Doing so appeared to have a beneficial effect on exposure to claims.

Topic 4: About the Claim Submitted

Breach in Confidentiality

The nonclaims respondents were less likely to report that they had breached a confidentiality principle than were the claims respondents.

31 BREACH IN CONFIDENTIALITY

Q: Was the incident related to a breach in confidentiality? (Claims) Q: Have you ever breached a confidentiality principle? (Nonclaims)	Claims	Nonclaims
Yes	11.2%	7.9%
No	88.8%	92.1%

Client as a Minor

Most incidents did not involve minor clients, and most nonclaims respondents did not believe that working with minor clients increased the likelihood of an incident.

35 CLIENT AGE

Q: Did the incident involve a minor client? (Claims) Q: Do minor clients increase the likelihood of an incident? (Nonclaims)	Claims	Nonclaims
Yes	36.0%	36.0%
No	64.0%	64.0%

Relationship with Client

The vast majority of counselors in both groups reported that they did not get involved emotionally or physically with clients.

37 CLIENT RELATIONSHIP

Q: Did you engage in an emotional or physical relationship with the client? (Claims) Q: Have you engaged in an emotional or physical relationship with a client? (Nonclaims)	Claims	Nonclaims
Yes	1.8%	0.4%
No	98.2%	99.6%

Clients Seen per Day

Most claims survey respondents see between three and five clients per day, which represents the category with the highest proportion of claims.

43 CLIENTS PER 8 HOURS

Q: At the time of the incident, how many clients did you see in an eight-hour period? (Claims) Q: How many clients do you see in an eight-hour period? (Nonclaims)	Claims	Nonclaims
1	2.7%	4.4%
2	5.7%	8.2%
3-5	58.3%	51.2%
6-10	29.4%	30.2%
11-15	3.0%	2.8%
16 or more	0.9%	3.2%

Treatment Type

Individual treatment sessions comprised 65.1 percent of claims-related incidents, but only 41.8 percent of nonclaims sessions. The percentage of claims was much lower for treatment involving both individual and group sessions, although this was the most common type of treatment for the nonclaims group.

44 TREATMENT TYPE

Q: At the time of the incident, which of the following best describes the type of treatment you provided to your client? (Claims) Q: Which of the following best describes the type of treatment you provide to your clients? (Nonclaims)	Claims	Nonclaims
The client was in individual treatment	65.1%	41.8%
The client was in couples, family or group treatment	23.6%	5.8%
The client was receiving both individual and group treatment	11.3%	52.4%

Disclosure of Error Policy

The majority of counselors who experienced a claim worked in a practice / facility that did not have a policy regarding error disclosure. This group reported a higher percentage of claims relative to settings with such a policy.

51 ERROR DISCLOSURE POLICY

Q: At the time of the incident, did your practice / facility have a policy regarding disclosure of error? (Claims) Q: Does your practice / facility have a policy regarding disclosure of error? (Nonclaims) *Note: Of those saying "yes," 73.5 percent used said policy in managing the incident.*	Claims	Nonclaims
Yes	31.1%	43.7%
No	68.9%	56.3%

Documentation Method

A majority of counselors rely upon handwritten medical records. However, sole reliance on handwritten records appears to produce a higher percentage of claims relative to the nonclaims group's documentation method. It appears that use of electronic medical records is associated with a smaller likelihood of claims.

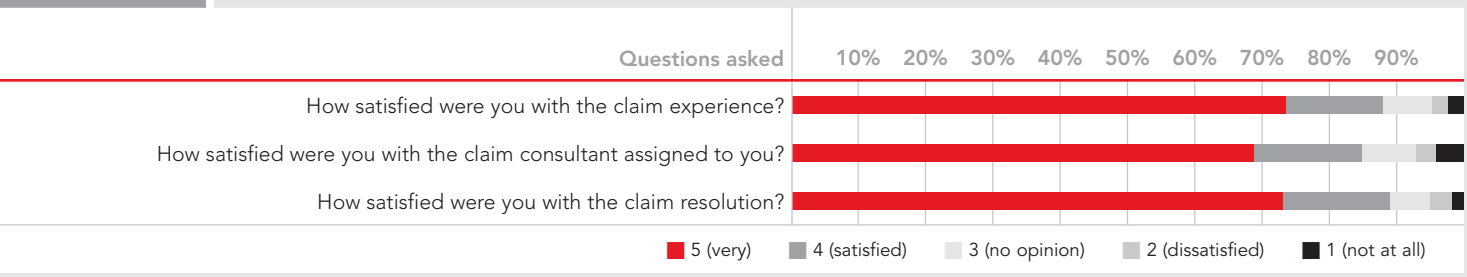
52 DOCUMENTATION METHOD

Q: At the time of the incident, which best described your documentation method? (Claims) Q: Which best describes your documentation method? (Nonclaims)	Claims	Nonclaims
I utilized handwritten medical records	66.1%	33.5%
I utilized a combination of electronic and handwritten medical records	20.4%	33.6%
I utilized electronic medical records	9.3%	25.9%
I did not document client sessions, interactions, information	0.3%	2.3%
I audio / videotape my sessions and retain the tapes	0.0%	0.7%
I audio / videotape my sessions, but do not retain the tapes	0.0%	0.4%
Other	3.9%	3.6%

Experience with the Claim Process

The graphs indicate that 74 percent of all respondents who experienced a claim were "very satisfied" with the claim resolution, 69 percent were "very satisfied" with the claim consultant and 73 percent were "very satisfied" with the claim experience.

53 EXPERIENCE WITH THE CLAIM PROCESS



54 SATISFACTION WITH THE CLAIM PROCESS

Questions asked	Average rating out of 5
How satisfied were you with the claim experience?	4.59
How satisfied were you with the claim consultant assigned to you?	4.46
How satisfied were you with the claim resolution?	4.57

Satisfaction with Policy Purchase

Almost all respondents with claims (99.1 percent) indicated they were thankful for the purchase of a professional liability insurance policy.

55 SATISFACTION WITH POLICY PURCHASE

Q: Were you thankful you had purchased your own professional liability policy? (Claims) Q: Do you have your own professional liability insurance policy? (Nonclaims)	Claims	Nonclaims
Yes	99.1%	98.2%
No	0.9%	1.8%

PART SIX

Risk Management Tools

Risk Management Recommendations

The following risk control recommendations – in addition to the strategies that follow the case studies in Parts Two and Three of this report – are designed to serve as a starting point for counselors seeking to assess and enhance their risk control practices.

Professional Liability Coverage

1. ***Ensure that supervising professionals, practice partners, and employing or contracting organizations maintain appropriate professional liability insurance limits,*** as required by the practice setting, state law and / or regulations.
2. ***If insurance is provided through the employer, review the policy and employment contract / agreement to determine if employment-based coverage is sufficient,*** or if it is advisable to obtain additional coverage for oneself. If coverage is employer-provided, determine how to ensure continued coverage if employment status changes or the employer changes insurers.
3. ***Ensure that individual professional liability coverage limits are aligned with the other members of the practice,*** in order to safeguard one's private assets against potential loss.

Scope of Practice

1. ***Perform only those actions that are included within the state scope of practice act,*** satisfy the licensure / certification requirements, adhere to the standard of care, reflect professional ethical guidelines and comply with employer policies / procedures / protocols.
2. ***Know and comply with the relevant state practice act.*** As governing / regulating / oversight bodies differ from state to state, research, know and comply with the scope of practice for each state where one is licensed or certified to practice.
3. ***Annually review the state practice act, other pertinent state and federal regulations, and employer policies and procedures.*** Counselors are responsible for knowing all regulations, laws and employee policies that apply to their practice, and for practicing within the most stringent of all applicable rules.
4. ***Seek additional information regarding scope of practice questions from the state-specific licensing / certifying body,*** as well as national, regional and local professional associations.
5. ***If practicing telecounseling or webcounseling, understand and comply with the scope of practice for each state where services are received,*** and comply with licensure and certification mandates in each state where clients reside.
6. ***When working for or contracting with multiple employers, understand and comply with all relevant policies and procedures.*** Employer / contracting organizational policies must never expand the counselor's scope of practice beyond the limits defined by the state.

Competence

1. *Maintain clinical competencies at a level that meets or exceeds the prevailing standard of care,* and reflects both the relevant client population and the licensed / certified clinical specialty.
2. *Proactively obtain whatever professional education and training are required to maintain and enhance clinical expertise.* Contact the ACA, state and / or local counseling professional associations, state licensing / certifying bodies, healthcare / mental health agencies and other counselor organizations for information about recognized educational offerings.
3. *Remain current regarding clinical practice, ethical standards and methods utilized for the diagnosis and treatment of clients' conditions,* and seek out new information and insights on clinical topics.
4. *Engage in regular peer review, supervisory counseling and / or continuing professional education* to maintain and enhance competence in one's specialty areas.

Diagnosis and Treatment

1. *Utilize evidence-based clinical practice guidelines or protocols when establishing a diagnosis and providing treatment,* and document both the clinical decision-making process and the clinical justification for deviations from protocols.
2. *Refer unstable clients for emergency inpatient treatment when necessary,* documenting the reasons for this action.
3. *Complete indicated diagnostic tests, referrals and / or consultations* before documenting the diagnosis and implementing the treatment plan.
4. *Consult with a supervising counselor whenever required,* including all cases where the client is difficult to diagnose or does not respond to treatment.
5. *If no collaborative or supervisory relationship is readily available, seek opportunities for peer review* within the practice or organization.
6. *Record all client noncompliance with the service plan,* as well as all counseling provided and other efforts made to encourage compliance.
7. *If noncompliance is due to a lack of health insurance or financial resources,* refer the client to appropriate social agencies and / or free or low-cost counseling clinics or related programs, and assist the client in making the transition.
8. *Maintain a clean and safe environment* to enhance the clinical experience and protect clients and others.

Professional Ethics

1. *Understand all laws or regulations that govern client interactions.* Ignorance of the law, employer policy or professional ethics does not absolve the counselor of the responsibility to act within established clinical, ethical and regulatory guidelines.
2. *At least annually, review the* ACA Code of Ethics, and understand the professional obligation to uphold the code.
3. *Practice in accordance with the standard of care, the limits of one's license / certification, and all regulations and ethical guidelines.* Seek peer review and / or clinical supervision as needed, and actively participate in continuing education programs relating to evolving ethical issues.

Client Privacy and Confidentiality

1. ***Obtain the client's written and dated authorization for the release of information to named parties*** – i.e., those with whom the counselor may communicate about treatment-related matters or share client documentation. Renew such authorizations on at least an annual basis.
2. ***Conduct and document a discussion with the client regarding information that may not be protected from release,*** including that relating to child endangerment / neglect / abuse, danger to self or others, and court-ordered disclosures. Obtain signed statements that the client understands these exceptions to privacy and confidentiality protections.
3. ***If practicing telecounseling or webcounseling, recognize potential issues regarding confidentiality, privacy, cyber stalking and identity theft.*** While telecounseling has existed for decades, webcounseling is an emerging risk, and counselors should use the most secure technology available to protect client confidentiality. Regularly review, upgrade or replace equipment, as necessary, to meet evolving technology needs and privacy standards.
4. ***Never ignore a subpoena.*** If the client has not authorized release of the requested materials and cannot be reached or will not provide authorization, obtain prompt assistance from a healthcare attorney.

Communication

1. ***Develop, maintain and practice professional written and spoken communication skills,*** as they are essential to providing quality care and minimizing risk.
2. ***Always consider what information to share, when to share it, how to share it (e.g., written versus spoken, in-person versus telephone or e-mail) and with whom it will be shared,*** in order to both communicate effectively and protect the client's privacy.
3. ***Ensure that verbal and written communications with the client or authorized third parties are timely, accurate, and relevant*** to the diagnostic and treatment needs of the client.
4. ***Determine the client's primary language and follow practice or organizational procedures regarding translation / interpreter services,*** in order to ensure that the client understands his or her diagnosis, treatment, plan of care and compliance responsibilities. Document the translator's name in the client's clinical record.
5. ***When covering for another counselor or transferring the client's care to another professional for any period, obtain client authorization and practice sound handoff communication methods.*** Always inform other professionals of necessary precautions and concerns regarding the client's health status.
6. ***If practicing telecounseling or webcounseling, understand the need to adjust one's communication style,*** in order to compensate for the absence of visual cues.

Clinical Records and Documentation

1. ***Retain client clinical records in accordance with relevant state and federal law,*** and consult state-specific recommendations issued by professional associations.
2. ***Perform periodic audits of clinical records*** to identify departures from documentation standards and determine opportunities for improvement.
3. ***Sequester the client clinical record if there is an incident of concern.*** When copies of client clinical records are released for legal reasons, the original records should be sequestered or maintained with limited access, in order to avoid allegations of tampering or making inappropriate late entries.

4. ***Designate an individual within the practice to manage legal demands regarding records,*** such as a request for client clinical records, a subpoena, or a summons and complaint. Solo practitioners should know how to manage requests and / or subpoenas for client records, depositions or court testimony. If questions arise, engage a healthcare attorney to answer questions regarding confidentiality, privacy or preparation for deposition or testimony. Again, never ignore or delay responding to a subpoena.
5. ***Safeguard counselor / patient records from loss and / or unauthorized access.*** This is especially important for counselors who lease and / or share office space.
6. ***Provide accurate, complete and current documentation,*** in order to enhance continuity of client treatment by another authorized counselor or healthcare provider. Documentation should support the treatment plan and satisfy third-party billing requirements.
7. ***If a documentation error occurs, it should be noted as such and corrected contemporaneously.*** Do not alter entries in any way once legal or regulatory action is initiated.
8. ***Know and comply with documentation requirements*** in accordance with state-specific practice acts, laws and regulations (for example, the Department of Health and / or Department of Mental Health, Child and Family Services, Department of Corrections, etc.), as well as prevailing standards of care and the policies of licensing bodies and employers or group practices. When more than one requirement applies, adhere to the most stringent.
9. ***When providing an assessment or evaluation of a client, include the date and time of the assessment, the specific findings and the length of time such findings are valid.*** For example, when assessing individuals or couples as adoptive or foster parents, include both an approval and expiration date, in order to ensure timely reassessment if necessary.
10. ***As a complete and accurate clinical record presents the strongest defense against any legal or licensing action, document the following information, at a minimum:***
    - the clinical decision-making process, as well as the client's diagnosis, service plan, response to treatment, results of diagnostic testing and / or consultation findings, and assessments of the client's risk of being a danger to self or others
    - session notes, including review and revision of problems and / or treatment plan, the client's response and any change in diagnosis
    - telephone encounters (including after-hours calls), documenting the name of the person contacted, advice provided and actions taken
    - dated and signed receipts of test results, referrals and consultations, including a description of subsequent actions taken
    - referrals for medical assessment and / or for the prescribing and monitoring of psychoactive medications
    - educational materials, resources or references provided to the client
    - the client's informed consent for proposed treatment and testing
    - missed appointments, including all efforts to follow up with the client
    - discussions regarding client privacy, confidentiality of personal information and possible exceptions to those protections
    - signed and dated consent forms for release of information, if necessary, to client-authorized parties, child welfare organizations in case of suspected child abuse, law enforcement personnel if the client is deemed to be a risk to self or others, and a court of law in response to an official court order or subpoena
    - counseling of noncompliant clients and / or responsible parties regarding the risks resulting from their failure to adhere to medication and treatment regimens

Sexual / Romantic Involvement

1. ***Prohibit and prevent any sexual activity with a current client.*** The *ACA Code of Ethics* (Section A.5.a) clearly states that such relationships are *never* ethically appropriate. Client consent to sexual relations or romantic relationships / activities of any kind does not waive the counselor's responsibility to prevent any such activity from occurring. The counselor will be deemed solely responsible and liable for any sexual or romantic relationship with a client, a client's significant other and / or a client's family member.
2. ***Manage transference and / or counter-transference with appropriate clinical techniques, obtaining clinical supervision and / or consultation as needed.*** If the transference / counter-transference cannot be successfully managed, the counselor should cease treatment, explaining the reasons for termination to the client and referring the client to another professional. Consult with the ACA and / or a healthcare attorney for additional assistance, if needed.
3. ***Document all instances of transference / counter-transference in the client's clinical record,*** including the counselor's clinical decision-making process, any supervisory counseling obtained and client discussion. If it is necessary to terminate the counselor-client relationship, record all supportive actions taken to assist the client in understanding the reasons for termination and obtaining alternative treatment.
4. ***Terminating the client does not cancel the prohibition against a sexual / romantic relationship.*** Cease written and verbal contact with the client upon termination and document any client communication attempts.
5. ***Do not engage in sexual activity or a romantic relationship with a prior or current client's significant other or family member.*** The *ACA Code of Ethics*, 2005 edition (Section A.5.b) states that such a relationship should not be entertained until at least five years from the last treatment date. Again, simply terminating treatment does not exempt the counselor from the responsibility for waiting the recommended period of time before considering a sexual / romantic relationship with a former client or anyone closely associated with the client. Even after the five-year waiting period has elapsed, consider whether such a relationship would be beneficial or potentially harmful to the client.
6. ***Avoid multiple relationships with clients, their significant others and their family members.*** This may involve declining invitations to participate in social / personal / family activities with the client or others outside of the treatment setting. Document all such invitations in the client's clinical record, as well as the response given and consequent communication. Occasionally, participation in such events may be beneficial to the client; refer to the *ACA Code of Ethics* (Section A.5.d.) for guidance. If the decision is made to participate, document the potential benefit to the client, the clinical decision-making process and the client's response.

Termination

1. ***If it becomes necessary to terminate the counselor-client relationship due to chronic non-compliance or other reasons,*** notify the client and offer to discuss the reasons. Draft and send a termination letter, retaining a copy in the client's file, and note the client's response to the termination decision.
2. ***Suggest at least three other counseling centers / counselors*** or professional resources to identify another counselor, and offer the client assistance in transitioning to a new counselor. Record the client's acceptance or refusal of assistance.
3. ***Obtain the client's written consent to provide the new counselor with a copy of his or her healthcare records.*** Note whether the records were forwarded, and if so, when and to whom.
4. ***Send all written communications via certified, registered mail*** and maintain the postal receipts in the client's clinical record, along with copies of all communications.

Supervising Counselors and Employers of Counselors

1. ***Provide appropriate clinical support for counselors,*** in compliance with supervisory or employment agreements.
2. ***Ensure that all parties understand each party's role under the agreement,*** and communicate openly and often about any question or concerns that may arise.
3. ***Know the current state scope of practice parameters for counselors,*** and do not ask staff members to go beyond their scope of practice.
4. ***Review all counselor agreements at least annually,*** and revise with the assistance of legal counsel, if necessary.
5. ***Implement standardized processes for credentialing counselors,*** and establish a process for routine review of counselor clinical privileges.
6. ***Ensure counselor competency through ongoing peer review and performance evaluation,*** focusing on the counselor's clinical conduct, documentation practices, ethical awareness and rapport with colleagues.

Ensure counselor competency through ongoing peer review and performance evaluation, focusing on the counselor's clinical conduct, documentation practices, ethical awareness and rapport with colleagues.

Counselor Risk Control Self-assessment Checklist

This resource is designed to help counselors evaluate risk exposures associated with their current practice. For additional counselor-oriented risk control tools and information, visit **www.cna.com** and **www.hpso.com**.

CLINICAL SPECIALTY	Yes	No	Action(s) needed to take to reduce risks
I work in an area that is consistent with my licensure, specialty certification, training and experience.			
I know that my competencies (including experience, training, education and skills) are consistent with the needs of my clients.			
I understand the specific risks of caring for clients within my clinical specialty.			
I decline an assignment if my competencies are not consistent with client needs.			
I ensure that my competencies and experience are appropriate before accepting an assignment to cover for another practitioner.			
I am provided with or request and obtain orientation whenever I work in a new or different client setting.			
I obtain continuing education and training, as needed, to maintain my competencies in my specialty.			

SCOPE OF PRACTICE AND SCOPE OF SERVICES	Yes	No	Action(s) needed to take to reduce risks
I read my state practice act at least once every year to ensure that I understand and comply with the legal scope of practice in my state.			
I know and comply with the requirements of my state regarding counselor or physician collaborative or supervisory agreements, and I review and renew my agreements at least annually.			
I comply with the requirements of my state regarding other regulatory bodies, such as the Department of Health and / or Department of Mental Health (if applicable).			
I collaborate with or am supervised by a counselor or physician as defined by my state laws and regulations and as required by the needs of my clients.			
I decline to perform requested actions / services if they are outside of my legal scope of practice.			
I am licensed / certified in each state in which I practice telecounseling, and I am aware of all applicable state-specific scope of practice regulations when telecounseling.			

ASSESSMENT	Yes	No	Action(s) needed to take to reduce risks
I elicit the client's concerns and reasons for the visit and address those concerns.			
I obtain and document a current list of the client's prescribed and over-the-counter medications, including vitamin supplements and holistic / alternative remedies.			
I compile, document and utilize an appropriate client clinical history, as well as relevant social and family history.			
I ascertain the client's level of compliance with currently ordered treatment and care instructions, medication regimens and lifestyle suggestions.			
I adhere to facility documentation requirements regarding assessment findings, documenting all pertinent information in a timely, accurate and appropriate manner.			

DIAGNOSIS	Yes	No	Action(s) needed to take to reduce risks
I utilize an objective, evidence-based approach, applying organization-approved clinical guidelines and standards of care to determine the client's differential diagnosis.			
I consider the findings of the client's assessment, history and psychological examination, as well as the client's expressed concerns, in establishing the diagnosis.			
I perform and document appropriate assessment techniques before arriving at the diagnosis.			
I consult with my collaborating / supervising counselor or physician, as required, to establish the diagnosis and treatment plan, and I document all such encounters.			
I request, facilitate and obtain other appropriate consultations, as necessary, to determine the correct diagnosis.			
I comply with the standard of care and my facility's policies, procedures, and clinical and documentation protocols when establishing the diagnosis.			
If a client is unstable and in need of immediate emergency treatment, I refer him or her to hospital emergency care, facilitating this process if necessary.			
If an assessment technique involves risk, I conduct and document an informed consent discussion with the client and obtain the client's witnessed consent.			
I obtain, document and respond to the results of consultations with other counselors, physicians or other healthcare providers.			
I establish the diagnosis, determine a treatment plan, document decision-making, and order and implement the treatment and care plan.			
I discuss findings, assessment results, the proposed treatment plan and reasonable expectations for a desired outcome with clients, and ensure their understanding of their care or treatment responsibilities. I document this process, noting the client's response.			
I counsel the client regarding the risks of not complying with treatment and consultation recommendations. If noncompliance is potentially affecting the safety of the client and regular counseling has been ineffective, I consider discharging the client from the practice.			
If the client is uninsured or unable to afford necessary counseling services, I refer him or her for financial assistance, payment counseling and / or free or low-cost alternatives.			
I regularly seek peer review to evaluate my assessment skills and expertise, and to identify opportunities for improvement.			

TREATMENT AND CARE	Yes	No	Action(s) needed to take to reduce risks
I educate the client regarding the diagnosis, treatment plan, and need for compliance with treatment recommendations, medication regimens and screening procedures.			
I discuss the client's treatment plan and ongoing response to treatment with my collaborating / supervising counselor or physician, as required and appropriate.			
I facilitate emergency medical treatment in the event of a crisis.			
I conduct and document an informed consent discussion with the client prior to implementing any aspect of the treatment plan that involves potential risk.			
I utilize regular assessment techniques and obtain consultations, as needed, to appropriately manage the client's condition(s).			
I schedule follow-up visits to monitor the client's response to treatment, and I adjust the client's treatment plan, as needed and appropriate.			
I remind clients of regular appointments and document these reminders.			
I contact clients after missed appointments for rescheduling and document these contacts.			
I explain to clients that if they are noncompliant to the point of self-endangerment or creating a liability risk, I may be forced to withdraw my care. I document this interaction.			
I counsel noncompliant clients about the risks and possible consequences of such behavior.			
I write legibly and use no abbreviations.			
If a late entry must be added to the client's record, I solicit advice about how to do so from my supervising counselor or physician, my organization's risk manager and / or legal counsel.			
I educate my clients regarding the desirability of adhering to medication regimens and beneficial dietary and lifestyle modifications.			
I terminate from treatment persistently noncompliant clients, assist them in transitioning to another healthcare provider, and document actions taken and support provided.			

COMPETENCIES	Yes	No	Action(s) needed to take to reduce risks
I attend continuing education and training sessions in compliance with state licensing regulations and facility requirements.			
I remain current regarding practice, medications, treatment and tools utilized for the diagnosis and treatment of conditions related to my clinical specialty.			
I consult regularly with my collaborating / supervising counselor or physician to ensure my competencies are appropriate and sufficient.			
I engage in peer review and / or quality review in my organization / practice.			
I participate in quality improvement and client safety committees or initiatives in my organization / practice / professional organization, in order to enhance my clinical competencies and client safety awareness.			
I contact the ACA to identify learning opportunities in my region and state, and seek additional learning opportunities through professional organizations.			

Your Role and Responsibility in Managing a Professional Liability Claim

The following strategies can significantly reduce professional liability risks. Also included are steps to take if you believe that you may be involved in a legal matter related to your practice:

- If you carry your own professional liability insurance, immediately contact your carrier if you become aware of a filed or potential liability claim against you, receive a subpoena to testify in a deposition or trial, or have any reason to believe that your license to practice may be threatened.
- If you carry your own professional liability insurance, report possible claims-related actions to your insurance carrier, even if your employer advises you that the organization will provide you with an attorney and / or cover you for a professional liability settlement or verdict amount.
- Refrain from discussing the matter with anyone other than your defense attorney or the claim professionals managing your claim.
- Promptly return calls from your defense attorney and the claim professionals assigned by your insurance carrier.
- Contact your attorney or claim professional before responding to calls, email messages or requests for documentation from any other party.
- When reporting a possible claim, provide your insurance carrier with as much information as you can, including contact information for the risk manager at your organization and the attorney assigned to the case by your employer.
- Never testify in a deposition without first consulting your insurance carrier or, if you do not carry individual professional liability insurance, your organization's risk manager or legal counsel.
- Copy and retain the summons and complaint, subpoena and attorney letter(s) for your records.
- Maintain signed and dated copies of all employment contracts.

Conclusion

Knowing the risks that confront today's counselors represents the critical first step in the process of enhancing quality of care, serving clients appropriately and reducing liability exposure. The claims data, analyses and risk control recommendations contained in this resource are intended to inspire counselors nationwide to carefully examine their practices, dedicate themselves to client safety and well-being, maintain appropriate boundaries and confidentiality, and direct their risk control efforts toward the areas of statistically demonstrated liability and loss.

In addition to this publication, CNA has produced numerous studies and articles that provide useful risk control information on topics relevant to healthcare professionals. These publications are available by contacting CNA at 1-888-600-4776 or at **www.cna.com/riskcontrol**. Healthcare Providers Service Organization (HPSO) also maintains a variety of online materials, including newsletters, articles, and useful clinical and risk control resources, as well as information relating to counselor professional liability insurance, at **www.hpso.com**.

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