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Can You Offer a First Session for Free?

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

Dr. Samuel Knapp

Would it be an effective or ethical marketing tool for a psychologist to offer the first session of therapy for free? Proponents argue that it offers patients an opportunity to learn about the psychologist, the nature of therapy, and ask whatever questions they might have. Nothing in the APA Ethics Code or State Board of Psychology regulations prohibits such meetings and it may help patients become better informed about the nature of therapy. In addition, psychologists could conduct such consultations in a manner consistent with General Principles of the APA Ethics Code, which urge psychologists to help patients and to respect their autonomous decision making. Critics argue that offering a first session free may actually harm patients if it lures them into therapy and encourages them to disclose difficult information only to have the psychologist refer them elsewhere because their problems were not within the scope of the psychologist's practice, or they lacked the financial resources to commit for a reasonable length of treatment.

In looking at this situation it is necessary to ask what is meant by a first free session. Does it mean giving the patient a 90791 (together with a detailed family history) without any charge? Or does it mean something else?

In making the decision about giving a first session for free, psychologists need to ensure that they clarify to the patient what they are offering. If they intend to have a brief (15 minute) consultation to meet the patient and discuss the general nature of therapy, then this should be communicated to the prospective patient. If that is what is being offered, then it may not be precise to refer to this as a "free session," because the word session is commonly used to refer to a professional

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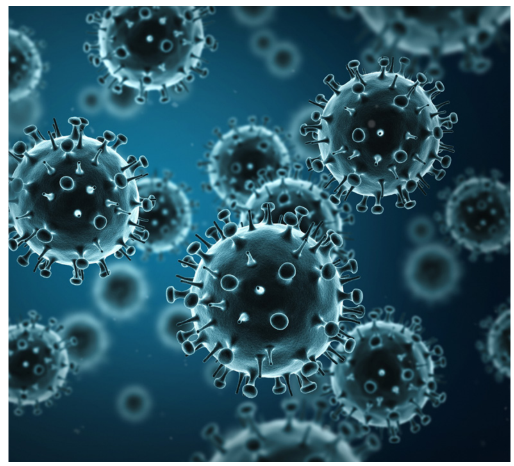

Health Concerns in the Office

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

A patient comes in to therapy with a runny nose and sneezes. This patient apparently has a cold. Should the psychologist still shake hands with the patient? What if it is not just a cold, but the beginning stages of the flu?

Such encounters are inevitable, but how can psychologists reduce the risk of catching a cold themselves or passing on colds to other patients? Once, when treating a patient with a fairly routine session, I asked the patient if he would like to leave early, given that the cold appeared to

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Are Client Productions Part of the Medical Record?

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

Consider the following situation:

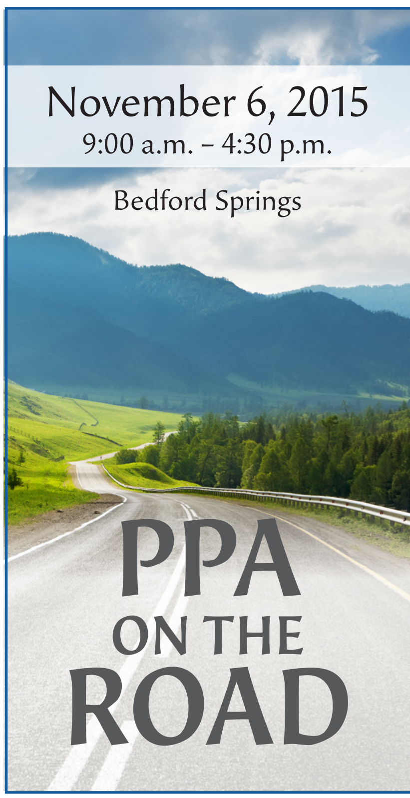
> *A patient wrote a very emotional and revealing letter to her psychologist. Six months later she contacted the psychologist and asked the psychologist to destroy the letter. The psychologist wondered if he can destroy the letter.*

If the patient simply wanted the letter back, then the psychologist could easily photocopy the original letter and keep that copy in the patient's chart. But in this situation, the patient requested that the psychologist destroy the letter. Although psychologists should not destroy portions of the medical records of an active patient, the issue arises as to whether these patient productions are a part of the patient's medical record.

I could find no regulation, statute, or court case that sets a standard for keeping productions of patients in the medical record. Neither the Pennsylvania State Board of Psychology nor the guidelines for the American Psychological Association make reference to keeping patient productions.

We can imagine different scenarios concerning patient productions. For example, a child patient may give her psychologist rather routine drawings that have little clinical significance. The decision to keep or discard these productions would appear to have no meaningful impact on the quality of documentation. On the other hand, some patients may write letters, poems, or create art work that reveal deep emotions or experiences that very much influence how the psychologist thinks about the case or treatment.

I recommend including any information in the chart that influences how the psychologist diagnoses or treats the patient. Depending on the content of the letter and how it relates to the needs of the patient, it is possible that the psychologist could view the letter in its entirety as essential to understanding the patient and refuse to destroy the letter. Nonetheless, if at all possible, it is prudent to defer to reasonable patient requests. In most situations, I suspect that psychologists only need to note that the patient gave them a letter which, upon the request of the patient was subsequently destroyed, but nonetheless document the clinical meaning of the letter. If it would be helpful, the note in the patient's medical record could include direct quotations from the letter.



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Future Directions in Maintaining Professional Competence

Maintenance of Certification (MOC)

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

For psychologists and other health care professionals, the most common mechanism for ensuring continued competence is through mandating continuing education as a condition of licensing renewal. Mandatory continuing education for health care professionals has been a success in many ways. The mandate has increased the amount of continuing professional development that health care professionals receive (especially for a minority of practitioners who tended to engage in no professional development activities). Also, some continuing education programs with physicians will result in improved patient outcomes, and one study with physicians found that an increase in the amount of group continuing education was associated with a decrease in patient complaints (Wengerhofer et al., 2015).

This is not to suggest that there is no room for improvement in the quest to ensure continued professional competence. The goals of mandatory continuing education are modest and focus only on providing a floor or minimal amount of continuing professional development that a practitioner should have. Although lectures may be an important component of an overall effective learning sequence; many CE programs rely too much on lectures and do not allow sufficient time for group interactions or direct applications.

In response to these and other concerns, the American Psychological Association (2013) adopted a resolution on continuing education which called for, among other things, the use of evidence-based educational interventions, assessment of outcomes, active learning techniques, and a link "between program content and the application of this content with the learner's professional environment."

Within medicine, an effort is underway to consider other ways to ensure professional development including recredentialing examinations for physicians with board certifications. Currently physicians qualify for board certification by completing an approved residency and then passing a board examination (Nora & Wynis, 2015). Heretofore, physicians received board certification for life. However, achieving board certification at one point in time does not ensure that the physician has kept up with changes in the health care field.

The recredentialing examination process (called maintenance of certification or MOC) is not without questions or challenges, however. Some specialties have narrowed so much that it is difficult to find assessments useful for everyone;[1] there is time, cost, and emotional investment in the recredentialing process; and the costs of failure can be substantial to practitioners and their patients (Irons & Nora, 2015). Moreover, the data on the actual benefits to patient care of time-limited certification vs. time-unlimited certification outcomes is mixed (Lee, 2015).

Within psychology, the American Board of Professional Psychology (ABPP) has instituted a Maintenance of Certification process which is mandatory for those board certified after January 1, 2015, but voluntary for those board certified before that date (American Board of Professional Psychology, 2015). Also, the Association of State and Provincial Psychology Boards (ASPPB)[2] has completed its own task force report on maintenance of competences (n.d.). ASPPB's task force saw benefits in moving toward a competence-based relicensing process. Still, it cautioned that such a process should not take [too much] time away from the delivery of services or efforts to build their practices, be overly rigid with respect to mandated content or CPD procedures, or unduly expose them to board discipline (p. 5).

The task force did not recommend a specific model for assessing continued competence. Nonetheless, it did establish some general principles to guide such a process. Ideally, the task force opined, this process would involve a professional development plan that would focus on the competencies that psychologists actually need in their work. It would rely heavily upon the self-assessment of the individual psychologist. It would establish work-relevant goals and allow psychologists to count learning activities that currently do not meet existing continuing education requirements.

Many practical and legal barriers need to be considered before the MOC process will become embedded in the regulation of professional psychology. Currently licensed psychologists will probably never be required to take a recertification examination. However, it may become a reality for those who are currently psychology students.

[1]I know psychologists with very highly specialized practices, such as reviewing BHRS evaluations, conducting pre-adoption evaluations, treating patients with transgendered issues, etc. The challenge would be to develop an evaluation that would be meaningful to their highly specialized areas of practice.

[2]ASPPB is the association of licensing boards from Canadian provinces and territories and American states, territories and the District of Columbia. Among other activities, ASPPB develops the Examination for the Professional Practice of Psychology (EPPP), and provides background information and resources for psychology licensing boards. The recommendations of ASPPB are not binding on any state, province, or territory. Nonetheless, they do reflect current thinking of some of the leaders in the regulation of professional psychology.

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HEALTH CONCERNS IN THE OFFICE

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interfere with his ability to benefit from the session. What about patients who appear able to benefit from treatment, even while sick? The Centers for Disease Control (CDC) emphasizes the importance of hand hygiene. Psychologists, like other health care professionals, should wash their hands routinely throughout the day and especially after encounters with infected patients. They should keep and use hand sanitizers and have disposable tissues available. They should clean their offices periodically (including wiping down door knobs and other objects commonly touched) and they can further reduce the spread of infections by being lenient with patients who cancel late because of illness.

How should a psychologist respond if a patient reports having bed bugs? Not only do psychologists risk becoming infected, but the infections may spread to other patients as well. Bed bugs are not confined to areas of poverty or a sign of uncleanliness, although there is a public perception to the contrary. The health concerns created by bed bugs is unclear; evidence that they transmit serious diseases is lacking (Harrison & Lawrence, n.d.). Nonetheless, the business implications of bed bugs are very clear; few events would reduce the caseload of a psychologist quicker than a rumour that the office contained bed bugs. Bed bugs may travel unobtrusively by embedding themselves in luggage, folded clothes, or areas ordinarily shielded from light. Transmission through ordinary clothing is rare, but it could occur.

Should psychologists bar patients who have bed bugs from their offices, at least until the infection has been addressed? That is certainly one option; however, entomologists claim that washing clothes kills bedbugs (Harrison & Lawrence, n.d.). Consequently psychologists may wish to have candid, but tactful conversations with their bed-bug infested patients about the need to wear newly laundered clothes before they come into the office of the psychologist.

On rare occasions, a psychologist may receive a request for outpatient services from a patient with Methicillin Resistant Staphylococcus Aureus (MRSA). In such cases, psychologists need to rely on the evaluation of the patient's physicians as to whether their patients are able to attend outpatient sessions without risking infecting others.

It is impractical to list every potential infection that a patient may bring in the office. Nonetheless, I have found advice from the CDC to be helpful. Although the advice is usually geared to outpatient medical practices or institutions, psychologists can usually discern reasonable precautions from the descriptions of the disease or condition and its management.

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Building Sign-In Sheets

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Because of increased concerns about security, many office buildings are requiring all visitors to sign a sign-in sheet that includes their names and destination. Sometimes these building requirements were imposed recently, long after the psychologist had already signed a lease, moved in, and started seeing patients.

Sign-in requirements can create a problem for patients for whom privacy is very important. Although the act of signing in may be minimally intrusive, there is a concern that other visitors may see the name of an acquaintance in the sign-in sheet and learn that he or she is visiting the office of a psychologist. Such actions are not HIPAA violations because the building managers or owners are not health care professionals covered by HIPAA. In addition, not everyone who visits a psychologist is receiving health care.

How should psychologists respond when their office building requires sign- ins? Some psychologists have found acceptable compromises to this requirement. For example, some building managers have agreed to allow the patients to sign in with a pseudonym (John or Jane Doe) or to have patients sign in with the room number of the psychologist as the destination (not the name of the psychologist). Furthermore, psychologists can ask the building managers to ensure that they lock away the sign in sheets so that they are not available for everyone to see. Finally, some psychologists have found it prudent to let prospective patients know ahead of time that this is a building requirement, thus affording prospective patients the opportunity to seek health care elsewhere if they so choose.

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We know that we have outstanding members of the psychological community – both psychologists and non-psychologists – in Pennsylvania who go above and beyond in their everyday lives.

Please consider taking a moment to submit a nomination for one (or all!) of PPA's three prestigious awards. Deadline for entries is **October 20**.

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  The Distinguished Contributions to the Science and Profession of Psychology Award is to be given to a Pennsylvania psychologist for outstanding scientific and/or professional achievement in areas of expertise related to psychology, including teaching, research, clinical work, and publications. http://www.papsy.org/?page=DistContAwards

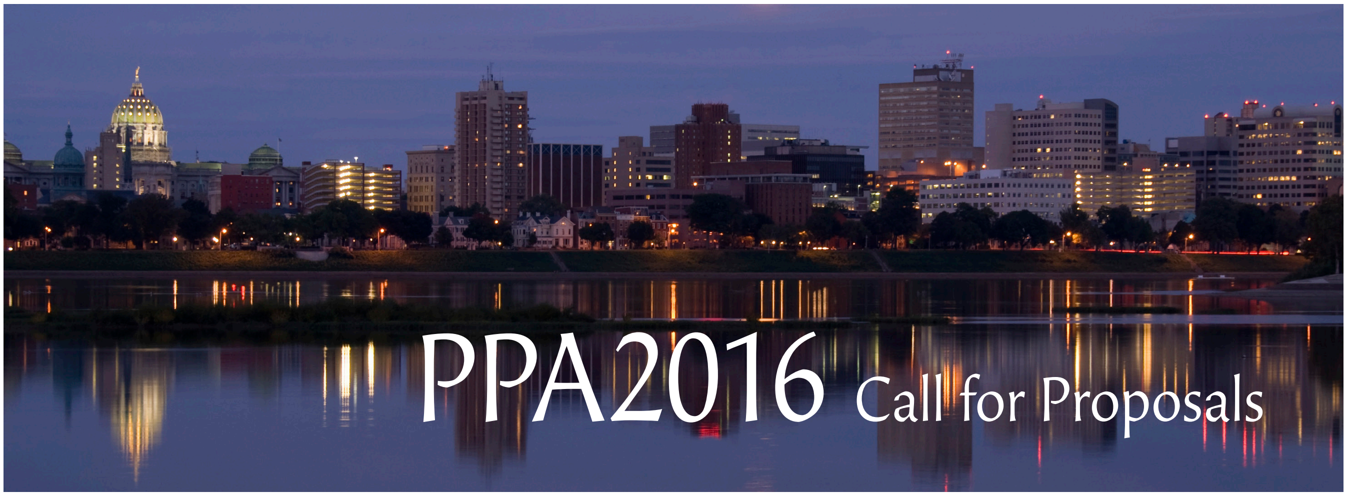
- **Distinguished Service Award**

  The Distinguished Service Award is to be given to a member of the association for outstanding service to the Pennsylvania Psychological Association. http://www.papsy.org/?page=DistServAward

- **Public Service Award**

  The Public Service Award is to be given to a member (individual or organization) of the Pennsylvania community in recognition of a significant contribution to the public welfare consistent with the aims of the association. http://www.papsy.org/?page=PubServAwar

Contact Judy Smith (judy@papsy.org) for any questions regarding this process.



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Confronting Interpersonal Violence Throughout the Life Span

The 2016 PPA annual convention will address multiple areas of interpersonal violence, including the lasting impact of these experiences on the attainment of developmental stages, positive interpersonal relationships, and healthy coping skills. Areas that will be addressed include child abuse, domestic violence, intimate partner abuse, school violence including bullying, workplace violence, elder abuse, abuse of the disabled, and sexual abuse across the lifespan.

The goal is to establish strategies to help our communities move from cultures of detachment and violence to cultures of cooperation, peacefulness, and nonviolence. Topics will seek to identify ways to highlight psychology's value in homes, schools, workplaces, and our communities at large. We, as psychologists, can become change agents by working with other professionals and agencies to identify causes that fuel violence and develop concrete tools that address and remedy these issues. Nonviolence can be promoted through advocacy and the dissemination of educational tools that reinforce an evolving view of cultural differences, self-awareness, violence, and trauma.

All topics submitted will be reviewed by the Convention Committee, but special consideration will be given to topics that relate to this year's theme. Submit your proposal online at http://www.papsy.org/?page=Convention.

Questions about this process?
Please contact Judy Smith at
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CAN YOU OFFER A FIRST SESSION FOR FREE?

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intervention. In addition, the psychologist can clarify the nature of the meeting through a brief phone call with the patient to ensure that the presenting problem is likely to be within the scope of practice of the psychologist (e.g., you do not want a parent coming in for child-related issues if you do not treat children) and that the patient has the financial resources to accept your services (either they have enough money to self-pay or they are on an insurance panel that the psychologist accepts).

One psychologist does not charge patients for the first session if she determines that the patient is inappropriate for treatment. She figures that the good will generated by the action will mitigate any disappointment or anger that the patient may feel about being referred. Another psychologist does charge, arguing that she offers a professional service and makes a clinical judgment and diagnosis which she shares with the patient, and uses her professional judgment in recommending appropriate referrals.

What legal obligations do psychologists incur if they see a patient for a free first session? The nightmare of a psychologist is that this free "patient" would be highly disturbed and generate obligations on the part of a psychologist to respond to an emergency with little background information or relationship to guide their deliberations. Also, in the highly unusual situation where a patient makes a serious and imminent threat to kill an identifiable third party and has the means and intention to follow through with the threat, a psychologist would have a duty to protect the third party, even if the information was obtained during the free consultation. Again, this unlikely scenario could be made even more unlikely by having a brief phone conversation with the patient before the first session.

What conclusions can be drawn about the effectiveness or ethical implications of offering patients a first session or consultation for free? Psychologists can ensure that such consultations help prospective patients, if they screen those prospective patients and clarify the goals and limits of the consultation ahead of time.

Classifieds

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PPA On the Road – CE Workshop
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June 15 – 18, 2016
PPA Annual Convention
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Contact: judy@papsy.org

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Registration materials and further conference information are available at www.papsy.org.

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