Summary of Considerations for APA Ethical Standards Revisions

Submitted by the Integrated Care Ethics Workgroup

Members:
Doug Tynan, PhD, ABPP (co-lead)
Jeff Reiter, PhD, ABPP (co-lead)
Kevin Arnold, PhD, ABPP
Kathy Ashton, PhD, ABPP
Anne Dobmeyer, PhD, ABPP
Elena Eisman, EdD
Parinda Khatri, PhD
Linda Knauss, PhD, ABPP
Christine Runyan, PhD, ABPP
Neftali Serrano, PsyD
Barbara Ward-Zimmerman, PhD

Process Overview

Psychologists working in integrated care have for many years expressed concern in presentations, books, peer-reviewed articles and other mediums about difficulties that commonly arise when applying APA’s Ethical Standards to their work in the relatively new field of integrated care. This workgroup formed in response to these concerns. A main goal of the workgroup is to ensure APA’s Ethics Code Task Force (ECTF) is aware of these issues as they consider revisions to the Standards in 2020.

This workgroup consists of psychologists from a wide variety of integrated care settings, as well as ethics specialists and APA representatives. The workgroup convened in March, 2019. The initial work product is this document, which contains recommendations for the ECTF. This document first provides background information, explaining the various ways that integrated care work often results in ethically challenging situations for psychologists. It then provides recommendations pertaining to specific Standards.

Because the Standards are being modified broadly by the ECTF, the goal of this workgroup was not to suggest specific wording changes to the Standards, but rather to highlight important issues for ECTF to consider in their revision.

In the course of its work, the workgroup noted many instances where the most significant challenges for the integrated care field lie not in adhering to the Ethical Standards as written, but rather in the interpretation of Standards that often happens in the field. Such interpretations put an undue burden on integrated care trainers, administrators and clinicians by questioning their ethics in situations where a clear reading of the Standards does not support such criticism. Challenges for the field also occur with respect to how government (both State and Federal) has translated some of the Standards into laws that inhibit integrated care. Thus, this workgroup plans as its next step to develop guidance
for the field to promote an improved understanding of the revised Ethical Standards, with respect to integrated care.

**Background**

In this “Background” section we outline the features of integrated care that often lead to challenging ethical situations under the current Standards. In the following section (titled “Review of Specific Standards”) we elaborate on this Background by providing examples of the challenges posed by specific Standards and make recommendations for revising those Standards.

Generally speaking, challenging ethical situations for integrated care psychologists occur when standards developed to guide the work of psychologists in the mental health system conflict with the demands of work in integrated care settings. The more psychologists assimilate into the medical culture and align their practice behaviors with those of the medical team, the more likely they are to encounter such challenges. This is particularly true for those in integrated primary care because of the unique goals, function and structure of primary care.

For example, psychologists in integrated primary care engage with patients for potentially many years/decades over the lifespan, because primary care is structured around a “birth-to-death” longitudinal relationship between patients and the primary care physician (PCP) and team. Visits occur episodically, separated by weeks, months or even years; the concept of “termination” of care does not typically apply. Thus, ethical standards geared toward a traditional psychotherapy relationship sometimes do not translate well to psychologists in integrated primary care.

Additionally, integrated care in both specialty and primary care settings often utilizes an interdisciplinary team model. Such teams must share information freely and be highly accessible to each other in order to functional optimally. Team members (including psychologists) are commonly expected to engage with patients with little or no notice throughout the day, and to be highly transparent with other team members regarding information obtained during patient visits. Ethical standards written for more traditional solo providers or mental health team models can be challenging to apply to an interdisciplinary team environment.

Another source of challenges encountered when applying the current Standards to integrated care comes from the generalist role that psychologists in primary care often fulfill. As the healthcare system’s point of entry for most concerns and patients, and the part of the healthcare system most responsible for preventive care, providers in primary care must function as generalists. Thus, psychologists whose role is to support the primary care provider and team are also commonly expected to be generalists. Most see patients of all ages, including pediatric, adult and older adult populations; provide preventive, acute and chronic care; and treat all manner of health concerns. Generalists, by definition and necessity, do not provide the type of care that would be provided by a specialist. Thus, standards written for traditional mental health settings (where therapists
must practice more like specialists in that they focus on conditions they have particular expertise in) can result in challenges for psychologists filling a generalist role.

Related to the preceding paragraph, providers in integrated care are largely unable to select patients in or out of their practice. In integrated care, the patients are typically selected by the medical practice’s population rather than the psychologist. Additionally, as the safety net of the healthcare system, primary care serves all patients, treating or helping treat problems of all complexities and types. Thus, psychologists working as team members in integrated settings need to adapt to their setting’s population and be willing/able to assist with it. Ethical standards written with the assumption that psychologists generally have control over who they engage with (i.e., selecting patients who best fit their competencies) can sometimes create challenges for psychologists in integrated settings who have less control.

Providers in integrated care also encounter ethical challenges when servicing multiple members of a given family. This is particularly true in primary care, where the care of multiple family members is the norm and where the longitudinal nature of care (discussed earlier) often results in various family members seeking help for various problems over the course of years. Sometimes family members present individually for concerns that they want to keep confidential from the rest of the family; sometimes they are seen collectively, with concerns discussed openly in front of all present in the exam room. Such situations do occur at times in traditional mental health settings as well, but what distinguishes primary care is the sheer volume of such encounters, together with the challenges of managing confidentiality in these relationships over the course of many years.

Lastly, ethical challenges arise when integrated care settings require psychologists to alter the traditional structure of patient encounters. For example, the primary care setting is intended to be highly accessible, so that patients can receive care when they most need it. In order to fulfill this potential, PCPs must see a very high patient volume, and in order to see this high volume they must rely heavily on help from the primary care team. Thus, psychologists who function as team members often need to be highly accessible and see a high patient volume in order to be of value. To accomplish this, these psychologists must utilize shorter visits and a different (less extended) follow-up structure than a traditional therapist. As such, ethical standards written with an assumption of longer visits and more controlled access to the psychologist may at times conflict with the practices of primary care psychologists.

Of note, the nature of the work performed by psychologists in integrated care does vary. Some practice very similarly to how they would in a traditional setting; as such, they might not experience as many potential issues with the Standards. However, many psychologists alter their practice considerably when working in integrated care. For example, in primary care many work as generalists, assisting patients of all ages, with any sort of behaviorally-influenced health condition, and any level of complexity for preventive, acute and chronic care needs; they prioritize and strive for same-day patient
access, accepting interruptions to visits when team members ask for their help; they function as a regular part of the team, providing frequent curbside consultations, regular case discussions and documentation that are accessible to the entire team; and they utilize brief (e.g., 10- or 30-minute) visits and a consultative follow-up structure in order to ensure access and service a high patient volume. These psychologists are typically the ones who have the most frequent issues with their practice behaviors and interpretations of the current Ethical Standards.

The workgroup asks that all of the above be kept in consideration by the ECTF when revising the Standards. In addition to this general background, the following are concerns and recommendations regarding specific Standards that the workgroup respectfully asks the ECTF to consider.

Review of Specific Standards

**Standard 1. Resolving Ethical Issues**

*Concerns:* When working in teams, psychologists may observe potential ethical violations by team members of other professions (e.g., a nurse or physician). Standard 1.04 discusses the informal resolution of ethical violations by other psychologists, but there is currently no guidance regarding how a psychologist should handle potential ethical violations by team members from other professions.

*Recommendation:* Provide guidance for how to handle situations in which a psychologist witnesses possible ethical violations by team members of other professions. (Note that this workgroup realizes it likely is not feasible to require psychologists to be knowledgeable of the ethics codes of other professions, but we believe that outlining general principles to follow when such concerns arise would be helpful.)

**Standard 2. Competence**

*Concerns:* This standard [especially in 2.01(d) and 2.02] discusses how psychologists should handle situations in which “appropriate mental health services are *not available*” for patients who the psychologist does not have the “competence necessary” to help. Integrated care psychologists often are asked to see patients who, for a variety of reasons, do not access “appropriate” mental health services even though those services are technically “*available*” to them. These patients commonly present with conditions the psychologist does not have specific training for. However, as noted in the “Background” section above, many integrated care psychologists are not providing traditional therapy; rather, they are part of a team-based care approach in which their role is better labeled “consultation” than “therapy.” This approach should enable them to assist with patients who they might not elect to engage with in a traditional therapy role. (Indeed, this workgroup actually questions whether it is ethical *not* to assist when in such a role.)
Relatedly, 2.02 states that in emergencies, psychologists seeing patients who they “do not have the necessary training for,” should “discontinue (care) as soon as the emergency has ended or appropriate services are available.” But for psychologists working in the longitudinal care model of primary care this is problematic because these psychologists should generally not be “discontinuing” care with any patient. Further, as noted in the preceding paragraph, primary care patients often do not access recommended services even when they are “available.”

Thus, the concerns are that this standard is not worded broadly enough to accommodate the work of integrated care psychologists who function as a consultant in a team-based approach (especially those in primary care).

Recommendations: Consider wording that encourages psychologists to engage with patients not accessing recommended/appropriate mental health services when the psychologist is part of an integrated care team that is continuing care to the patient.

Avoid wording that prompts psychologists to “discontinue” services to patients in primary care.

Standard 3. Human Relations

Concern: None

Recommendation: None

Standard 4. Privacy and Confidentiality

Concerns: A central component of good team-based care is the free flow of information between team members. In integrated care models that utilize psychologists as members of a team, the psychologists must be able to freely share relevant patient information with other team members as needed. This is important not only for quality of care issues but also for safety issues. For example, psychologists may learn during a patient visit of prescription medication abuse, high-risk sexual behavior, interpersonal violence or other behaviors with significant health and safety implications. Such information is clearly important for other members of the patient’s healthcare team to be aware of. However, this Standard as currently written contains wording that can be easily misunderstood by psychologists, thereby creating barriers to this information flow. For example, Standard 4.06 instructs psychologists to be protective of information when “consulting with colleagues,” wording that can easily be misconstrued as restrictive for psychologists who consult with physician colleagues and others throughout the day as part of team-based care.

This workgroup contends that psychologists in integrated settings all too often are overly protective of important health information that should be shared with relevant team members, potentially limiting the value of integrated care and even placing patient safety at risk.
Recommendations: Adopt wording that more clearly encourages the sharing of relevant health information with appropriate team members (assuming the usual practice of informing patients of this practice at the outset of care).

Standard 5. Advertising and Other Public Statements

Concern: None

Recommendation: None

Standard 6. Record Keeping and Fees

Concerns: Concerns about this Standard are similar to those described for Standard 4. For psychologists on integrated care teams, sharing information in medical records with other members of the team (as appropriate) is a key to effective care. Wording in this Standard, however, can easily dissuade psychologists from such sharing. For example, 6.02b instructs psychologists to “use coding or other techniques” to guard against disclosure of information to “persons whose access has not been consented to;” this sometimes is misunderstood by psychologists who insist on using “firewalls” or other such protective measures to block team members from accessing their clinical documentation.

Recommendations: Adopt wording that more clearly encourages the sharing of relevant health information with appropriate team members (assuming the usual practice of informing patients of this practice at the outset of care).

Standard 7. Education and Training

Concern: None

Recommendation: None

Standard 8. Research and Publication

Concern: None

Recommendation: None

Standard 9. Assessment
Concerns: Psychologists in integrated care frequently administer, score and interpret screening and outcome measures (e.g., the PHQ-9) for common conditions. It is unclear how, or if, this Standard applies to the inclusion of test data from such screening and outcome measures into the patient’s health record, where others can access it.

Recommendations: Consider an additional clarifying statement regarding the reporting of screening and outcome measure data in a shared health record.

Standard 10. Therapy

Concerns: This Standard evokes the most concern from this workgroup. In general, use of the term “therapy” is overly narrow to represent the services psychologists provide in integrated care settings and connotes a traditional behavioral health level and type of intervention. This Standard has resulted in many challenging situations for psychologists in integrated care, especially those in primary care whose work involves the practices described in the next-to-last paragraph of the “Background” section (above). In many cases, the interpretation of this Standard by psychologists in the field is more problematic than the actual wording of the Standard; however, this workgroup hopes that a revised Standard could be worded in ways that help avoid such problematic interpretations.

For example, some States and organizations require that the informed consent outlined in 10.01 be done in writing. This single requirement can be extremely challenging in particular for psychologists in primary care who frequently initiate care with patients spontaneously when concerns are identified during a primary care provider visit. It potentially stigmatizes the work of the psychologist (other team members in primary care do not typically have such a requirement), and inhibits the workflow of same-day visits such that patients who are the most in need often are not reached because they do not tolerate reading and signing a form. This workgroup realizes that Standard 10.01 does not specifically require use of written consent. However, it also does not prompt psychologists to consider how the informed consent process may create barriers to the psychologist’s accessibility in certain settings. Revised wording could encourage the use of an informed consent process such as verbal consent that minimizes barriers to access.

Standard 10.02a also creates confusion. It states that when providing services for several persons who have a relationship, the psychologist must “clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person.” In integrated care, multiple family members are commonly engaged in care with the same psychologist, but independent of each other and without the awareness of the other family members. This can happen in any setting (integrated or not), but is particularly common in integrated primary care where family and community members commonly present in the same clinic. In such situations, the requirements of 10.02a can place psychologists in a bind as they endeavor to protect confidentiality while also attempting to clarify the parameters of care with the related individuals. An additional complication is that in the longitudinal care model of primary care it is not
realistic to always expect that the identity of patients and the relationship the psychologist has with family members/patients will be clear at the outset.

Standard 10.04 is another example of a commonly misinterpreted standard in need of re-wording. While the Standard does not actually prohibit providing services to those served by other behavioral health clinicians, the Standard is often interpreted much more rigidly by psychologists in the field. Many integrated care psychologists refuse to see patients who are engaged in traditional therapy elsewhere, owing to concerns about violating this Standard, even when the patient needs only brief assistance or is referred for a problem not being addressed by the external therapist. This undermines the value the integrated care psychologist offers the medical team and their patients. This workgroup believes the wording of this Standard should be revised to more clearly allow care to be provided to patients who are also served by others (with the caveat that such care should be coordinated as needed with the other behavioral health provider).

Finally, Standard 10.10 (c) also poses a challenge, especially for psychologists in primary care, where the longitudinal care model means care is episodic but never “terminated.” Certainly, psychologists in primary care do disengage with patients (repeatedly) over the course of time, and for the reasons outlined in 10.10 (a) and (b). But in these instances, the “pretermination counseling” mandated in 10.10 (c) is not clearly reasonable for the primary care setting. If “pretermination counseling” is interpreted liberally, to include for example just a few sentences to a patient regarding when/how to return to the psychologist, then it might be reasonable. But there is clearly the opportunity for a more rigid interpretation that can create confusion in integrated care work. This workgroup assumes that the intent of the Standard is to allow for more liberal interpretations, but the current wording does not make that clear.

**Recommendations:** Differentiate the work of psychologists who conduct “therapy” from those who conduct “interventions”. While this workgroup consists of psychologists who utilize interventions in a consultative, team-based care model, there are certainly psychologists in other settings who also would consider their work more aligned with an “intervention” model than a “therapy” model. More clearly promote an informed consent process that minimizes barriers to the accessibility of psychologists in team-based settings. Clarify guidance for psychologists who see couples or families in integrated care, in order to avoid the confusion referenced above regarding Standard 10.02. Clarify that in integrated care settings parallel work with traditional mental health is commonplace and should be complementary. Promoting “coordination of care” in these situations might be a more appropriate expectation. More clearly delineate a broad range of “pretermination counseling” practices that allow psychologists to align with the structure and needs of diverse settings, including longitudinal care settings.

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References


**Integrated Care Ethics Workgroup Members**

Doug Tynan, PhD, ABPP (co-lead)
Professor of Pediatrics
Sidney Kimmel Medical College
Thomas Jefferson University

Jeff Reiter, PhD, ABPP (co-lead)
Clinical Associate Professor
College of Health Solutions
Integrated Behavioral Health Program
Arizona State University

Kevin Arnold, PhD, ABPP
Director, The Center for Cognitive and Behavioral Therapy of Greater Columbus
Clinical Assistant Professor, Department of Psychiatry and Behavioral Health, OSU Wexner Medical Center
Chair, American Board of Professional Psychology Foundation

Kathy Ashton, PhD, ABPP
Associate Professor of Surgery, Cleveland Clinic Lerner College of Medicine
Cleveland Clinic Breast Center
Digestive Disease and Surgery Institute

Anne Dobmeyer, PhD, ABPP
CAPT, US Public Health Service
Section Chief, Science, Development, and Education
Primary Care Behavioral Health
Psychological Health Center of Excellence
J-9/Defense Health Agency (DHA)
Elena Eisman, EdD
Director, Center for Psychology and Health and AED for Governance Operations
Practice Directorate
American Psychological Association

Parinda Khatri, PhD
Chief Clinical Officer
Cherokee Health Systems

Linda Knauss, PhD, ABPP
Professor, Institute for Graduate Clinical Psychology
Widener University

Christine Runyan, PhD, ABPP
Professor, Dept of Family Medicine and Community Health
Director, BH Integration
Director, Behavioral Science Worcester Family Medicine Program
Director, Post-doctoral Fellowship in Primary Care Psychology
University of Massachusetts Medical School

Neftali Serrano, PsyD
Chief Executive Officer
Collaborative Family Healthcare Association

Barbara Ward-Zimmerman, PhD
Independent Practice, Integrated Care Consultant, Glastonbury, CT
Chair, Society for Health Psychology Integrated Primary Care Special Interest Group