Issues, Dilemmas, and Ethical Decision Making in the New Millennium

....if it is not right do not do it;
if it is not true do not say it.
Marcus Aurelius

Adult Protective Services
Social Service Workers
2003 Fall
Training Event
September 16, 17, 18

Donaghey Plaza South
7th and Main Streets Little
Rock, Arkansas
Conference Rooms A and B

Sponsored by:
Division of Aging and Adult Services
Arkansas Department of Human Services
1 Schedule and Presenters

2 Ethical Concepts

3 APS Issues

4 LTC Ombudsman Issues

5 Legal Issues

6 Medical Issues

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8 Adult Maltreatment Statute
APS Training 2003

Tuesday, September 16th

8:30-11:00 – Ethical Concepts – Randy Frazier
Randy Frazier received a Bachelors degree from the University of Central Arkansas and has worked for Arkansas Department of Parks and Tourism since 1974. For the past 20 years he has managed Pinnacle Mountain State Park. With over 25 years experience in public speaking, management and leadership development, Mr. Frazier has launched a secondary career as President of his own company, Frazier Communications, Inc. His training background is as varied as his interests. He is a graduate of LeadAR class II; a Ropes Course instructor; former President of the Arkansas EMT Instructor/Coordinator Society; a certified self defense instructor with a 1st degree black belt in Karate; and has served on the Cooperative Management Team for Training Community Organizations for Change, a leadership development program sponsored by the Winthrop Rockefeller Foundation. Mr. Frazier is one of Arkansas’ most sought-after trainers and motivational speakers, and in addition provides training in Leadership and Management, dealing with Change, Organizational Board Development, Team Building, Cultural Diversity, Stress Management, Goal Setting, Public Speaking, Strategic Planning, Paradigm Shift and the Visioning Process.

12:00-2:30 – APS: Issues, Dilemmas, and Ethical Decision-Making – Paula Mixson, LMSW AP
Paula Mixson has worked in the field of adult protection since 1980. Her responsibilities in the state office of the Texas Adult Protective Services (APS) program include strategic planning, performance measurement, legislative analysis and tracking, inter-agency coordination, community development, facilitating special projects and research efforts, and supervising the production of the annual Texas APS Conference. Ms. Mixson is a founding member of both the National Association of Adult Protective Services Administrators (NAAPSA) and the National Committee for the Prevention of Elder Abuse (NCPEA). In 2002, she received NAAPSA’s Rosalie Wolf Memorial Award. She received a B.A. in Drama from Sam Houston State University in Huntsville, Texas in 1968; was an East-West Center grantee at the University of Hawaii in 1968-69 and in 1974 studies Spanish at El Proyecto Linguistico in Antigua, Guatemala; and completed secondary teacher certification in Spanish, English, and Drama in 1976. Ms. Mixson has numerous professional publications to her credit, including the material she is presenting for this training.
2:30 – 4:40 – LTC Ombudsman Services: Issues, Dilemmas, and Ethical Decision-Making – Alice Ahart

Alice Ahart received a B.A. degree from the University of Arkansas in 1972. She spent the last 16 years working with disenfranchised adults in both community and institutional settings. While working with adults with disabilities, she served as a grant coordinator for one of the first supported employment programs in Arkansas. Alice served on the committee that developed the protocol that was implemented by Arkansas Rehabilitation and Developmental Disabilities Services for subsequent statewide supported employment programs. Her work with community based programs continued with the then nascent Home and Community Based Waiver for people with disabilities. She wrote the policies and procedures for this component at Arkansas Easter Seal. While serving as State Long Term Care Ombudsman, Alice had the opportunity to testify and advocate on behalf of residents of long term care facilities. She developed the Arkansas Ombudsman web page, updated the NORS reporting system to an on-line database, created a training curriculum for the Regional Ombudsman, which included testing and certification, and served on a national committee charged with developing long term care ombudsman program outcome measures.
Wednesday, September 17th

8:30 – 11:00 – Legal Issues, Dilemmas, and Ethical Decision-Making – Dent Gitchel, J.D.
Dent Gitchel is Arkansas Bar Foundation Professor of Law at the University of Arkansas at Little Rock William H. Bowen School of Law, where he teaches courses in Conflict of Laws, Evidence, Legal Profession, and Legal History. This fall he is also teaching a seminar in advanced trial practice at the University of Arkansas Law School in Fayetteville. For a number of years, he has served as a team leader in Emory University School of Law’s Trial Techniques Program and has been a visiting professor at the University of Richmond. Dr. Gitchel has served on the faculty of many National Institute For Trial Advocacy continuing legal education programs and is a Master of the Bench Emeritus in the William R. Overton Inn of Court in Little Rock. He is a graduate of Hendrix College and the University of Arkansas School of Law. He practiced law privately in Little Rock from 1969 until 1984, when he became a full-time law professor. He has authored several professional publications.

12:00 – 2:30 – Medical Issues, Dilemmas and Ethical Decision-Making – Chris Hackler, Ph.D.
Chris Hackler joined the faculty of the College of Medicine in 1982 as the first director of the new Division of Medical Humanities. He came from East Tennessee State University where he chaired the Department of Philosophy and taught in the Department of Family Practice. After graduating from Hendrix College and studying in Germany on a Fulbright Scholarship, he received a Ph.D. in philosophy from the University of North Carolina. He has also received fellowships from the Woodrow Wilson Foundation and the National Endowment for the Humanities. He was a visiting scholar at the Institute of the Medical Humanities at the University of Texas Medical Branch at Galveston in 2001. Dr. Hackler has authored numerous publications on medical ethics.

2:30 – 4:30 – Mental Health Issues, Dilemmas, and Ethical Decision-Making – A.J. Zolton, Ph.D.
A. J. Zolton is the Director of Neuropsychology at St. Vincent’s Senior Health Clinic. He received a Bachelor of Arts in Psychology from the University of Cincinnati, a Master of Arts Degree in Anthropology also from the University of Cincinnati, earned a Doctor of Philosophy at the University of North Texas, and Interned at John L. McClellan Veteran’s Administration Hospital. He holds an Arkansas Medical License and is affiliated with eight local hospitals. Dr. Zolton has done extensive clinical research involving the safety and efficacy for drugs involving drug treatment for seizures and epilepsy. He has also done several clinical research trials of the efficacy and tolerability of drug treatment of patients suffering from dementia of the Alzheimer’s type, and has authored and co-authored numerous publications.
Thursday, September 18th

8:30 – 11:00 – HIPPA
   Jan Speed, J.D.
   Jan Speed has been an attorney with the Department of Human Services (DHS) since 1998. She is responsible for the development and implementation of DHS policies and procedures related to compliance with the Health Insurance Portability and Accountability Act (HIPPA). In addition to her responsibilities as the HIPPA Privacy Officer, her duties include drafting and negotiating contracts and assisting in setting DHS contracting and grants policy. She is a graduate of Vassar College, Poughkeepsie, New York (B.A., 1982), and the University of Arkansas School of Law at Little Rock (J.D., 1986).

12:00 – 2:30 – Legislative changes in the Adult Maltreatment Statute
   Lisa McGee, J.D., Michael Chase, J.D., Kay Forrest, J.D.

   Lisa McGee is Deputy Counsel for County Legal Operations with the Office of Chief Counsel for the Arkansas Department of Human Services. She has been an attorney with DHS since 1991, and has been Deputy Counsel since 1996. Ms. McGee supervises a unit of 32 child welfare and adult protection attorneys. She is an UALR Law School graduate, and received a Juris Doctorate in 1991. Ms. McGee clerked for Pulaski County Chancellor Ellen B. Brantley during her last year in law school. She was a member of the UALR Law Journal and received the Judge Henry Wood Scholarship in 1989. Ms. McGee was appointed by the Arkansas Supreme Court to the ad hoc Committee on Juvenile Court Improvement.

   Michael Chase is licensed to practice law both in Arkansas and Missouri. He was in private practice 15 years prior to being employed by the Office of Chief Counsel, Arkansas Department of Human Services in 1966. Mr. Chase worked in the field as an attorney for County Legal Operations in the 14 and 19 E circuits for more than four years. He is presently responsible for the western-half of Arkansas, supervising 17 field attorneys and their 13 secretaries, who are providing services to 28 circuit judges in over 44 counties. Mr. Case has been extensively involved in the areas of child maltreatment pursuant to the Arkansas Juvenile Code and the Child Maltreatment Act, as well as adult abuse pursuant to the Adult Maltreatment Act. He has established close working relationships with APS Social Service Workers, caseworkers, Attorney ad litem, CASA volunteers, foster parents, parents’ legal counsel, and judges during his tenure in the field.

   Kay Forrest is an attorney supervisor with the Office of Chief Counsel, Department of Human Services. She has worked for OCC for 18 years. She is a Licensed Certified Social Worker, vice chairman of the Arkansas Coalition for Juvenile Justice and a CASA advisory board member. Ms. Forrest received a Juris Doctorate at Memphis State University School of Law, an MSSW at the University of Tennessee, and M.A.-B.A. at Memphis State University.

2:30 – 4:30 – Exam
MARY AND MARTHA

Mary is 70 years old, widowed, and lives in a rural area with her sister Martha. Mary was referral to APS by an anonymous phone caller who complained that she was dumping garbage around her property. An initial home visit disclosed that there was refuse outside the kitchen door and window, but the client claimed that it was her sons who discarded the garbage this way. Her bills and other mail were stacked carelessly in one place where, she said her sons could find the mail when they came on their monthly visit to help her. She said that if she had better vision she would be able to pay her bills herself. According to Mary her sons had taken care of her bills on their last visit, but statements from the utility companies were showing that her payments were overdue. There was little food in the house (her sons brought food each month she said), and what was available was mostly spoiled. Meals-on-Wheels was making deliveries on a regular basis; however, Mary and her sister appeared malnourished, leading the APS worker to suspect that the women were not eating the meals that were delivered.

Mary had always been a tidy housekeeper, managed the household budget even when her husband was still alive, and took pride in being able to help others. She had been an active member of her church for 62 years and regularly attended worship service as well and participated in the women’s groups until the care of her sister required her to stay home more often. Church members frequently visit Mary and her sister and provide the only social contacts other than the visits of Mary’s sons.

Mary acknowledged difficulties with her memory, “but not more than anyone else my age” she declared. She received an in-home psychological assessment to evaluate her competence to live independently. Her mental examination revealed evidence of moderately severe dementia. As is characteristic of many patients with Alzheimer’s type dementia, Mary’s social graces were maintained and she presented with the demeanor of someone who took pride in herself despite her disheveled appearance. Neither she nor her sister had bathed recently. She insisted, however, that her sister was well cared for and that her sons were always willing to help out. She became defensive and visibly annoyed when questions implied that she was not able to adequately take care of herself or her sister.

In some ways her sister, who had suffered a stroke, was of greater concern as she was unable to communicate her needs. Mary was responsible for administering her sister’s blood pressure medication but it had not been given on a regular basis during the past year. Mary agreed to have a visiting nurse check Martha’s blood pressure, which turned out to be high. She also consented to a physical exam for herself, which revealed bruises on her right hip and right arm. She attributed these to a fall a few days earlier. She described the fall vaguely and defensively, leaving little doubt about her ability to accurately retell the circumstances surrounding the fall.
Several visits over the period of a month revealed that Martha’s health was stabilizing, probably due to the intervention of the visiting nurse. Mary insisted that she could take care of herself and her sister and refused homemaker services or offers of assistance for her sister’s hygiene.

The sons were reached by telephone and were able to arrange to meet the APS worker. Their homes were in the city about 30 miles away. They brought food when they came. They appeared to be minimally supportive of their mother and aunt. They insisted that when their current business obligations were concluded over the next couple of months, they were going to make another attempt to move their mother and aunt to their neighborhood in the city. There was a senior high rise nearby their homes where a friend had situated his mother. If their business arrangements fell into place, they hoped to have some money to contribute to the move. Mary, of course, felt this would not be feasible for them. “They really can’t afford it,” she insisted, “the business is shaky and it’s hard for them to admit it.” Additionally, she didn’t feel comfortable living in a big city because she would lose the contact with, and support of her church. She was also concerned about moving her sister to a high rise where people lived “on top” of each other.
JOHN AND MANNY

John, age 82, had operated a small business for 60 years in the community where he lived. He had reluctantly sold the business at his wife’s urging so that they could travel in their retirement. John had always hoped that Manny, their only son, would return home to run the family business. Shortly after he retired, John suffered a stroke, which left him partially paralyzed. This delayed the plans he and his wife had for travel. Six months later, John’s wife had a heart attack and died. When his wife died John was the sole inheritor of their estate—a fact that Manny never accepted. Manny had recently returned from abroad where his employment with an oil company had abruptly ended. He offered to move into the home and help his father. After moving in, he had the telephone disconnected so John would not be “bothered” by friends and neighbors calling to see how he was doing. Manny installed a new phone with an unlisted number in his room, which he kept locked when he was away. He would not allow John to use the phone when he was home.

Although John was alert, lucid, and mentally capable of handling his affairs, Manny began to lay the groundwork for John’s supposed mental incapacity. When family, friends, and neighbors dropped by, he told them that John was not receiving visitors because his health was poor. He told John, however, that his friends told him that they thought John was losing his mind. Manny boxed up John’s favorite books and fishing equipment and donated them to the Salvation Army and then told John that he would never be healthy enough again to use them. However, Manny told his father’s friends that John had destroyed his possessions “in a fit of anger.” Manny also mentioned to others that he might have to go to court to become John’s guardian so he could more effectively take care of his father and the estate. Under the pretense of “cleaning out the junk,” Manny began removing valuable antiques. He shifted money from his father’s bank account to his own and had his name put on the title to the house, convincing his father this was best.

Manny told John that in his present mental and physical condition he was lucky to have anybody to help him. Believing that his friends had abandoned him, John was persuaded to change his will so that Manny would inherit everything. Manny began to yell at this father and on several occasions pushed him and treated him roughly when John would not do what Manny asked. People who saw Manny in town began to be concerned and talked about how odd he was behaving. While everyone recognized he was intelligent and articulate, they thought that things Manny said about the government, television news, and spy satellites were bizarre. People were also concerned that John, who had been active and visible in the community for so many years, did not go out of the house.

Concerned about John’s withdrawn behavior and Manny’s excuses for why family could not see John, John’s sister called Adult Protective Services. Manny did not want to let the APS worker in the house, but he did so when told the APS worker had a legal responsibility to see John and could return with a court order. John was frail, appeared malnourished, and had bruises on his face, which he said were the result of a fall. The APS worker wanted a second opinion from a mental health professional before making a decision about John’s mental capacity. The APS worker suspected that John was being abused and
neglected by Manny and offered services to John, but he refused.

Before the APS worker could return to the home with someone to do a psychological assessment, the hospital called reporting that John had been admitted with another stroke. John admitted to the hospital social worker that Manny had started hitting him. He defended Manny though, saying Manny was under a lot of stress. John said he felt bad about not seeing his friends or family and wished they would visit. He also felt badly about the responsibilities his son had to take for his care and said it was not right for a child to have to take care of a parent. He thought that if he could still be the provider and father figure that Manny wouldn't be having the problems he was having. John was a faithful churchgoer and took his family obligations seriously. His religious conviction emphasized parental responsibility. Therefore, John believed that his role as a father took precedence over concerns for his own personal safety.

While in the hospital a psychiatric evaluation was done revealing that John had the mental capacity to understand the situation he was in; he was mildly, but not clinically depressed and did not require treatment; and he was able to make informed choices about what he wanted. Both the APS worker and the hospital social worker tried to persuade John to go to a nursing home from the hospital so he could recover in a safe environment while legal action was taken to get Manny out of the house. When John was discharged from the hospital, he decided to return home.

Two more hospitalizations followed over the next eight months with signs of physical abuse evident each time John was admitted. On the second admission it was determined that John’s mental capacity had declined and that he no longer had the capacity to understand his situation. The hospital called APS and a petition for custody was filed. Manny filed for guardianship for his father and his father’s estate. It was determined as part of the court proceedings, that Manny was suffering from a mental illness, which was the reason, he had suddenly lost his job, so he was not suitable to be his father’s guardian.
Bonnie

Bonnie is a 60-year-old woman who is small, frail, and appears much younger than her age. She has a history of cerebral palsy. Sadly, she had some renown for her progress as a child, but she has degenerated physically in adulthood and now resides in a nursing home. She is highly intelligent, has an M.A. in psychology, is separated from her husband, and has one son. She now requires nearly total care. She is non-ambulatory and cannot move from her bed to her wheelchair. She can eat (with difficulty), can use the phone (with difficulty), has poor hearing (usually does not wear her hearing aid), and has severely impaired speech. When she entered the nursing home, she was addicted to Valium and meperidinomate, which were allegedly used for muscle spasms. Her attending physician says Bonnie didn’t need these medications for the degree of spasms she had on admission. It is suspected that she was “doctor shopping” prior to admission because she had had several physicians prescribing medications for her.

Bonnie has been diagnosed with a personality disorder, and she exhibits manipulative behavior and very poor judgment. She is unrealistic regarding her ability for self-care. She uses frailty and diminutiveness to seduce people into looking after her. For example, she gets other patients who are ambulatory to wheel her outside on the porch or get her a soda. When she does not get what she wants, she can become verbally abusive. She accuses staff and other patients of stealing. She refuses to admit she had a drug addiction problem but claims she knows how and where to get Valium if the nursing home staff won’t give it to her. Her son seldom visits and appears impatient with his mother when he does see her. Her husband, Pete, from whom she separated shortly before admission to the nursing home, does visit regularly.

On several occasions, staff in the facility have noticed that Bonnie seems more lethargic and withdrawn after her husband’s visits. A few times they thought they overheard shouting in the room when Bonnie’s roommate was gone and her husband was visiting. Once Bonnie told an aide that her husband had taken her spending money. No one thought much about this behavior because Bonnie was so manipulative and had accused just about everyone of stealing at some point in time. None of these observations of shouting or theft were recorded in her chart.

One weekend when Bonnie’s husband was visiting, an aide saw him give something to Bonnie, which looked like a pill. She swallowed it before the aide could tell what kind of pill it was. The aide reported this to the nurse in charge of that shift and was told not to worry about it. Sometime on the day after her husband’s visit, the staff noticed bruises on Bonnie’s arms, chest and shoulders. Documentation of the bruises was made in her chart, but no further examination was done and neither Bonnie nor her husband were confronted.

This nursing home was part of a national chain and had been experiencing difficulties keeping beds filled and staff employed in key positions. While Bonnie was there, 10% of the beds were vacant and several of the head nurses were hired through a temporary service. The staff did not want to “rock the boat” because they already knew if more vacancies occurred headquarters would close the facility.
When Bonnie's husband arrives on his next visit, her roommate was in the room. The roommate did not like Bonnie's husband and usually left the room when he came for visits. He seemed particularly agitated on this occasion. Bonnie's roommate wanted to gather a book and some other things before she left the room and as she was doing so Bonnie and her husband began to fight. They were shouting at each other and her husband pushed Bonnie's wheelchair up against the wall. The roommate left immediately and reported what she had seen to the head nurse.

This time the nurse did go to the room. As she neared, she thought she heard noises that sounded like someone was being struck. When she got to Bonnie's room, Bonnie was in her wheelchair against the wall where her husband had pushed her, and he was sitting on Bonnie's bed. The nurse questioned them both about the shouting and noises she had heard. Both Bonnie and her husband denied any beating, but the nurse was able to convince Bonnie's husband to end his visit for the day and leave the facility. She recorded the incident to Bonnie's chart, but no physical exam was done.

Later that evening an aide noticed that Bonnie was having difficulty breathing and was in pain. The nurse in charge of that shift was notified and she contacted the physician who requested Bonnie be brought to the hospital. Upon examination, it was discovered that Bonnie had severe bruising and two fractured ribs. When the lab work was completed, it revealed she also had elevated blood levels of what appeared to be Valium. Bonnie was admitted to the hospital. Social work services were requested for Bonnie, and the social worker learned from the son that there had been a long history of mutual physical and emotional abuse in he parents' marriage; both had abused drugs as well. He thought the nursing home knew this and should have taken better measures to limit or supervise the visits by his father. He said his mother separated from his father because the physical abuse was becoming more violent during the time period before she entered the nursing home.
Ethical Concepts and Assumptions Handout

Human services professionals in the United States identify seven major ethical concepts.

1. **Autonomy**
   Individuals have the right to make choices about their welfare as long as they are competent and cause no harm to anyone else in the process.

2. **Privacy**
   Individuals have the right to maintain their privacy regarding information about themselves, interpersonal relationships, physical environment, and lifestyle as long as it does not infringe on the rights of others.

3. **Beneficence**
   Individuals have the right to receive care by others that maintains and/or enhances their welfare.

4. **Justice**
   Individuals have the right to be treated equitably whether they are a caregiver or care receiver.

5. **Nonmaleficence**
   Individuals have the right to expect others to do no harm in the maintenance and/or enhancement of their welfare.

6. **Fidelity**
   Individuals have the right to have others show loyalty or commitment to them when they need help or assistance.

7. **Accountability**
   Individuals have the right to expect others to tell the truth and be responsible for their actions as well as expose the deception and irresponsibility of others.
Handout #5

ETHICAL CONCEPTS EXERCISE

1. Identify and record the ethical dilemmas in Case #1 and the ethical concepts that can be applied in making decisions in the case.

   Example:
   
   Dilemma: Martha’s right to have adequate care versus Mary’s wish (right) to provide care
   
   Ethical concept: nonmaleficence vs. fidelity

2. Repeat above for Case #2

3. Repeat above for Case #3
Handout #6

A Framework for Ethical Decision-Making

1. Identify the problem

1.1. Be alert; be sensitive to morally charged situations. Look behind the technical requirements of your job to see the moral dimensions. Use your ethical resources to determine relevant moral standards. Use your moral intuition.

1.2. Gather information and don’t jump to conclusions. While accuracy is important, there can be a trade-off between gathering more information and letting morally significant options disappear. Sometimes you may have to make supplementary assumptions because there is insufficient information and no time to gather more information.

1.3. State the case briefly with as many of the relevant facts and circumstances as you can gather within the decision time available.

1.3.1. What decisions have to be made?
       There may be more than one decision to be made.

1.3.2. By whom?
       Remember that there may be more than one decision-maker and that their interactions can be important.

2. Specify feasible alternatives

State the live options at each state of decision-making for each decision-maker. You then should ask what the likely consequences are of various decisions. Here, you should remember to take into account good or bad consequences not just for yourself, your unit or clients, but for all affected persons.

3. Use your ethical resources to identify morally significant factors in each alternative

3.1. Principles

There are principles that are widely accepted in one form or another in the common moralities of many communities, professional groups, and health care institutions.

3.1.1. Respect autonomy
       Would I be exploiting others, treating them paternalistically, or otherwise affecting them without their free and informed consent? Have promises been made? Are there legitimate expectations on the part of others because I am an Adult Protective Services worker?

3.1.2. Don’t harm
       Would I be harming someone to whom I have a general or specific obligation as an Adult Protective Services worker or as a human being?
3.1.3. **Do good**
Should I be preventing harm, removing harm, or even providing positive benefits to others?

3.1.4. **Be fair**

3.2. **Moral models**

Sometimes you will get moral insight from modeling your behavior on a person of great moral integrity.
Diagnostics of Ethics

I. Origins:
   • Where did the quandary start?
   • At what level do you want to handle this problem? (as a problem between two individuals; as a problem with the way the facility, or agency operates; as a problem with societal functions)

II. Who are the participants
   • Who is involved in this problem?
     o This can be narrow or fairly broad
     o Is it the older adult and the person directly attributable for the harm?
     o Are the participants in the problem broader than this, perhaps the board of directors, people who set policy?

III. Outcomes
   • What would be the consequences to the participants?
   • What would be the consequences to the larger system if the problem spreads?

IV. What should we do?
   • Is there anything we can do that would put the abused or neglected person back in the same position she or he was before the harm occurred?
   • If we cannot restore the person to her or his prior situation, is there anything we can do to minimize the harm that has already occurred?
   • What can we do to improve the situation?
   • What kind of effort will this take?
   • Are there mitigating factors?
   • Are there things we can do to prevent this from happening again?

V. What are the likely results of this intervention?
   • What are the intended results?
   • What are the unintended results?
   • What are the short-term results?
   • What are the long-term results?

Mark Wexler, Simon Fraser University, Vancouver, British Columbia, Canada
INSIDE ADULT PROTECTIVE SERVICES

— A BALANCING ACT —

Ethical Decision-Making in Adult Protection

Presented by:

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for the

Adult Protective Services/Social Service Workers

2003 Fall Training Event
September 16, 17, 18

Sponsored by:
Division of Aging and Adult Services
Arkansas Department of Human Services
The APS Continuum of Services

Intake

Investigation/Assessment

If valid and protective services needed, then

Casework,

which may involve

Possible Services

<table>
<thead>
<tr>
<th>Errands to:</th>
<th>Direct Delivery, Case Management, and ECS</th>
<th>Institutional Care</th>
<th>Legal Interventions</th>
<th>Guardianship</th>
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<tbody>
<tr>
<td>SSA</td>
<td>in home</td>
<td>nursing home</td>
<td>entry</td>
<td>contracted</td>
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<tr>
<td>DHS</td>
<td>out of home</td>
<td>state facility</td>
<td>removal</td>
<td>- direct delivery</td>
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<td>MHMR</td>
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<td>protective orders</td>
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<td>TDH</td>
<td>medication</td>
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<td>mental health orders</td>
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<td>TRC</td>
<td>medical/psychiatric assessment</td>
<td>Same problems</td>
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<td>non-profits</td>
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<td>money management</td>
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Evaluate and Follow-up until Closure is Appropriate

Least Restrictive

Less impairment
Some support systems
Low risk, at least temporarily

Most Restrictive

Significant impairment
No support systems
High risk
THE CONTINUUM OF INTERVENTION

Autonomy

Advocacy

Empowerment

Persuasion

(Questionable Capacity)

Capacity

Surrogate Decision-Making

Incapacity

Concept adapted from H.R. Moody (1988) by Paula M. Mixson
<table>
<thead>
<tr>
<th>Ethical Concepts</th>
<th>Definitions</th>
</tr>
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<tbody>
<tr>
<td>Autonomy</td>
<td>Self-determination, self-government, freedom, independence</td>
</tr>
<tr>
<td>Privacy</td>
<td>Freedom from unauthorized intrusion, confidentiality</td>
</tr>
<tr>
<td>Beneficence</td>
<td>Kindness, goodness, humanitarianism, the quality or state of doing or producing good</td>
</tr>
<tr>
<td>Justice</td>
<td>Fairness, fair play, impartiality, equity, evenness</td>
</tr>
<tr>
<td>Nonmaleficence</td>
<td>Not producing harm or evil</td>
</tr>
<tr>
<td>Fidelity</td>
<td>Faithfulness, loyalty, constancy, devotion</td>
</tr>
<tr>
<td>Accountability</td>
<td>Responsibility, liability, to answer for or explain truthfully</td>
</tr>
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## Concepts Exercise

*Match the ethical concept to the assumption that reflects it by connecting them with a line.*

<table>
<thead>
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<th>Assumptions</th>
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<td>2. Individuals have the right to maintain their privacy regarding information about themselves, interpersonal relationships, physical environment, and lifestyle as long as it does not infringe on the rights or others.</td>
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<tr>
<td>3. Beneficence</td>
<td>3. Individuals have the right to expect others to tell the truth and be responsible for their actions as well to expose the deception and irresponsibility of others.</td>
</tr>
<tr>
<td>4. Justice</td>
<td>4. Individuals have the right to make choices about their welfare as long as they are competent and cause no harm to anyone else in the process.</td>
</tr>
<tr>
<td>5. Nonmaleficence</td>
<td>5. Individuals have the right to have others show loyalty or commitment to them when they need help or assistance.</td>
</tr>
<tr>
<td>6. Fidelity</td>
<td>6. Individuals have the right to expect others to do no harm in the maintenance and/or enhancement of their welfare.</td>
</tr>
<tr>
<td>7. Accountability</td>
<td>7. Individuals have the right to receive care by others that maintains and/or enhances their welfare.</td>
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Adult Protective Services

Ethical Principles and Best Practice Guidelines

Adult Protective Services are those services provided to elderly and disabled adults who are in danger of mistreatment or neglect, are unable to protect themselves, and have no one else to assist them.

Interventions provided by Adult Protective Services include, but are not limited to, receiving reports of adult abuse, exploitation or neglect, investigating these reports, case planning, monitoring and evaluation. In addition to casework services, Adult Protection may provide or arrange for the provision of medical, social, economic, legal, housing, law enforcement or other protective, emergency or supportive services.

Guiding Value: Every action taken by Adult Protective Services must balance the duty to protect the safety of the vulnerable adult with the adult’s right to self-determination.

Secondary Value: Older people and people with disabilities who are victims of abuse, exploitation or neglect should be treated with honesty, caring and respect.

Principles

• Adults have the right to be safe.
• Adults retain all their civil and constitutional rights unless some of these rights have been restricted by court action.
• Adults have the right to make decisions that do not conform with societal norms as long as these decisions do not harm others.
• Adults are presumed to have decision-making capacity unless a court adjudicates otherwise.
• Adults have the right to accept or refuse services.

Practice Guidelines

• Recognize that the interests of the adult are the first concern of any intervention.
• Avoid imposing personal values on others.
• Seek informed consent from the adult before providing services.
• Respect the adult’s right to keep personal information confidential.
• Recognize individual differences such as cultural, historical and personal values.
• Adults have the right to receive information about their choices and options in a form or manner that they can understand.
• To the best of your ability, involve the adult as much as possible in developing the service plan.
• Focus on case planning that maximizes the vulnerable adult’s independence and choice to the extent possible based on the adult’s capacity.
• Use the least restrictive services first—community based services rather than institutionally based services whenever possible.
• Use family and informal support systems first as long as this is in the best interest of the adult.
• Maintain clear and appropriate professional boundaries.
• In the absence of an adult’s expressed wishes, casework actions should support that which is in the adult’s best interest.
• Use substituted judgment in case planning when historical knowledge of the adult’s values is available.
• Do no harm. Inadequate or inappropriate intervention may be worse than no intervention.
A Process for Resolving Ethical Dilemmas

Gather and assess the facts to define the problem

- Medical, social, psychological, situational
- Patient preference
- Views of family and friends
- Views of the caregivers
- Legal, administrative, and external factors

Pinpoint the dilemma

- Autonomy
- Beneficence
- Nonmaleficence
- Justice
- Privacy
- Fidelity
- Accountability

Consider alternative courses of action

- Brainstorm possibilities and determine consequences of each
- Eliminate the impractical, improper or illegal
- Consider effects on stakeholders
- Consult as needed

Implement and follow-up

- Select most appropriate action
- Evaluate it
- Document your plan and carry it out
- Monitor and adjust as necessary

Instructions for Case Scenario Exercises

Break into small groups, attempting to have a mix of participants in each group. E.g., strive for variety in:

- Work histories
- APS experience and tenure
- Geographic assignments
- Personalities and outlook
- Professional backgrounds

Move to a different table if necessary to ensure a good mix.

Select a note-taker and spokesperson for each group.

We will consider each scenario and discuss it before moving to the next.

In each scenario, decide how you would work the case. Use the framework on pg. 7 as your guide. As you work the process, you may want to ask yourself the following questions:

1. Have you defined the problem accurately?
2. How would the problem be defined if you stood on the other side of the fence?
3. What ethical values are conflicting?
4. Do you have the information you need to make a decision?
5. Are your sources credible?
6. What else do you need to find out or do?
7. Who are the stakeholders in this situation?
8. What are the likely consequences to them?
9. Which ethical concept standard are they most likely to promote?
10. Do you agree or disagree with what happened in the case up to this point?
11. How do your perspectives differ from each other?
The Arkansas Ombudsman Program

Enhancing the Lives of Residents of Nursing Homes

What Is an Ombudsman?

Om-Buds-Man

- Swedish for Citizen's Representative
- From a Monarchy to a Democracy
- Listened to Grievances of Citizens

The Long-Term Care Version

- Residents in Nursing Homes Needed Advocates
- Became Federal Law in 1978
- Funded by the Older Americans Act
Authority

- Older Americans Act
- Federal Regulations
- Arkansas State Statute

The Ombudsman is Not A Regulator

- Office of Long Term Care Is Solely Responsible
- Surveyors Must Notify Local Ombudsman
- Ombudsman May Supply Information
Principles of Decision Making

✓ Informed Consent
✓ Best Interest
✓ Substituted Judgment

Informed Consent

If a person has decision-making capacity, the doctrine of informed consent applies. The intent of this doctrine is to safeguard the autonomy of an individual's decision-making in both treatment and research settings. The Ombudsman's role frequently is to help assure that resident's choices are heard and acted upon.

Best Interest

This principle has its origins in the judicial system as cases have been litigated regarding treatment for patients who are incompetent. In the medical field, it implies that the benefits of treatment are weighed with the burden of treatment in order to determine what best interest is. Application of this principle invokes the reasonable person standard. The resident's interests are promoted, as they would probably be conceived by a reasonable person in the resident's circumstances, selecting from within the range of choices that reasonable people would make. Key questions to ask:

Who is making the decision:
- Family members?
- Physician?

Are decisions made according to the best interest of the resident, or for the family caregiver?

Is best interest determined on the basis of allocation of health care resources?

Does ageism influence the decision-making process?

Substituted Judgment

Where capacity is lacking, the Ombudsman attempts to discover information regarding what kind of choice the client would have made were he or she able to do so. Following what the individual wants or would choose is a priority value. Where it is possible, the Ombudsman would be in contact with family or friends who had knowledge of what personal values or preferences the individual expressed. The question asked here is,
“What would this person choose, if he/she were able to express a choice?” Then a decision is made according to that knowledge.

**Categories of Ethical Dilemmas Facing Ombudsmen**

- **Conflicting interest among potential clients**
- **Individual resident wishes versus facility rules**
- **Long term goals and principles versus the immediate reality**
- **Biomedical decisions**

**Conflicting Interest Among Potential Clients**

These situations are probably the most frequently encountered dilemmas for Ombudsmen. This category gets at the root of the manner by which an Ombudsman engages in advocacy: those times when it is hard to determine or act upon, what a resident wants. It also includes the issues of: who’s the client, the resident’s right to confidentiality, and conflicting laws.

**Individual Resident Wishes Versus Facility Rules**

What should an Ombudsman do when the wishes of a resident conflict with appropriate/good facility rules, with laws, regulations, or even with the interest of society? To what extent are residents allowed to take risks, to choose a set of circumstances, when their choice affect a number of other people?

**Long Term Goals and Principles Versus the Immediate Reality**

In these situations the issues may be how far one goes on principles versus accepting the immediate reality of the situation. How far should the limits be pushed? What compromise might be made in the short term in order to move toward achieving long-term goals?

**Biomedical Decisions**

These issues revolve around life-sustaining treatment and medical treatment decisions. When faced with treatment decisions, what is the role of the Ombudsman? Laws, regulations and policies of the facility are guidelines for the action the Ombudsman takes.
LEGAL ISSUES, DILEMMAS, AND ETHICAL DECISION-MAKING

DESCRIPTION OF UNIT

Purpose: To demonstrate the application of criminal and civil systems’ goals, the rules of governing them, and their processes in resolving ethical questions.

The Unit begins with a presentation on the legal goals, rules, and processes that guide decision making in the criminal and civil systems. Working in small groups, the participants will identify the criminal and civil issues involved in the three case studies and describe how legal principles and rules are used to resolve issues and dilemmas involving autonomy and competency.

LEARNING OBJECTIVES

1. To become familiar with the legal goals of the criminal and civil systems, rules governing them, and their processes

2. To apply the goals, rules, processes to case studies

3. To improve skills in evaluating the ethical issues and dilemmas related to elder mistreatment from the perspective of the criminal and civil justice systems

The text of this Unit is taken from Elder Mistreatment: Ethical Issues, Dilemmas, and Decisions Chapter Eight “A Legal Perspective" by Candace J. Heisler and Mary Joy Quinn.
Legal Issues, Dilemmas, and Ethical Decision-Making

Learning Objectives
- To become familiar with the legal goals of the criminal and civil systems, rules governing them, and their processes.
- To apply the goals, rules, processes to case studies.
- To improve skills in evaluating the ethical issues and dilemmas related to elder mistreatment from the perspective of the judicial system.

Goals of the Legal System
The goals of the legal response to elder mistreatment are:
- Stop the unlawful, improper, or exploitative conduct.
- Protect the victim and society from the perpetrator and further inappropriate or illegal acts.
- Hold the perpetrator accountable for the conduct and communicate a message that the behavior is unacceptable and exceeds societal norms.
- Rehabilitate the offender, if possible.
- Make the victim whole by ordering restitution and/or the return of property.
Rules of the Legal System

- **DUE PROCESS**: the extent to which the law requires that perpetrators and victims are informed of their rights and how to exercise those rights.

Rules of the Legal System

- **LEGAL PROTECTION AND NOTICE**: the extent to which the law requires that people involved in a case are officially notified of the various legal steps in the case.

Rules of the Legal System

- **MANDATORY REPORTING**: the duty of various individuals to report suspected cases of elder mistreatment to the proper authorities.
Rules of the Legal System

- LEVELS OF PROOF: the party making the accusation must provide evidence that proves in the mind of the judge or jury that they are correct to some degree of certainty.
  - Preponderance of evidence: slightly over 50% certainty that the accusations are true
  - Clear and convincing evidence: the accuser has the burden of providing evidence that the accusations are true so that a jury is convinced
  - Guilt beyond a reasonable doubt (criminal cases)

Process in the Legal System

- The law establishes the threshold for when and how actions may be taken. The legal system is adversarial in nature.

Civil Proceedings

- Plaintiff: the person who files the suit, must meet one of the two legal burdens to prevail;
- Plaintiff and defendant can settle the case, come to agreements, and otherwise direct what takes place;
- Petitioner: the person who files the case for a guardianship; traditionally guardianship cases have not been adversarial but system reforms are becoming more complex and adversarial to protect the proposed wards.
Criminal Proceedings

- Prosecution: represents the government or society at large; the chief law enforcement officer in the jurisdiction.
- Crime victim/client: a potential witness, the person or entity who (which) was directly affected or injured by the conduct of the defendant.
- Defendant: perpetrator, usually represented by an attorney totally committed to representing the best interest of the client.

Criminal Proceedings

- Professional ethical protocols guide prosecutors. The charging process is exclusively within the province of the prosecution and consists of two separate evaluations:
  - Does sufficient evidence exist to support a charge?
  - If so, is it in the interest of justice to file the case?

Criminal Proceedings

- The prosecutor must seek justice, not just convictions because:
  - The prosecutor represents the government and should use restraint in the discretionary exercise of governmental power.
  - The prosecutor is not only an advocate but may also make decisions normally made by an individual client; those decisions affecting the public interest must be fair to all.
  - The accused is to be given the benefit of all reasonable doubt.
Ethical Concepts and Principles

- Justice
  To the legal practitioner, justice means:
  - The fair and even-handed application of laws so all members of society know what their rights and duties are.
  - The creation of rules that permit individuals to live within society.
  - The expectation of society that by relying on laws and rules, members need not resort to self-help, vengeance, and/or withdrawal from interaction with others.

Ethical Concepts and Principles

- Autonomy
  In the criminal justice system, autonomy is not really a consideration. The issue comes into play (the closest application) when the elder is informed and consulted about the various options available to keep him/her safe, and when the sentencing of the offender is under consideration. The prosecuting attorney makes the decision whether criminal charges will be brought against an offender.
  In guardianship cases, when an adult is thought to be incapable of managing his/her affairs, decision-making is placed in the hands of the surrogates. Serious considerations given to the wishes of elders have resulted in modifications in guardianship laws.

Ethical Concepts and Principles

- Least Restrictive Alternative
  Least restrictive alternative is a legal doctrine, primarily civil in nature, first articulated in the field of mental health. It creates an ethical duty of practitioners to fashion individualized solutions that are least intrusive upon their client's personal freedom.
"Least Restrictive Alternative con't."
- In civil law, the options available in order of increasing restrictions on the autonomy of the client are:
  - Client handles his/her own affairs
  - Client signs name to checks but someone else fills out checks
  - Direct deposit to bank accounts
  - Representative payee arrangements for certain checks
  - Joint tenancy on bank accounts/real property/trusts
  - Various powers of attorney, protective orders
  - Guardianship of estate
  - Involuntary placement in a variety of facilities

"Least Restrictive Alternative con't."
In criminal law, the concept of least restrictive is not a guiding principle although most courts decide sentences by balancing what a perpetrator did with available sentencing alternatives while attempting to protect the victim and the public and hold the offender accountable. Interventions may begin in the civil arena and move to the criminal side if the offender does not comply. This process is sometimes used in situations involving public nuisances or neighborhood disputes. It is used, however, with respect to persons found criminally insane. Persons are placed in facilities according to the amount of treatment and control they need and the degree of protection the community requires.

Ethical Concepts and Principles
- Competency/Capacity
Over the years, competency has been variously measured by age, the quality of decision-making, medical or psychiatric diagnosis, risk of impoverishment through needless spending, and physical endangerment. As yet, there is no mutually agreed upon definition. Each discipline functions with its own definition. The legal profession focuses on what an elder is incapable of doing while psychology, social work, and medicine determine what the elder is capable of doing.
Competency/Capacity continued

- There is a growing reliance on a constellation of factors to determine competency/capacity:
  - What the older adult actually does to take care of the needs of daily living including the management of material assets
  - Consideration of the elder's past decision making
  - Medical and psychiatric diagnoses
  - Mental and physical functioning

Competency/Capacity continued

- In the absence of valid tools to accurately measure the various features of competence, it is necessary to rely on a variety of pieces of knowledge about elders and the conditions that affect them.

- A legal definition with respect to providing testimony includes the following:
  - The ability to differentiate truth from fantasy
  - The ability to communicate about the evidence (or information) on which they will give testimony

Competency/Capacity continued

- In general, practitioners look for two elements:
  1. Does the individual have the capacity to assimilate the relevant facts?
  2. Can the person appreciate or rationally understand his/her own situation as it relates to the facts at hand?
     - Can the person make and express choices regarding his/her life?
     - Are the outcomes of these choices "reasonable"?
     - Are the choices based on "rational" reasons?
     - Does the person understand the personal implications of the choices made?
NOTES TO LEGAL ISSUES PRESENTER

1. Read Chapter Eight in *Elder Mistreatment: Ethical Issues, Dilemmas, and Decisions*

2. Present a lecture on the goals, rules, and processes of the criminal and civil systems and the ethical issues of autonomy, least restrictive alternative and competency

3. Distribute Handouts

4. Provide instructions for conducting the Exercise including an example

5. Divide participants into workgroups of 4-5 for small group work

6. Conduct Exercise

7. Convene workgroups

8. Record on a flip chart the results from the workgroups

9. Conclusion

10. **Timetable**

    | Activity                        | Time   |
    |--------------------------------|--------|
    | Presentation on Ethical Concepts| 45     |
    | Q&A on presentation            | 15     |
    | Case Study presentations       | 5      |
    | Instruction for exercise       | 5      |
    | Exercise                       | 40     |
    | Group discussion               | 20     |
    | Conclusion                     | 10     |

**140 Minutes**

RESOURCES

- Handout #1 – Mary and Martha
- Handout #2 – John and Manny
- Handout #3 – Bonnie and Pete
- Handout #4 - Exercise
EXERCISE: DEcision-Making From The Legal Perspective

1. Select a participant to read Case #1 to the workgroup

2. Select a participant to serve as recorder

3. Pose Questions #1-3 in Handout #4 to the workgroup for Case #1. Record responses

4. Repeat steps #1-3 for Case #2 and #3 (note there will be different readers and recorders for each Case)

5. Read results to plenary group
Handout #4

Legal Exercise Questions

Answer the following questions for each of the cases:

1. What criminal and civil issues are involved in the case?

2. In what ways does the issue of competency affect this case?

3. How does the principle of least restrictive alternatives apply to this case?
Arkansas Division of Aging and Adult Services
APS Training Manual

Case #1 Mary and Martha

1. What types of criminal conduct might be involved in this case? Who are the victims? Who are the perpetrators?

There may be caregiver neglect of Martha. She is unclean, malnourished, probably improperly medicated and is completely helpless and unable to even ask for help. The available information strongly suggests that Mary has assumed the role of caregiver and is unwilling to relinquish her position; in fact, she became defensive and annoyed when it was suggested that she was unable to adequately care for her sister. However, if Mary is unable to provide care because of her own physical or mental infirmity, she cannot be guilty of criminal neglect as she lacks the requisite intent.

The other potential criminal conduct is the presence of garbage which might be considered injurious to the public’s health and welfare. Because of the likelihood that garbage will attract animals, rodents, and vermin and will release unpleasant odors if sufficient amounts collect, it will certainly constitute a public nuisance. Nuisances are matters that are sometimes brought to the attention of the criminal justice system.

The Meals-on-Wheels staff members might be cited under the mandatory reporting provision if they were aware of the situation.

2. What evidence might be used to support claims of criminal conduct?

A police officer or a health department official would view the property, interview Mary and her neighbors, and attempt to determine who is responsible for the nuisance. Efforts would be made to encourage Mary to correct the problem. Should that be unsuccessful, a letter advising Mary of possible legal consequences would be sent, followed if necessary by a stronger letter mentioning possible criminal consequences for failure to act. If efforts through APS, Mary’s attorney, sons, and mediation fail, then prosecution might be pursued.

Assuming that Mary is Martha’s caregiver and is legally responsible for Martha and capable of forming criminal intent, then she might face criminal charges if the evidence establishes the elements of criminal neglect beyond a reasonable doubt.

3. What evidence might be used to support the need for guardianship for Mary and Martha?

Because both sisters are moderately to severely impaired, they meet the criteria for guardianship. It is questionable whether Mary understands the consequences of her actions: disposition of garbage, failure to provide adequate nourishment to Martha and herself, mishandling of Martha’s medication, memory problems with regard to how she was bruised.

Martha is unable to communicate and needs total care.
4. If guardianship is warranted for Mary and Martha, who might the petitioner be? Who is the most suitable or likely guardian [sons, APS, church member, private attorney] and why?

APS might petition the courts to rule on custody.

Although the sons are the most likely guardians, the facts suggest that they do not adequately provide for their mother or aunt; they visit monthly and provide no financial support. Their insight into Mary’s and Martha’s needs is poor. They are neither able or willing to be more involved and their plans are ill-formed. The least desirable solution appears to be the appointment of Mary’s sons as guardians unless they are willing and able to take a much greater role in the lives of the two women. Extensive interviews should be conducted with the sons to address Mary’s and Martha’s real needs and to determine if they can or want to be proper guardians.

Mary’s and Martha’s ties to the church suggest that there may be a possibility of a less restrictive alternative. There may be a particular ministry to the aged or homebound in the church or a reliable church member who would be willing to take informal or formal responsibility (power of attorney) for the sisters if they would cooperate. Someone may even serve as guardian or conservator.

Other possible guardians include a respected accountant or attorney. Probably Mary would object and most likely ask that her sons serve as guardians. A case could be made at court by the visiting nurse and APS as to the inappropriateness of such an appointment.

5. In what ways does the principle of least restrictive alternative apply in this case?

The most restrictive action in the case would be the appointment of guardians for the two sisters and possible nursing home placement. Trying to find a solution that might be less restrictive depends on the willingness of Mary to accept more help. If Mary is suffering from dementia, some short-term solutions might be used but it appears that in the long term, guardianship would be required.

Case #2 John and Manny

1. What criminal and civil issues are involved in this case?

This case has clear criminal conduct. John has been the victim of numerous illegal acts: theft of possessions and money, financial exploitation, improper transfer of title to the house, assault and battery, and elder abuse.
2. What steps need to be taken to insure that John’s person and property are protected?

Although John’s wishes about Manny will be considered, the decision to file will be made by the prosecutor. John will be involved in determining whether an order of protection will be sought; identifying the restrictions that are appropriate as conditions of pre-trial release, determining if a criminal court no contact order should be obtained while the case is pending; and the conditions that should be requested if Manny is placed on probation.

A multidisciplinary team meeting should be called where the many concerned parties and agencies could agree on a plan to present to John. Once he became mentally incompetent, the team response can guide the development of a service plan that will give him the greatest degree of autonomy.

A guardian might arrange for in-home care to provide needed care, to reduce the isolation, and serve as a witness of the dynamics between father and son. He/she could provide an allowance to Manny so that the father would still know that he was providing for his son. The guardian could also bring a civil action to restore all of John’s belongings to him including the title to the house.

3. Under what criteria will John be adjudged legally competent to give testimony?

John is legally competent to give testimony if he is able to distinguish truth from falsity, understand his duty to testify truthfully, and is able to perceive, recollect, and communicate his information.

4. What procedure is used in obtaining a guardianship?

A petition is filed in the courts. It appears that there was enough evidence with regard to John’s competency/capacity and Manny’s undue influence over him to convince a judge that a guardianship was appropriate in John’s case. John might have objected but a petition for guardianship could have been filed against his will. John also could be represented by counsel appointed by the court or retained by the family. The attorney might negotiate the return of John’s assets, an allowance for Manny, and provisions for household help.

A hearing held by the court would allow all parties to state their case. It is likely that Manny would have come to the hearing and evidence of his mental illness and inability to care for his father would be evident.
5. If guardianship is warranted for John, who might be petitioner? Who is the most suitable or likely guardian [son, sister, APS, private attorney] and why?

Manny indicated that he thought he should serve as a guardian. It is not clear whether the sister who made the original referral to APS might serve as guardian as well as other members of the family. A respected accountant or attorney are also options. APS and state custody with nursing home placement would be the most restrictive option.

6. In what ways does the principle of least restrictive alternatives apply in this case?

Placing a person under guardianship is the most restrictive option however it can be mitigated by inclusion of certain restrictions as terms of the guardianship. Allowing John to be at home instead of placing him in a nursing home is using a less restrictive environment than might have been selected.

Case #3 Bonnie and Pete

1. What criminal and civil issues are involved in this case?

Bonnie’s case presents a number of criminal and civil issues: 1) reporting violations, 2) the nursing facility’s failure to properly discharge its duties to protect and care for Bonnie and other residents, and 3) Pete’s abuse of Bonnie and his supplying of drugs.

2. How did the nursing home fail to protect Bonnie?

The physical abuse and drugging were ignored by the nursing home as well as Bonnie’s allegations that she had been the victim of theft. As long as the facility accepts money to care for her, they must protect her.

The facility failed to obtain appropriate social information at Bonnie’s admission. When they learned of suspicious interactions with her husband, they failed to act. They failed to follow up on her accusations of theft. They saw she had been bruised and did nothing. If Bonnie was a Medicaid patient, there also may have been Medicaid violations.
3. Under what circumstances would Bonnie be subject to prosecution?

*Because of Bonnie’s abuse of drugs, there may be some thought given to charging Bonnie although it is extremely unlikely that sufficient underlying facts could be developed to allow for prosecution. Proving her illegal use of drugs would be impossible in the absence of drug screens, seizures of illegal drugs, witness to her drug taking and complete documentation of her actions by nursing home staff. In addition, her medical and mental conditions make it unlikely that even if sufficient cause exists, she would be charged.*

4. What course of action could be taken if Bonnie refuses treatment for drug addiction?

*Bonnie is alert and able to make her own medical decisions. The staff and physician should encourage her to enter a drug rehab program if one exists that could provide for her medical needs. The facility should monitor visits from her family to make certain that drugs are not brought into the facility. If the husband does not refrain from bringing drugs into the facility, the nursing home could obtain a restraining order to keep him from visiting. If none of the above worked out, Bonnie could be discharged.*

5. How might prosecution of the nursing home result in a less desirable situation for Bonnie?

*Closing the nursing home might leave Bonnie and other residents in a vulnerable situation. Relocation, especially when done without adequate preparation can have a deleterious effect on the physical and mental status of institutionalized persons. Often times it is difficult to find other facilities to admit patients especially those who have special needs and those who are Medicaid patients.*

6. In what way does the principle of least restrictive alternatives apply in this case?

*For a person like Bonnie, who has physical and emotional needs that require total care, the nursing home is the appropriate (and least restrictive) environment. She might have remained at home if she had family members who could provide care supplemented with formal care providers, on a 24-hour basis. It is unlikely that she would qualify for assisted living.*

*Because she is alert and able to make her own medical decisions, she is not a candidate for custody so the facility staff and family members will have to use persuasion, trust, counseling, and negotiation to help Bonnie achieve a more positive quality of life.*
MEDICAL ISSUES, DILEMMAS, AND ETHICAL DECISION-MAKING

DESCRIPTION OF UNIT

Purpose: To demonstrate the role of the health care professional in resolving ethical questions

The Unit begins with a presentation on the ethical principles that guide decision-making by health care professionals. Using the three case studies, participants, assuming the role of health care professionals, show how ethical principles guide the course of action in cases involving suspected cases of abuse and/or neglect.

LEARNING OBJECTIVES

1. To become familiar with the ethical concepts that guide health care practice

2. To link the ethical concepts to practice using three case studies

3. To improve skills in the identification and resolution of ethical dilemmas arising in suspected cases of abuse and neglect

1The text of this Unit is taken from Elder Mistreatment: Ethical Issues, Dilemmas, and Decisions Chapter Three "A Medical Perspective" by Terrie T. Wethe and Terry T. Fulmer.
Ethical Issues, Dilemmas, Health Professionals and Patients

The codes of professional practice are built on the ethical concepts and societal values: nonmaleficence, beneficence, individual autonomy, privacy, accountability, justice, and fidelity.

The application of these ethical concepts to specific cases of elder mistreatment often engenders ethical dilemmas involving conflict between two or more values or concepts.

Ethical Issues and Dilemmas in Patient Autonomy and Best Interests

The most difficult ethical dilemma for health professionals is to respect the expressed wishes of the patient (autonomy) while protecting the patient from harm (beneficence). The professional is obligated to:

✓ Withhold a service or action that is in opposition to the expressed wishes of a competent patient. Yet, health professionals are required by law to report cases of suspected elder mistreatment.

✓ To determine that the patient’s refusal of assistance is an autonomous decision, free of coercion or undue duress. These cases are often complicated by questionable decisional capacity or cognitive impairment of the elder patient.

✓ To respect the confidentiality of the patient. However, reporting laws override the obligation for confidentiality. It is not a blanket override. Information is shared only on a “need to know” basis.

Many professionals are concerned that an elder abuse report and subsequent investigation will have deleterious effects on their relationships with the patients and the patients’ families. To reduce the negative impacts the health professional will:

- Inform the patient that a report will be made
- Describe the process
- Identify the potential positive outcomes of the process and suggested interventions
- Work with the family as a unit if possible
- Recognize the needs and concerns of all involved

Ethical Issues and Dilemmas Related to Families and Health Professionals

The health professional faces a thorny dilemma when treating two members of a family and during treatment encounters evidence of mistreatment of one by the other. How are the professional’s obligations to be balance among various family members?

First level responsibility is to the person who appears to be mistreated, but information and services to all involved parties should be included.
The health professional should be aware of the relationship patterns and specific relationship history of family members in their roles as caregiver and caregiver receiver. This knowledge may help to explain observed family dynamics and provide crucial information for developing effective intervention strategies. The health professional should assist caregivers in recognizing the limits of their own health and promote their well-being by identifying supportive services and encouraging their use.

Ethical Issues and Dilemmas Among Health Professionals, Institutions, and Agencies

Increasingly health professionals work with other professionals in the context of multiple agencies, institutions, and regulatory bodies. The complexity of such relationships contributes to ethical concerns and value conflicts relevant to elder abuse and mistreatment

- When mistreatment occurs in institutional settings and results in investigation of the professional’s own peers and colleagues
- When professionals disagree as to whether a case should be reported
- When agency rules and state regulations are in conflict

Raising institutional awareness and coordination of response is likely to improve recognition of abuse symptoms and reporting.
NOTES TO MEDICAL ISSUES PRESENTER

1. Read Chapter Two in *Elder Mistreatment: Ethical Issues, Dilemmas, and Decisions*

2. Present a lecture on the goals, rules, and processes of the criminal and civil systems and the ethical issues of autonomy, least restrictive alternative and competency

3. Distribute Handouts

4. Provide instructions for conducting the Exercise including an example

5. Divide participants into workgroups of 4-5 for small group work

6. Conduct Exercise

7. Convene workgroups

8. Record on a flip chart the results from the workgroups

9. Conclusion

10. **Timetable**

    | Activity                        | Duration |
    |--------------------------------|----------|
    | Presentation on Ethical Concepts| 45       |
    | Q&A on presentation            | 15       |
    | Case Study presentations       | 5        |
    | Instruction for exercise       | 5        |
    | Exercise                       | 40       |
    | Group discussion               | 20       |
    | Conclusion                     | 10       |

**140 Minutes**

RESOURCES

Handout #1 – Mary and Martha
Handout #2 – John and Manny
Handout #3 – Bonnie and Pete
Handout #4 - Exercise
Handout #4

EXERCISE PROBLEM: ETHICAL ISSUES AND DILEMMAS FROM THE MEDICAL PERSPECTIVE

Show how ethical concepts of autonomy, beneficence, nonmaleficence, justice, fidelity (*filial piety*), privacy and accountability might guide the course of action you would take in the following situations:

Case #1 – Mary and Martha

You are the visiting nurse contacted by the local APS worker to visit Martha who is suspected of being neglected.

Case #2 – John and Manny

You are a physician in the Emergency Department of a local hospital where John has just been admitted and found to have had another stroke. There is suspicion that he has been emotionally abused.

Case #3 – Bonnie

You are a staff nurse at the nursing home where Bonnie is suspected of being abused by her visiting husband.
Medical Issues, Dilemmas, and Ethical Decision-making Questions

Case #1 – Mary and Martha

1. What course of action should the health care professional pursue if the patient (Mary, Martha) chooses to remain in risky or abusive situations or refuses requisite services?

An important task for the health professional is to determine the underlying causes for the physical and cognitive declines observed in each of the patients. Perhaps Mary's change in cognitive status is secondary to medications or an undetected illness such as depression. Successful treatment could return Mary to previous levels of functions, improve her ability to make decisions and exercise good judgment and improve her capacity to care for Martha.

The prescription of a home health nurse to provide care to Martha and Mary's acceptance of it, provides an opportunity to observe improvements or deterioration in health and function. It would be important for the health care team to converse with the patient and family members at regular intervals to determine whether or not the goals of the care plan are being met and are ensuring the safety of the elder.

The health care professional can also facilitate communication among family members, clarifying preferences and wishes, testing the feasibility of family plans of action, and suggesting viable and desirable alternatives.

2. What concerns do health care professionals face with regards to mandatory reporting, when the patient asks that the abuse/mistreatment not be reported?

The professional is concerned that an elder abuse report and the subsequent investigation will have deleterious effects on the relationship with the patient and patient's family. Much progress has been made in improving the response system; yet even the most skilled response may damage the relationship. Several steps can be taken to reduce the negative impact, including informing the patient that such a report is to be made, describing the process, identifying potential positive outcomes of the process and suggested interventions, recognizing the needs and concerns of all involved.

3. How might the health care professional facilitate communication among the various parties in this case (Mary, Martha, sons, church members, other professionals)?

The health care professional can participate in a multidisciplinary team that comes together to review the case. As noted in the answer to question #1, the health care professional can facilitate communication among family members, clarifying preferences and wishes, testing the feasibility of plans of action, and suggesting variable and desirable alternatives.
4. How does the health care professional balance the competing needs (wishes) of Mary and Martha?

The health care professional is guided by the moral obligation to do no harm. A comprehensive assessment of both Mary and Martha should be done to determine whether there are any underlying medical conditions which can be treated and which may be responsible for the physical and mental deterioration in the two women. A formal evaluation of cognitive capacity might be indicated in Mary’s case. Mary’s acceptance of a home health nurse was one strategy that benefited both women for ongoing care with activities of daily living.

Facilitating a group meeting consisting of the professionals, family members, church friends, and the two clients might result in actions that would be agreeable to the women.

5. How does the health care professional’s code of ethics (non-maleficence, beneficence, individual autonomy, confidentiality, justice, and filial piety) affect his/her approach to this case?

The code of ethics provides a framework for action by the health care professional. Although it is apparent that Mary is unable to care for her sister and that she herself may be in a state of cognitive deterioration, the code of ethics requires that the rights of the patients be respected and patient confidences safeguarded. Unless Mary is found to lack capacity to make decisions, she has the right to determine what will happen to her. As long as she is responsible for her sister, she has the right to make decisions about her sister’s care.

Case #2 – John and Manny

1. How does the health care professional’s moral obligation to protect John from harm conflict with John’s desire to remain at home with Manny?

When a victim’s personal values system holds strongly a concept such as family responsibility, the issue of non-maleficence may be raised. Would more harm be done to John by finding him incompetent and placing him in a nursing home against his wishes or by letting him return home to an abusive son?

2. To what degree does the health care professional have a moral obligation to Manny?

The health care professional’s obligation is to protect John from the actions of a son who is engaging in criminal behavior. The ethical dilemma presented in this case is to balance John’s autonomous wish to continue to be a “father figure” and remain with his son against the health care provider’s moral obligation to protect John from harm. To the degree that the actions of the son may be due to his mental state, the health professional would have an obligation, as part of the treatment plan for the father to encourage the son to seek treatment.
3. How does the health care professional's code of ethics (non-maleficence, beneficence, individual autonomy, confidentiality, justice, and fidelity) affect his/her approach to this case?

As stated in question #1, more harm (non-maleficence) might be done to John by finding him incompetent and placing him in a nursing home against his wishes than letting him return home to an abusive son. In respecting John's autonomy, the health care professional cannot override John's decision to have his son remain in the home unless John is found to lack capacity to make that decision. The health care professional also recognizes the filial piety (fidelity) is guiding John's actions. He is responding to his son in his time of need.

Case #3 – Bonnie and Pete

1. What is the responsibility of the health care professionals (nursing staff, physician) to the various participants in this case (Bonnie, husband, son, other residents, nursing home administration)?

The health care professional's responsibility is to first determine Bonnie's decisional capacity. Despite her poor judgment, she appears to have adequate decisional capacity for this decision. Under those circumstances, they should be available to provide family counseling and other supports to Bonnie and her family, but not to override Bonnie's expressed wishes.

The health care professional should recognize that the abuse of medications is an illness for which there are appropriate treatments and should offer such care to Bonnie. Although it is likely that Bonnie will refuse any intervention, health care professionals should be patient, sensitive, respectful, compassionate, but persistent in trying to gain Bonnie's trust, not only to improve Bonnie's quality of life but that of the residents in the nursing home who are disturbed by her behavior.

The health care professionals also have an obligation to inform the nursing home administration about the options as well as the limitations of the case.

2. At what point does the facility staff (nursing staff) has a responsibility to intervene with Bonnie and her husband's privacy and observe, supervise, or restrict visits?

The facility staff has a responsibility to intervene with Bonnie and her husband's privacy when nursing home rules are broken. Sanctions according to facility policy can be imposed. However, it is possible that greater harm will be done to Bonnie if her visits with her husband are restricted.
3. How does the health care professional’s code of ethics (non-maleficence, beneficence, individual autonomy, confidentiality, justice and fidelity) affect his/her approach to this case?

The health care professionals’ code of ethics requires that Bonnie’s wishes be honored, unless she lacks decisional capacity or she violates the rules of the nursing home. Because Bonnie is a resident in a nursing home, her actions are also a concern to the nursing home staff and the other residents. The ethical principle of justice requires that the other residents of the nursing home not be unduly disadvantaged with respect to their needs because of the attention that Bonnie requires. The health care professional also must honor the allegiance which members of a family feel toward each other especially when a member’s actions are challenged by outsiders. Despite previous or current actions, Bonnie still has feelings for her son and husband which must be recognized in trying to intervene.
HIPAA AND APS

Jan Speed
HIPAA Privacy Officer
682-8764

Health Insurance Portability and Accountability Act

PENALTIES FOR NON-COMPLIANCE
Civil Money Penalties - $100 per violation with a $25,000 cap on violations of any one single requirement. Enforced by OCR.
Criminal Penalties - $50,000-$250,000 in fines up to 10 years in prison, Enforced by DOJ.
Protected Health Information is information which identifies the individual or offers a reasonable basis for identification.

- Is created or received by DHS;
- and

- Relates to an individual's past, present, or future health:
  - Physical or mental health,
  - Provision of health care, or
  - Payment for health care.

You are sending an e-mail to your supervisor to tell her that Beth, an adult in your caseload, has fallen and broken her arm.

Is this PHI? - √

You write a health care specialist to tell him you took a 72-hour hold on an 88-year-old gentlemen because he had been physically abused.

Is this PHI? - √
You just finished your court report for a hearing next month. You write in your report that Charlie Bartlett, a 77-year-old, tested positive for AIDS on his last drug screening.

Is this PHI?

You are a worker in Pulaski County. Your supervisor heard you lost an administrative hearing, where it was alleged sexual abuse had occurred. She has asked you to forward a copy of the decision to her. Upon pulling the order, you notice the adult victim’s name is referenced by initials.

Is this PHI? ✓

You obtained a psychological evaluation from the adult victim’s doctor during the course of an adult maltreatment investigation, and the evaluation is now part of your investigative file.

Is this PHI? ✓
You are taking an adult in DHS custody for her comprehensive health assessment. During the interview you are asked for information about her diagnosis 12-years-ago of Alzheimer's.

Is this PHI? √

While dropping Charles Collins off at his nursing home, you brief his caretakers. You tell the chief nurse that Charles has just eaten and you give her his bottle of insulin.

Is this PHI? √

When can I disclose PHI?
APS primarily maintains files in 3 different types of cases:
- Adult Maltreatment Investigations
- Adults in DHS Custody
- Protective Services

Is the PHI contained in an investigation of Adult Maltreatment File?

Is the PHI being requested for an adult in DHS custody?
This is permissible disclosure under HIPAA, however, check to make sure it is a permissible disclosure under Arkansas state law.

You DO NOT have to track disclosures when you are doing them as a custodian, since you are acting in the role of the guardian.

Is disclosure for Treatment, Payment, or Operations?

Treatment
The provisions, coordination, or management of health care and related services.
Payment
Activities undertaken to obtain or provide reimbursement for health care.

Operations
Functions such as quality assessment and improvement activities.

Is disclosure for Treatment, Payment, or Operations?
This is a permissible disclosure under HIPAA, however, check to make sure it is a permissible disclosure under Arkansas State Law.

Is the request one of the following:
- Order by Court or ALJ
- Law Enforcement request where disclosure is required by law
- Disclosure is authorized by Adult Maltreatment Law
- Signed authorization of individual or court-approved Personal Representative on DHS Form 4000 (guardian or personal representative)
- Subpoena with a protective order
- Oversight Committee

This is permissible disclosure under HIPAA, however check to be sure it is permissible under Arkansas State Law.
This is NOT a permissible disclosure under HIPAA.

Is the PHI contained in a file for an adult in DHS custody?

Is the PHI being requested for an adult in DHS custody?
This is permissible disclosure under HIPAA, however, check to make sure it is a permissible disclosure under Arkansas State Law.

Is disclosure for Treatment, Payment, or Operations?

This is permissible disclosure under HIPAA, however, check to make sure it is a permissible disclosure under Arkansas State Law.
Is the request one of the following:
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- Law Enforcement request where disclosure is required by law
- Disclosure is authorized by Adult Maltreatment Law
- Signed authorization of individual or court-approved Personal Representative on DHS Form 4000 (guardian or personal representative) 
- Subpoena with a protective order Oversight Committee?

This is a permissible disclosure under HIPAA, however, check to make sure it is a permissible disclosure under Arkansas State Law.

This is NOT a permissible disclosure under HIPAA.
Is the Adult's PHI contained in a Protective Services file?

Seek guidance from the DHS Privacy Officer.

Is disclosure for Treatment, Payment, or Operations?
This is permissible disclosure under HIPAA, however, check to make sure it is a permissible disclosure under Arkansas State Law.

Is the request one of the following:
- Order by Court or ALJ
- Law Enforcement request where disclosure is required by law
- Disclosure is authorized by Adult Maltreatment Law
  - Signed authorization of individual or court-approved Personal Representative on DHS Form 4000 (guardian or personal representative)
  - Subpoena with a protective order
  - Oversight Committee

This is permissible disclosure under HIPAA, however, check to make sure it is a permissible disclosure under Arkansas State Law.
This is NOT a permissible disclosure under HIPAA.

Tracking Disclosures

If the entity is bolded on the decision tree, this means that these disclosures must be tracked.

To track the disclosure, you must complete a DHS Form 4002 available on DHS Gold.

HIPAA permits the following disclosures:

If the PHI is contained in file for an adult in DHS custody, and:

- the PHI is being requested for an adult in DHS custody, OR
- the disclosure is for treatment, payment or operations; OR
- the request is made by one of the following:
  - Order by Court or ALJ
  - Law enforcement when disclosure is required by law,
    Signed authorization of Individual or Personal Representative (guardian or court-approved personal representative) on DHS Form 4000,
  - Subpoena + protective order
  - Oversight committees.
HIPAA permits the following disclosures:

If the PHI is contained in a file for an adult in DHS custody, and:
- the PHI is requested for an adult currently in DHS custody, OR
- the disclosure is for treatment, payment or operations, OR
- the request is made by one of the following:
  Order by Court or ALJ
  Law enforcement when disclosure is required by law,
  Signed authorization of Individual or
  Personal Representative (guardian or court-approved personal representative) on DHS Form 4000,
  Subpoena + protective order
  Oversight committees.

HIPAA permits the following disclosures:

If the adult's PHI is contained in a Protective Services file, and:
- the PHI is requested for an adult currently in DHS custody, OR
- the disclosure is for treatment, payment or operations, OR
- the request is made by one of the following:
  Order by Court or ALJ
  Law enforcement when disclosure is required by law,
  Signed authorization of Individual or
  Personal Representative (guardian or court-approved personal representative) on DHS Form 4000,
  Subpoena + protective order
  Oversight committees.

You have learned from the decision tree what types of PHI are permissible disclosures.

But, you can't stop here!

HIPAA imposes a "minimum necessary" standard on all disclosures of PHI.
You bring Beth who broke her arm to a dental appointment. The dentist has requested ALL of Beth’s medical history. Can you tell the dentist about the broken arm?

Beth’s dentist has a need to know all of her medical history. This disclosure is a permissible one under HIPAA and meets the “minimum necessary” test.

A TEA worker who is in the next office heard from a neighbor that Beth had gone to the hospital recently and has asked you what happened to Beth, can you tell her Beth broke his arm?
Remember, unless the worker has a need-to-know, this is not a permissible disclosure - even though the disclosure would be to someone within DHS.

The Court has ordered DHS to release everything in Beth’s investigative file, including all of her medical history, to the prosecuting attorney and public defender in the criminal trial about Beth’s sexual abuse by her caregiver.

Do you apply the “minimum necessary” test and if meets the test release the information?

Not unless you want to go to jail! Court orders are not discretionary and must be followed or you may be sanctioned by the court.
Prior to the court hearing, Beth needs therapeutic treatment. You have a staffing with her current guardian, employees from the therapeutic facility, her Aunt Mary and Uncle Bob, her mother, and step-father.

You intend to discuss her current mental and physical condition and why therapeutic care is necessary. Who can remain in the room during this discussion?

Prior to the staffing, you must ask only those individuals with a legitimate need-to-know to remain.

The others must be asked to leave the meeting. In this situation, Aunt Mary and Uncle Bob should be asked to leave.

Confidential?

- You place Minnie with family members and close the case. Later, Mickey moves in with Minnie, bringing along his papillons who jump on Minnie causing Minnie to fall again and break her hip for the third time. Her treating doctor is suspicious because he sees scratches on her legs and calls APS to ask about any old reports of founded abuse concerning Minnie. Can you tell the doctor about the old founded report?
5-28-213 Founded Reports

- Law Enforcement call from Bill's meth house. They are considering taking custody of Bill and want to know if we have any history with him. Can you say anything?
- Founded reports are confidential and shall be made available only to:
  - Person authorized to place adult in protective custody when person before them and reasonably believes person may have been maltreated and need information to determine if hold needed.

Release or not Release?

- Mickey is upset that you got into his house while you are investigating abuse concerning Minnie. He sends a letter invoking the Freedom of Information Act, demanding a copy of the investigative file compiled thus far. You finish your investigation, is the report now disclosable?
- Is there a way to make the information de-identified?

Release or Not Release?

- Jill was upset that Jack called the hotline about getting his tooth pulled. You sent her a letter telling her that the report was unfounded, but she is still upset that this is going on her record (she works in a nursing home). She writes a letter asking for a copy of the investigative file, can you release it to her?
5-28-213 Founded Reports

- Information in the registry may be made available to bona fide and approved research groups solely for the purpose of scientific research, but in no event shall the names of the individuals be released, not shall specific circumstances or facts related to a specific individual be utilized in any research report which might be identifiable with such individual.
Disclosures To APS & HIPAA

- A.C. A. 5-28-306 authorizes DHS to investigate allegations of adult abuse or neglect;
- HIPAA Section 164.512 (e) permits a CE to disclose PHI about an alleged victim's abuse or neglect to the extent the disclosure is required by law and the disclosure complies with the law;
- PHI includes photographs or x-rays if they identify or can be used to identify;
- Notification to subject of report may be required.

Disclosures to Personal Representatives

- Guardians Ad Litem
- Personal representatives approved by the court
- APS may elect not to treat a person as a personal representative of an individual if there is reasonable belief that individual has been or may be subjected to domestic violence, abuse or neglect by such person, or treating such person as the personal representative could endanger the individual, and
- APS, in exercise of professional judgment, decides it is not in the best interest of the individual to treat the person as the personal representative.

Psychotherapy Notes

"Notes recorded (in any medium) by mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's medical record. (emphasis added)"
Psychotherapy Notes Exclude:
- Medication prescription & monitoring,
- counseling session start and stop times,
- the modalities and frequencies of treatment furnished,
- results of clinical tests,
- any summary of the following items: diagnosis, functional status, the treatment plans, symptoms, prognosis and progress to date.
☆ These items may be disclosed to the patient pursuant to Section 164.502.

Access to Psychotherapy Notes

- Patient not entitled to access to psychotherapy notes
- Section 164.508 requires authorization for any use or disclosure of psychotherapy notes, except:
  - TPO consistent w/ 164.506
  A use or disclosure required or permitted for oversight of the originator of the notes.

Clients’ Rights under HIPAA
- Request restrictions on uses or disclosures of medical information (for example, they can request that information not be shared with a particular individual) The provider or health plan then decides if it will honor this request.
- Request that communications from DHS be made in a certain way (such as prohibiting phone calls to the patient’s home or work). The regulations state that this request must be honored unless it is “unreasonable and creates an undue administration burden”.
- Accounting of Disclosures
Sending E-mail & Faxes
DHS Policy 4006

- E-mail – only in state system using WebAccess
- Faxes – procedures set out in policy must be followed
- Confidentiality Message on both

Research

- HIPAA has specific requirements regarding PHI and research;
- Please consult Privacy Officer if you have questions.

Frequently Asked Questions:

- Consult the Privacy Standards at 45 CFR Parts 160, 164
- DHS Policy at http://dhagold/
- See also for FAQ http://www.hipaa.state.ar.us
- CMS website: http://cms.hhs.gov/hipaa/hipaa2/
- Contact Privacy Officer 682-8764.
- Err on side of non-disclosure,
- See handout of FAQ
Questions?
Call the DHS HIPAA Privacy Officer at 682-8764.