**OPEN LETTER** *(continued)*

in our community there is a true interest in understanding and working with the older patient, as well as a need for clinical social workers' involvement in research.

Your responses to the study have been gratifying and exciting, as were your notes of good wishes and encouragement; they are truly appreciated and wonderful to receive.

Once again, please accept my thanks for your time and effort in responding to the questionnaire.

*Sincerely,*
*Ellen Gussaroff, CSW, BCD*

**CONFERENCE** *(continued)*

chaos and whose play revealed his helplessness and feeling of worthlessness. Over time a play animal emerged who felt completely 'stuck,' but gradually began to interact with other farm animals, reflecting his feeling safer and his movement in the therapeutic relationship as well as replicating themes of his own family interaction.

Through symbolic play the child was able to share his affective experiences and begin to see links between his inner feelings and fantasies. His play revealed a lessening of guilt (his older sister had died when he was one year old) as he began to feel better about himself while organizing his sense of self. "He had been able to engage in analytic work on conflicts, fantasies and defenses, as long as one met him at his own level," i.e., in keeping with his cognitive capacities.

When Rees saw the boy as an adolescent, he demonstrated an "incredible" advance in his conceptual abilities and was able to work at a new level of understanding. Now aware of his age appropriate anxieties which were stirring up old feelings, he was able to verbalize his anxieties.

Rees reiterated that increased knowledge of conceptual and cognitive transformations offered child and adult analysts the opportunity to deal with a greater range of pathology.

### Dale R. Meers, DSW, BCD

**Ego Psychological Distinctions Between Maturational, Pathological and Culture Deviance**

Dale R. Meers paid tribute to Anna Freud, to her "quiet, classical, revolutionary application of theory to practice". He

*continued on page 6*

# Confidentiality and the Victim of Sexual Abuse

## What is the Therapist's Obligation?

*By Hillel Bodek, MSW, CSW, BCD*

We have received a number of inquiries recently from CSWs who are concerned that records of their treatment of sexual assault victims are being subpoenaed, usually by prosecutors.

It should be noted that **a subpoena is only a command to produce** a given record or for a person to appear at a given time and place. **A subpoena does not order the disclosure of the material produced, nor does it compel the subpoenaed person to give testimony.** *People ex. rel. Hickox v. Hickox,* 64 AD2d 412 (First Department, 1978.)

Absent certain special circumstances (e.g., child abuse), communication between certified social workers and their patients are privileged. *(Civil Practice Laws and Rules* section 4508.) Therefore, generally without the **informed** consent of the patient, neither the records of the patient's treatment nor information concerning his/her treatment should be disclosed.

In cases of sexual assault, prosecutors sometimes wish to review the records of the victim's therapy to help determine whether an assault actually took place or to help prove that the victim manifests psychosocial sequelae of having been sexually assaulted. Similarly, defense lawyers also seek the records of alleged victims' treatment.

**Limits of Privilege**

A recent decision by the Appellate Division – First Department of the New York State Supreme Court clarifies the limits of the social worker/patient privilege in this situation. In *People v. Berkley,* 157 AD2d 463 (First Department, 1990) the court upheld the conviction of a rapist who alleged that he was denied a fair trial because the trial court refused to compel the social worker at the Victim Services Agency to provide his lawyer with the record of the victim's treatment.

The Appellate Division held that although under the so-called *Rosario* rule a defendant generally has an absolute right to review prior statements made by prosecution witnesses, the courts have recognized a limitation on this disclosure rule with regard to materials for which a privilege is asserted and for materials that are not in the actual possession of the prosecutor.

It was undisputed that the records of the Victim Services Agency were not in the possession of the prosecutor and that the prosecutor had no way of obtaining them other than compelling their disclosure by judicial order, which the trial court refused to issue. However, the defendant asserted that the victim in this case had waived the social worker/patient privilege by testifying at the trial.

Generally, when a person places his/her mental state at issue, such as by suing someone for infliction of emotional distress, this plaintiff is deemed to have waived any privilege that exists between herself/himself and the health care professional with regard to such emotional problems.

The Appellate Division held that the social worker/patient privilege was not waived by the victim when she testified at the criminal trial. "[w]e cannot agree that such a privilege, if it existed, was waived by the complainant's testimony. The complainant is not a party to a criminal prosecution and, in this instance, she did not place her mental state at issue."

***CSWs should not turn over materials regarding their patients who are crime victims.***

CSWs should not turn over materials regarding their patients who are crime victims nor discuss their treatment of patients with a prosecutor or defense lawyer in a criminal case absent the explicit, written, informed consent of the patient. If a prosecutor requests the victim's treatment record, the CSW should point out to the prosecutor that, under the *Rosario* rule, once records are turned over to the prosecutor, such records will be in the prosecutor's possession and

*continued on page 4*

**MANAGED CARE** *(continued)*

less care) must "reprioritize" around mental health issues. Its challenge is how to deliver the most cost-effective (not the cheapest) care: combining the right mix of clinician and service to produce the best outcome in the shortest (but not necessarily short) time or with the least amount of resources. For this to occur, HMOs must respond to the outcry of both clinician and patient, and review guidelines for mental health benefits.

**Necessary vs. Unnecessary**

Currently HMOs see their goal as eliminating "unnecessarily" lengthy psychotherapy treatment and providing the most cost-effective care for "necessary" mental health services. Necessary services are defined as those services required to restore function to a dysfunctional individual. Ongoing dysfunction (and therefore the need for extended services) is defined in terms of risk for hospitalization or danger to oneself. While mental health providers agree with managed care professionals that restored function is a prime concern and focus of mental health services, they are quick to add that just as important is the ability to maintain one's functioning and avoid future dysfunction. The latter treatment goals may require more extended treatment and concomitant extension of mental health benefits by the HMO.

***Necessary services are defined as those . . . required to restore function to a dysfunctional individual.***

**Indemnity Plans vs. Managed Care**

Can a compromise between the financial constraints of the employer and the mental health needs of employees be reached in this climate? The solution may not be too far from today's indemnity plan insurance and the HMO. The differences between an indemnity insurance plan (e.g., Blue Cross, Met Life, etc.) and an HMO plan are the limitations placed on services approved and the amount of provider reimbursement allowed. That is, instead of having a mental health benefit dollar ceiling as most indemnity plans have, the HMOs impose a ceiling on allowed services. This translates into major savings for the HMOs. Whereas new major medical contracts written in 1991 will have a $1500 minimum outpatient reimbursement for mental health benefits in New York State, HMOs typically are liable for one-fourth that amount. For example, US Healthcare will pay $370 for 20 outpatient sessions per year: $40 for the first two sessions, $30 for the next eight sessions ($10 co-pay), and $5 for the next ten sessions ($25 co-pay). Any further outpatient treatment (other than to avoid hospitalization or in life-threatening cases) will be totally at the patient's expense (an HMO therapist must agree to accept a maximum fee of $50 for sessions after the 20 sessions allotted).

What happens if treatment must continue past the 20 sessions? In such a case, the HMO plan would still only reimburse $370, the patient would be liable for $1830, (assuming 30 additional sessions) and the therapist would receive $2200 (total) for the 50-session treatment. On first consideration one might say that this is beneficial for the patient who would have to pay more under an indemnity plan. For example, at $80 per session for a 50-session treatment, the plan would reimburse $1500, and the patient would pay $2500 plus deductible. However, in reality neither patients nor EAP personnel are finding this to be so. Many patients find the jump from paying $25 a session to $50 a session to be prohibitive to their continuing in treatment, and they opt for short-term treatment where a longer treatment would be advisable. This burdens the EAP counselor who too often must provide additional service because of the limitations of the employee's insurance plan. Patients often find that with an indemnity plan they are able to negotiate a fee which affords them the choice of longer term treatment.

***Can an HMO tailor individualized treatment plans?***

The solution to the dilemma of meeting both patient needs and employer financial constraints would appear to lie in the HMO's ability to tailor individualized treatment plans, to clarify both long- and short-term goals, and to provide a reasonable portion of the resources necessary to meet these goals. Perhaps programs such as the new Blue Cross/Blue Shield "Blue Choice: Point of Service Indemnity Program" currently being reviewed by the NYS Department of Insurance is a move in that direction. Once this new program is clarified, the vendorship committee will report. □

## Vendorship Update

Clinical social workers treating **Medicare** patients must accept Medicare assignment. CSWs must accept the determination by the Medicare carrier of the "allowable charges" for covered services as their fee for those services. Clinical social workers may only bill Medicare patients the difference between what Medicare allows and the amount Medicare pays. There are severe penalties for not following this law. (See Hillel Bodek's "Medicare Guidelines for Clinical Social Workers" in the December 1990 National Federation newsletter.)

# People in the News...

"Can This Marriage Be Saved?" This long-running monthly feature in *Ladies' Home Journal* was based on **Arden Greenspan-Goldberg's** contribution in the December 1990 issue.

Arden (Rockland) is also negotiating a book contract on eating disorders of the female athlete.

**Mary Anne Cohen** (Brooklyn) is the producer of a weekly radio show on eating disorders: "French Toast for Breakfast: Declaring Peace with Emotional Eating." Tune in — Wednesdays, 8:15 a.m., WNWK, 105.9 FM. Mary Anne is director of The New York Center for Eating Disorders.

Congratulations to **Roslyn Gold** (Queens) for receiving her doctorate. Roslyn Gold, DSW, is a clinician in private practice. Her doctoral dissertation discussed aspects of suicide; her research concerns death, dying and bereavement. Dr. Gold is a board member of Queens Mental Health Society, a member of the American Association of Suicidology and the Hemlock Society.

**CONFIDENTIALITY** *(continued)*

must be turned over to the attorney for the alleged rapist/sexual abuser.

A far better way of helping the prosecutor to be assured that there is no clinical evidence that the alleged sexual abuse did not take place would be to speak with the prosecutor after obtaining the patient's explicit, written informed consent, for the limited purpose of indicating that fact.

**Note:** Emphasis added throughout. □