

6-30-2015

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BEST PRACTICES IN TEAM-BASED TREATMENT TERMINATION

A DOCTORAL PAPER

PRESENTED TO THE FACULTY OF THE

GRADUATE SCHOOL OF PROFESSIONAL PSYCHOLOGY

OFFICE OF GRADUATE STUDIES

UNIVERSITY OF DENVER

IN PARTIAL FULFILLMENT

OF THE REQUIREMENTS FOR THE DEGREE

DOCTOR OF PSYCHOLOGY

BY

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DATE: JUNE 30, 2015

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Abstract

Termination of psychological treatment is a necessary part of the therapeutic process, but it can pose complex clinical, ethical, legal, logistical, and social challenges. This complexity becomes even more evident in the current era of treatment delivered by a team of healthcare professionals. Appropriate termination will usually involve a team decision and synthesis of the various team members' recommendations for appropriate follow-up, medications, or transfer of care into an integrated formal document to be communicated to the patient. The healthcare team may also face other considerations such as record keeping and communication responsibilities when the patient (or the patient's insurer) terminates prematurely and unilaterally. There is limited empirical data on the frequency and effects of adequate and appropriate termination of treatment versus termination done sub-optimally, particularly when a healthcare team is involved. Practical guidelines and a standardized team-based approach are needed to provide a framework for dealing with this issue, which eventually arises in every patient's evaluation and treatment. This paper explores the multiple aspects of treatment termination in the context of team-based inpatient care, utilizes a clinical vignette to provide an illustrative example of the complexities, and then provides a best practice approach to psychological treatment termination in the Appendix.

Termination of psychological treatment of patients by a psychologist is a necessary part of the therapeutic process, but it can pose complex clinical, ethical, legal, and social challenges. This complexity becomes even more evident in the current era of treatment delivered by a team of healthcare professionals (Davis, 2009; Younggren & Gottlieb, 2008; Simon & Schuman, 2009; Younggren, 2011).¹ This paper explores multiple aspects of treatment termination in the context of team-based care utilizing a clinical vignette as a working case example to facilitate discussion and highlight a best practice approach for team-based treatment termination.

In the evolving world of managed and integrated healthcare, team-based treatment across medicine, psychiatry, psychology, and social work has emerged as a new therapeutic model. This in turn has resulted in multiple providers contributing to a single patient's treatment regimen. Despite the move to team-based care, most practical advice to psychologists for treatment termination does not deal with the issue of multiple providers collaborating on psychiatric treatment termination (Melonas, 2010). Reasons for this include some of the unique ambiguities faced by psychologists involved in team treatment² as well as the absence of a standardized definition of treatment termination across fields, the paucity of empirical studies addressing the quality and documentation of provider-initiated termination of mental health treatment, and the lack of emphasis on team-based termination in training or clinical practice (Davis, 2008; Davis & Younggren, 2009; Swift & Greenberg, 2012; Swift & Greenberg, 2015). Additionally, many mental health providers do not have adequate information or plans in place

¹ Throughout the paper the term "patient" refers to the person being treated/psychotherapy client. Likewise, the term "psychologist" refers to the professional responsible for the patient's behavioral health services, and is intended to encompass any psychotherapist or mental health services provider.

² Such as seasonal or episodic care when the patient is accessing different care providers in different geographical locations and it is unclear if there will be a transfer of the patient's overall care, and who is responsible for the patient's care, if so.

to address all of the potential issues termination raises. A team-based approach to termination of care enables and also requires an entire group of providers—not just the treating psychologist—to assume shared responsibility (and perhaps liability) for patient care and to participate actively in the design, implementation, *and* termination of psychiatric treatment.

In some team-based inpatient treatment settings, the treating psychologist effectively serves as the provider responsible for initiating and coordinating aspects of treatment, including quality of care and comprehensive therapies, as well as the treatment termination process with input from the other team members. Treating psychologists sometimes have the primary ethical, legal, and clinical responsibility for patients given their understanding of the needs and complexities of specific patients and those of the particular healthcare systems under which treatment is delivered. However, in some cases it can be argued that each member of the treatment team has similar responsibilities, and the member with primary responsibility is influenced by the organizational structure of the specific institution, rather than a hierarchy based on discipline or license. Psychologists rarely work with patients in isolation; in all likelihood, other providers (primary care physicians, nurses, social workers, specialists) are involved in the patient's overall patient care. By facilitating information sharing across all aspects of the treatment process, providers involved in team care create shared risk as well as responsibility for the full spectrum of patient continuity of care.

This paper will summarize the current literature on treatment termination in light of ethical, legal, and clinical considerations, as well as social factors. While the same considerations affect all of the participating team members in some fashion, for simplicity's sake, this paper will focus predominantly on the treating psychologist's role in team-based treatment termination in an inpatient setting. It will address specifically the psychologist's

responsibility to organize, in some cases lead, and manage risk on behalf of the team to ensure the appropriate ethical, legal, and clinical standards are met. The Appendix will summarize proposed best practices for a team-based approach to psychological treatment termination.

Clinical Vignette

To provide context to the discussion of treatment termination the following clinical vignette will be referenced throughout the paper to illustrate, through example, the complexities of team-based treatment termination.

John Doe³ was a 26-year-old medical student with a history of Major Depressive Disorder and anxiety. He was not in ongoing therapy, but had been prescribed an antidepressant for his mood and a benzodiazepine he took as needed for anxiety. Six months prior to admission he had reportedly become distrustful of others and engaged in odd behaviors (e.g., going running in the middle of night and riding with a local motorcycle gang on weekends). The police found him crying, verbally nonresponsive, and rocking back and forth on a park bench; seeing his noticeable wrist scabs, on Friday night they took him to the emergency room.

John voluntarily agreed to be transferred to the hospital's psychiatric inpatient unit where he was assigned to the inpatient unit's "B team." The B team consisted of a psychiatrist, psychiatry resident, social worker, and psychology resident. John met independently with both the psychiatrist and the psychiatry resident. With the psychiatry resident, he endorsed performance anxiety and using cocaine intermittently, but denied addiction. In the B team's treatment meeting on Monday morning, the team agreed that, prior to discharge, John needed to: 1) complete a written safety plan, 2) agree to a scheduled intake with the outpatient behavioral healthcare center (the staff of which included a therapist and psychiatrist), and 3) meet with the

³ John Doe is a fictitious patient; any resemblance to a real person is entirely coincidental.

psychologist or psychology resident to receive an introduction to cognitive behavioral therapy (CBT) for his anxiety.

Three providers met with John individually the following Friday morning. Both the psychology resident and psychiatry resident concluded that John should not be discharged because, although he had completed the agreed-upon items on the discharge plan, they perceived his statements as lacking authenticity. The team psychiatrist, however, stated that John appeared to be at baseline, forthright, not an imminent safety risk, and agreeable to outpatient care. The seasoned psychiatrist was the *de facto* team-lead as the physician of record. John was discharged Friday. He completed a safety plan, met with the psychology resident, and the social worker confirmed his intake appointment with the hospital's outpatient clinic in one week. John committed suicide one week post-discharge, one day before his scheduled outpatient therapy appointment.

John's case includes a life-ending mental health problem, substance abuse, inpatient treatment, care coordination, and psychopharmacology. The suicide may have been beyond the control of any of his mental healthcare providers. Nevertheless, as John's story illustrates, it is important that appropriate termination and transfer of care steps be employed for clinical, legal, and ethical reasons. This paper will explore some of the challenges highlighted in this vignette, as well as offer suggestions for more effectively managing them using principles drawn from best team-based termination practices.

Literature Review

What Is Treatment Termination?

Younggren and Gottlieb (2008) describe treatment termination as the ethically and clinically appropriate process by which a professional relationship is ended (Younggren &

Gottlieb, 2008, p. 500). Much of this is absent in unilateral (or premature) termination.

Premature termination (when a patient self-initiates termination) also poses a number of unique concerns. However, for simplicity sake, this paper will focus on best practices in multidirectional team-based treatment termination in an inpatient setting.

While the definition of treatment termination seems clear, the process itself is less well-defined because the various stakeholders in the process (psychologists, patients, social workers, physicians, specialists, or other third parties such as the insurance provider) may have different perceptions of what is involved in treatment termination and also may have competing or divergent interests. For example, appropriate treatment termination to a psychologist might include completion of established goals, behavioral changes, reduction in symptoms, improved functioning, patient-reported satisfaction, or transfer of care (Davis, 2008). A patient, however, might believe termination occurs when the relationship feels awkward or uncomfortable or when the patient feels compromised because the patient does not understand the therapeutic process (Davis, 2008). In addition, termination could be brought about by a variety of factors outside of the direct control of either party, as when managed care practices change, insurance companies limit or revise services covered, or providers or patients relocate (Davis, 2008).

The definition of treatment termination also shifts based on the lens through which it is viewed, whether ethical, legal, clinical, or social. According to the American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct (hereafter referred to as ethical standards), there is a responsibility to end therapy if the patient is not benefiting, the continuation of therapy is contraindicated, the psychologist's safety is compromised, the actions by a third-party payer dictate termination, or the behavior of the patient requires termination (APA, 2010, p. 14). This ethical approach also takes into account whether mental health

providers have protected the patient from harm and respected the individual's right to self-determination during the termination process (Davis & Younggren, 2009, p. 573). From a legal perspective, termination has historically focused on ensuring that the appropriate standard of care has been met and that there is no question of abandonment (Younggren & Gottlieb, 2008). Within a clinical framework, termination incorporates the reason for the termination, goals attainment, closing out the patient record, the patient's current clinical condition and level of risk, and a review of the feelings associated with the dissolution of the therapeutic relationship (Vaquez, Bingham, & Barnett, 2008). The social perspective includes considerations such as access to care, the impact on the patient's familial and social supports, treatments reimbursement (or non-reimbursement) by a third party payer (insurance, managed care), and other external elements (geography, cultural components, language barriers). For example, imagine that John's insurance limited him to only three days on the inpatient unit and upon discharge his outpatient therapy would be covered at 50% after he met his deductible. Might these two factors have influenced his desire to remain on the inpatient unit voluntarily or his commitment to outpatient treatment?

Regardless of which approach is taken, it is important to keep in mind that there are duties owed to the patient by providers (such as offering appointments at appropriate frequency and arranging for transfer of care to other providers if the psychologist is not capable of delivering the standard care), and duties the patient owes providers (such as showing up for scheduled appointments and following the provider's treatment protocols). Likewise this bi-directionality in the treatment relationship affects the termination process.

Treatment relationships are contractual: *I will do X for you and you will do Y in return.* This also entails establishing the rules for the contractual relationship, such as pay structure,

session scheduling, emergency plans, and the expectations and goals for the treatment. At the beginning of the relationship, both parties need to work collaboratively to set the frame for the therapeutic work; in an ideal world, this would include developing a shared understanding of both conceptual and logistical matters related to termination. However, hellos are easier than goodbyes, as the saying goes, and—with the exception of those providing time-limited psychotherapy or other treatments with established parameters known to all parties at the outset—psychologists may focus little attention on termination in the initial phases of treatment. This may be a particularly problematic omission in team-based treatment: Waiting for a termination process to unfold “naturally” may be contraindicated if the patient may see a given provider only once or twice.

However, even under the circumstances described in the clinical example, steps could have been taken to make sure John understood the need to comply with the spirit, not just the letter, of the discharge plan. Often patients met with their teams in isolation, as was the case with John, creating ambiguity among providers and with the patient. In the clinical example, instead, the team could have met with John in an integrated care visit to establish the team/patient consensus on the treatment and discharge approach and what factors would constitute failure to fulfill that discharge plan. This might, in turn, have opened the door to meaningful communication around John’s needs, concerns, and level of risk.

Both APA standards and legal precedent recognize the bidirectional dynamic. The APA’s ethical standards call for bidirectionality except where precluded by the actions of patients (APA, 2010, p. 14). Likewise, the California Court of Appeals decision in *Ensworth v. Mullvain* (1990) found that patients and psychologists both have responsibilities in the treatment relationship (Younggren, Fisher, Foote, & Hjelt, 2011) and introduced the legal concept of

inconsistent conduct, which arises when appropriate bidirectionality does not occur (Younggren & Gottlieb, 2008).

In a team-based setting, the bidirectional relationship becomes multidirectional to incorporate all of the providers contributing to patient care. In the clinical example, John's providers had a reasonable responsibility to establish a collaborative treatment effort that accounted for how the individual nuances of his case (for example, his occupation as a medical student) might have impacted his willingness to access care (see Appendix: team-based termination, step four). The team agreed that John needed transfer of care in the form of outpatient services (see Appendix: team-based termination, step one). Besides documenting this in John's record and formally notifying him in writing of the need for additional treatment, it would be important for the team to emphasize that John had a responsibility to them to follow-up with such care and to request notification from John that this was happening (see Appendix: team-based termination, step four, bullet f).

Current research provides only a modest amount of quantitative data related to the factors that influence treatment termination. Cook and colleagues (2014) provide an assessment of racial and ethnic disparities in therapeutic treatment, although many of the gaps they identified were driven by initiation disparities (Cook, Zuvekas, Carson, Wayne, Vesper, & McGuire, 2014). Results indicated that African American and Latino patients had shorter initiation and treatment sessions, fewer psychotropic drug fills, and a lower quality of care even though other data showed African Americans had more episodic mental healthcare needs (Cook et al., 2014). However, the data also revealed no significant racial or ethnic disparities for termination of care before "minimally adequate care" was given: 78% of White patients, 79% of African American

patients, and 79% of Latino patients were all terminated before achieving what authors referred to as “minimally adequate care” (Cook et al., 2014, p. 13).⁴

The Cook study examined data on 47,903 adults, of whom 5,161 received mental health care during 6,832 discrete episodes (Cook et al., 2014, p. 12).⁵ Data included prescribed medicines; fills of psychotropic drugs; care initiation, quality, and utilization; the percentage of specialist visits; the use of acute psychiatric facilities; and whether care was stopped for 12 weeks or longer before “minimally adequate care” was achieved. The study found that, regardless of race or ethnicity, once initiated, less than one-third of individuals actually received sufficient mental healthcare, yet a large number of all of the patients in the study continued to receive psychotropic drug fills without outpatient visits or other types of supervision to monitor treatment (Cook et al., 2014, p. 16).

As the clinical example illustrates, determining what constitutes minimally adequate care can become difficult when a patient interfaces with multiple providers. In the context of an inpatient setting, John’s meeting with four different providers over the course of a week might be construed as minimally adequate care. In a team-based approach, the discussion of care levels is useful when establishing what would constitute fulfillment of his termination plan. For example, a team-based psychologist and psychiatrist might determine that one session of CBT with a patient and evaluation of medications by the psychiatrist constituted minimally adequate care. While not specified in the initial vignette, it also might be worth considering what impact John’s racial, ethnic, and other salient sociocultural identities might have on his ability to access and

⁴ The authors describe “minimally adequate care as four or more mental health care visits or events with at least one psychotropic medication fill, or eight or more visits for mental illness to a psychiatrist or other mental health care provider” (Cook et al., 2014, p. 6).

⁵ For the purposes of the study, the authors considered a mental healthcare episode to begin after 12 or more weeks without treatment and to end when mental healthcare stopped for \geq 12 weeks.

fully utilize a complete course of treatment. Other socioeconomic factors might impact John's care. Electroconvulsive therapy is cost prohibitive and few insurance companies cover it. Further, even if such care were covered, John might not have felt able to remain on an inpatient unit because of his medical school obligations. John might also have perceived outpatient therapy as untenable because of similar time commitments and difficulty attending sessions during work hours.

Cook and colleagues also identified various settings for healthcare delivery, but they did not address the role of individual versus team-based treatment termination, nor did they examine whether any kind of formal treatment termination plan was implemented at all. The large percentage of patients that experienced termination without receiving minimally adequate treatment, the continuation of psychotropic drug fills without supervision (a factor also present in the clinical vignette), and the absence of follow-up visits all indicate the need for a defined treatment termination plan, preferably one that includes team-based termination protocols.

APA's Position(s) on Treatment Termination

The evolution of the ways treatment termination has been viewed by the APA brings to light the ambiguity with which treating professionals still view termination today. In previous years, the APA encouraged psychologists to gain patient concurrence for treatment termination or referrals (APA, 1953, Standard 2.51-2.53) and, as noted above, the standards required psychologists to end therapy under a number of important circumstances (APA, 2010, p. 14). Yet all of these considerations seem to have been overshadowed by the APA's historically strong focus on avoiding patient abandonment, which in the past encouraged psychologists to continue treatment even when the therapy was unsuccessful, counterproductive, dangerous, or otherwise detrimental (Younggren & Gottlieb, 2008). For example, at a 2005 APA ethics committee

symposium, a dilemma was presented regarding how many sessions were required after a patient had threatened a psychologist's life. While the audience speculated, Judge Stephen Hjelt remarked, "Let me humbly suggest that the answer is zero" (Younggren et al., 2011, p. 167). The patient had effectively self-terminated by threatening the psychologist, essentially breaching the therapeutic contract (Younggren & Gottlieb, 2008, p. 498). That the audience members suggested various numbers of additional sessions highlights the potential for some psychologists to ignore common sense, compromise their safety, and hold themselves to an unrealistic standard out of fear of abandoning a patient or being perceived as unethical. It is perhaps better to think of delivery of mental health care under threatening circumstances as similar to delivery of emergency medical care under dangerous conditions. If the psychologist determines that the scene is not physically safe, the psychologist can unilaterally terminate treatment (hopefully with sufficient documentation in the patient's record) —a course which, without the safety concerns, might otherwise be considered abandonment.

John's behavior, as presented in the clinical vignette, did not constitute a danger to his providers. For the sake of discussion, however, consider a scenario in which John threatened one—but not all—of his providers. Questions would arise regarding whether the team should terminate care, and what, if any, access John should have to other members of his service team as he transitioned to another care setting (see Appendix: team-based transfer of care).

Both emergency and elective medical procedures may include defined diagnostic or therapeutic steps and may require the patient's informed consent to begin. Psychological treatments may likewise include diagnostic and therapeutic prescriptions, although a treatment course in psychotherapy may not be as clearly defined as, for example, that for pneumonia. At some point, the psychologist must decide that maximum treatment benefit has been reached, that

further treatment would be contraindicated, and/or that the patient should be discharged. In team settings, it is the treating psychologist's responsibility to inform and collaborate with the members of the team to clearly articulate the diagnosis and then develop and implement the treatment plan. Likewise, it is the treating psychologist's responsibility to inform and collaborate with the other team members in planning and then implementing treatment termination. In the clinical example, John presented differently to the psychiatrist, psychiatry resident, and psychology resident. It was reasonable for the psychiatry resident and psychology resident to argue in favor of a longer inpatient stay based on their impression of the patient (see Appendix: team-based termination, step two).

Thus, broadly speaking, the relevant literature shows agreement on the need for a timely, organized, and well-implemented termination plan that takes into account various ethical, legal, and clinical considerations. However, there is little agreement on what constitutes the best approach or standardized best practices (Younggren et al., 2011). For this reason, the Appendix summarizes practical advice derived from the current literature and a possible best approach for standard practices in team-based treatment termination initiated by a psychologist.

Barriers to termination

Barriers to proper termination can include a wide variety of patient, psychologist, and logistical factors, several of which were found in the clinical vignette, including (a) patient lack of adherence to appointments, (b) at-risk/vulnerable patients, (c) lack of current patient contact or healthcare information, (d) episodic nature of care by one or more providers, (e) patient boundary violations, (f) psychologist safety concerns, (g) psychologist absence (including absence of available mental health facilities that can assume treatment of the patient), (h) death of psychologist or patient, (i) changes in insurance or managed care practices, and (i)

psychologist or patient moving (Davis, 2008). The daunting scope of these obstacles underscores the need for a team-based approach to termination, and each element requires a termination plan as part of a holistic treatment process.

Influence of Practice Settings on Treatment Termination

Just as there have been major changes in the delivery of medical care, the delivery of psychological services has also changed dramatically. Psychotherapy has moved steadily toward a health service model that incorporates measurable behavioral changes and goals, multiple providers across the field, evidenced-based theoretical models, episodic care, cost-effective delivery, and emphasis on patient satisfaction (Davis, 2008). In practice, factors such as episodic care or truly integrated treatment protocols tend to be secondary considerations to therapeutic goals and costs of treatment. As discussed above, one of the more notable changes in delivery has been movement toward bidirectional or multidirectional models versus a unilateral model, which means that patients play a larger role in clinical decision-making and the responsibility of care is shared among a team of providers.

The physical setting or location of treatment can also affect the treatment termination process. For the sake of clarity, the clinical vignette focuses on an inpatient treatment setting. Other settings may present additional challenges and opportunities that are worth noting. For example, a psychologist with a private practice who has a patient in long-term care might establish a standard of termination that includes a termination session, closing letter, and referral to other providers (if appropriate), whereas a psychologist practicing in a family healthcare center might only see the same patient a few times (or even once) and therefore have no opportunity to plan or implement formal clinical closure. In fact, in such a setting the beginning and the end of treatment could take place in a single session (Davis, 2008; O'Donohue &

Cucciare, 2008). Without a team-based approach, the role of treatment duration (whether long or short), the individual treatment termination process, and the effects of both on the patient might result in disruptions to the continuity of care.

Psychologists practicing in a community health or managed care setting will typically be part of a defined treatment team. In contrast, private practice psychologists may not be formally involved with team-based treatment, there are almost certainly other providers participating in the patient's care, and the patient may benefit from the inclusion of those providers in the treatment termination process. However, this would characterize an outpatient team, which is beyond the scope of this paper. Nonetheless, given the inherent differences between short-term treatment, long-term treatment, and seasonal/transient/episodic treatment, a termination model must take into account the clinical setting and type of treatment (psychotherapy and/or psychopharmacology) involved—but, again, best practices for team-based termination need to be employed and tailored to the various setting or treatment type. In the clinical vignette, John was left in an arguably open-ended treatment status following his inpatient stay, given that he was transferring from one group of providers (inpatient team) to another (outpatient team) with no integrated transfer of care plan. This process might have been streamlined by a more formalized team-based approach that incorporated care across providers (see Appendix: team-based transfer of care, step three).

In addition, rapid changes in the field around what kinds of services are provided, how, and by whom affect treatment termination in various ways. For instance, there are now multifaceted psychotherapeutic intervention models that include groups, telephonic counseling, case management, medication management, support groups, and skills classes. There may also be reduced time for open-ended termination periods and a focus on goal-based termination, in

addition to termination at the end of a first session or situations involving multiple providers serving a single patient (Davis, 2008). Standardizing team-based best practices for treatment termination will mitigate much of the conflict, ambiguity, and confusion that result from multidisciplinary and patient participation in the termination process. In John's case, a team-based termination approach by the psychiatrist, psychology resident, psychiatry resident, and social worker that incorporated his acceptance of a termination process (see Appendix: team-based termination, step three) might have solidified John's commitment to establishing outpatient treatment. In addition, the inpatient team might have worked together to establish a broad, cross-discipline approach to help John establish concrete, and perhaps time-limited, goals for therapy that included a medication regimen and therapy. Also, a team-based approach might have highlighted any concerns John or his providers had about outpatient therapy, and influenced the options that the social worker could have provided to him.

Termination Viewed Through an Ethics-based Lens

APA ethical standards regarding treatment termination suggest that psychologists should terminate therapy when there is no benefit to the patient or when harm is being done to the patient or the psychologist. Psychologists are encouraged to offer pre-termination counseling and referrals (unless the actions of a patient or third-party payer prevent it) and "make reasonable efforts to provide for orderly and appropriate resolution of responsibility for care when relationship ends" (APA, 2010, p. 14). The "reasonable efforts" clause offers at least directional guidance for the proper handling of treatment interruption or termination, and the "informed consent" section requires psychologists to inform patients of the "anticipated course of therapy," which implies the discussion of the commencement and termination of prospective treatment (APA, 2010, p. 13).

Nevertheless, when discussing treatment termination, the standards for the most part speak to the contractual arrangement between patient and psychologist (APA, 2010, p. 5) and then expand to emphasize the legal and ethical duties of the psychologist to the patient. The standards make mention of the collaborative role that psychologists should use while working with other health professionals, but they do not cover a standardized approach to collaborative (team) treatment termination, nor do they explicitly address the non-rational processes such as context, perception, relationships, or emotion that can become involved in ethics-based decision making (Rogerson, Gottlieb, Handelsman, Knapp, & Younggren, 2011).⁶ Rogerson and colleagues (2011) remarked that a literature review showed how important automatic, intuitive, and affective processes can lead to systematic biases that are often unrecognized in ethics-based decision making. A patient-focused approach to treatment termination that involves consultation, documentation, and informed consent (Rogerson et al., 2011) can utilize team protocols to mitigate bias, ambiguity, or emotions that add undue complexity to thorny ethical issues. As part of this, it is important to consider how the inherent power differential in the provider-patient relationship may affect termination. A collaborative approach to treatment termination must take into account the variances in ethical requirements across disciplines and reconcile ambiguities between, for example, an APA ethical guideline and a similar dictum of the American Medical Association. It also must hold all team members accountable for the patient's best interest and overall health and wellness. A shared ethical standard across providers would therefore facilitate team-wide access to patient health information and records to ensure

⁶ The APA standards also cover a number of general principles that, while not specifically mentioning termination, do indicate important themes that should also be considered during the treatment termination process. These include beneficence and non-maleficence (do good; avoid harm), fidelity and responsibility (keep the welfare of the patient paramount; manage conflicts of interest), integrity (balance accuracy, honesty, and truthfulness), justice (serve fairly while being mindful of boundaries), and respect for patient rights and dignity (APA, 2010, pp. 3-4).

actions by all team members are coordinated in the best interest of the patient. Consideration of ethics of care across providers can also be an important tool to prevent patient abandonment.

“Across the different mental health disciplines of psychology, psychiatry, social work . . . there is much similarity in the ethical codes for general professional conduct and the provision of therapeutic services” (Davis, 2008, p. 36). The similarities in ethical principles introduce and allow for discipline-based clinical discretion; however, “with the freedom of discretion comes greater risk for error misjudgment” (Davis, 2008, p. 37). Some of these risks may be alleviated with a standard team-based approach to termination.

In the case of John, it was important to determine who should have been responsible for managing and following-up on John’s suicidal ideation until the outpatient treatment team assumed responsibility for his care. The inpatient team members have a responsibility to make sure there is formal transfer to an appropriate provider and make themselves available for bridge care until that transfer is complete (see Appendix: team-based termination, step four, bullets a and b).

Termination Viewed Through a Legal Lens

In addition to the ethical duties and roles framed by the APA and other medical standards, the termination of mental health treatment involves therapeutic risk management that requires both clinical competence and an understanding of the legal concerns involved (Simon & Shuman, 2009). Thus, understanding how mental health treatment and the law interact in treatment termination is essential for effective team-based care (Simon & Shuman, 2009). As a practical matter, it is important for each provider to know when the therapeutic relationship has ended, and the best way to do this is to explicitly address termination. As part of legal considerations, courts have recognized that the provider-patient relationship begins when the

patient has a reasonable expectation that it has begun, not when the therapist believes it has begun. To help ensure a shared understanding about when treatment begins, informed consent procedures could make it clear that the first visit constitutes a consultation period, at the end of which the patient and provider will mutually decide whether to continue treatment. Likewise, there needs to be a formal communication of termination to the patient so that the patient can be reasonably expected to know the relationship is terminated.

Psychologists have a fiduciary responsibility to their patients and become vulnerable to legal action when they do not act in good faith. When assessing and managing a psychologist's risk of litigation, a few basic guidelines should be followed. The psychologist should provide reasonable notice, review the patient's condition, allow access to patient records when permissible, and offer information on, or access to, resources for alternate or specialized treatment. Melonas (2010) notes that psychologists should follow the same protocol even if the patient initiates termination. Premature termination by patients (discussed in the next section) can provide considerable difficulties and challenges for psychologists, such as when patients simply stop coming to therapy without any communication, or even explicitly tell their psychologists that they want no further contact. In these situations, as discussed in the Appendix, the psychologist must document this in the patient's record, and then send a registered letter (or equivalent) to the patient communicating the psychologist's recommendations concerning the patient's treatment and steps to be followed with termination (such as transfer of care).

Psychologists must also assess whether termination actually occurs in the event of transfer of care from one provider to another. Melonas (2010) asserts that transfer of care does *not* necessarily constitute termination, so it is helpful to think of care as being suspended while

the patient is under another provider's care. Take, for example, the patient who is being managed on an outpatient basis who is hospitalized as a result of a crisis (say, suicidal ideation which occurred in the vignette for John, or medication mismanagement). In this case, the outpatient provider has suspended and not terminated care with the inpatient admission. The outpatient provider needs to educate the patient either before or after that acute episode that there has been a temporary transfer of care to manage the acute condition and ensure that the patient understands the symptoms and severity associated with the acute episode. In that way, the treating psychologist can fulfill the duty of care and remove any question of abandonment should the patient require care from other providers either during or after the acute episode.

The definition of duty of care falls under the legal construct of standard of care in tort law and is designed to offer relief to individuals injured by the unreasonable actions of others—a civil (as opposed to criminal) wrong (Standler, 2011). In order for a tort to be upheld in court, the plaintiff (or claimant) must establish the presence of a duty, breach of duty, causation, and injury (Prosser & Keeton, 1984). Duty is embedded in the idea that a relationship has been established and an obligation is owed from one party to another. Breach of duty implies one party failed to act according to terms agreed to by both parties and covers areas such as negligence, reckless disregard, and intent. Causation speaks to a cause-and-effect relationship: The defendant's action or lack of action was the proximate cause of the claimant's injury. Finally, the claimant must show that injury occurred to the claimant's property or person, including emotional distress, embarrassment, or other forms of injury (Standler, 2011).

Duty of care in the psychologist/patient sphere presupposes the relationship is both established and extant. When the law examines whether duty of care has been violated, the court bases its determination on what society at large would conclude a reasonable person would do in

a similar situation (Clarkson, Miller, Jentz, & Cross, 2008). A team-based approach to termination extends the psychologist/patient relationship to include all participating members of the patient's healthcare team. To avoid any ambiguity regarding liability under duty of care, all providers must be considered primary caregivers. A playing field of equal responsibility creates an environment of shared liability that encourages the team to share patient information and work collaboratively—which is ultimately in the best interest of each team member, as well as the patient.

For a psychologist to function effectively with the rest of the treatment team in both providing care and in developing and implementing team-based termination of treatment, details of the patient's case need to be discussed with the team members. To do this might require a patient to give permission to release information. For example, some states require a specific release for substance abuse information. Similarly, the military has different rules regarding release of mental health information (specifically in regards to substance abuse and domestic violence) (Center for Substance Abuse Treatment, 1997, pg. 96). In *Jaffee v. Redmond* (1996), the U.S. Supreme Court affirmed the psychotherapist-patient privilege in federal courts. Thus, to have a successful team-based treatment termination process, it is necessary to determine from the outset which team members may have access to such confidential information. In John's case, the importance of making the early determination of who should have access to privileged information and obtaining consent for this access is apparent. It is reasonable to assume that John might want to limit access to his medical record given his substance abuse in light of his status as a medical student.

In addition to duty of care, the question of patient abandonment is a primary concern to the APA and therefore treating psychologists. Younggren and Gottlieb (2008) describe patient

abandonment as the absence of the process of treatment termination. Psychologists who fail to make clinically and ethically appropriate decisions for treatment termination could find themselves vulnerable to liability under the tort of abandonment (Simon & Shuman, 2007; Younggren & Gottlieb, 2008). On the other hand, a psychologist is not required to provide services indefinitely. To remove ambiguity—and liability—the psychologist must establish a formal end to the patient relationship, even if the patient initiates termination. Without a clearly defined termination of treatment, psychologists remain vulnerable as providers in perpetuity, which also leaves them vulnerable to legal action under both duty of care and abandonment. A well-defined team-based termination process mitigates this risk, as well, by holding all members of the team accountable for the entire care cycle, thus encouraging them to be active in the termination process.

The clinical example illustrates that many of the providers owe John a duty of care. Often the *de facto* liability falls on the physician of record, but it is not necessarily the last person who treated John who has a duty. Many, if not all, of the providers may have liability to varying degrees. Nevertheless, the inpatient team had a duty of care to provide not only the inpatient treatment, but to formally notify John of the need for outpatient follow-up treatment and to take additional steps as necessary to determine if he was indeed getting appropriate care. The steps outlined in the Appendix help provide formal recognition and documentation of this duty and best practices to avoid legal issues that could arise if these steps are not followed.

Termination Viewed Through a Clinical Lens

Clinically, termination can be loosely divided into two broad categories: completion of treatment and premature termination. Completion of treatment is characterized as termination by the mutual agreement of psychologist and patient and should include completion of goals,

patient/psychologist agreement, and patient satisfaction (Younggren & Gottlieb, 2008).

Premature termination occurs when treatment ends, but the goals are not met (or perhaps were never established), or when there is no agreement regarding termination. Lack of agreement may result from many factors, including patient/psychologist misalignment, a psychologist's lack of competency, a patient's financial limitations, adherence issues, or boundary violations (Younggren & Gottlieb, 2008).

A team approach holds all participating providers to higher clinical (as well as ethical and legal) standards by maintaining team accountability and eliminating the pass-the-buck effect, even in the case of a change in insurance or other outside factor affecting treatment termination. Without a team-based model, the provider who conducts the last session with the patient becomes the *de facto* terminator of treatment. Consider the implications of such a situation. Talk therapy may be occurring with the psychologist, but not the psychiatrist. The primary care physician and the psychiatrist may be unaware that the therapy is taking place, although they both may be prescribing medications that affect the patient's health and behavior. The treating psychologist may notice marked changes in the patient's health, mood, or behavior, but—without thorough knowledge of the patient's medical history and a complete inventory of all medications prescribed—may attribute those changes to faulty causes, and the therapeutic treatment may fail. All of the patient's healthcare providers need to be aware not only of medical history and past and current medication, but of all therapeutic treatments offered by the psychologist as well. If the psychologist terminates treatment but the psychiatrist and primary care doctor are not informed, the patient's health could be at risk, just as when one of the medical

doctors alters a medication or discontinues care.⁷ Continuity of care requires comprehensive, continual communication among all team providers to ensure patient safety and wellness. It may be argued that John's treatment lacked continuity of care. Pragmatically, who in his inpatient care cycle was responsible to establish and formalize the transfer of care—the social worker, psychologist, or psychiatrist? John himself? Clear, specific, and mutually agreed-upon apportionment of duties among inpatient team members would have helped them meet John's transfer of care needs, once the acute inpatient treatment and stabilization had ended (see Appendix: team-based transfer of care).

The unique challenges of unilateral termination

Although beyond the scope of this paper, given the paucity in research related to team-based termination, review of patient-initiated termination (also known as premature or unilateral termination) may assist teams in implementing termination protocols in the absence of a patient.

Premature termination, particularly when a patient drops out of treatment unilaterally prior to resolving the issues that led to treatment in the first place (Swift & Greenberg, 2012, p. 547), poses a number of unique clinical concerns. Swift and Greenberg (2012) prepared a meta-analysis of 669 studies involving 83,834 patients and discovered a patient-initiated dropout rate of approximately 20% (Swift & Greenberg, 2012, p. 547). Many factors influenced the dropout rate: diagnosis, patient age, provider experience level, and treatment setting (although other

⁷ The risk of adverse events related to the discontinuation of antidepressant medication is significant and its role in appropriate team-based termination protocols could be an entire study unto itself. The discontinuation of antidepressant medications of many pharmacologic different classes can be associated with development of psychological and somatic symptoms (Fava, 2006, p. 14). Fava reviewed prospective studies of antidepressant drug discontinuation-emergent symptoms and found that 30% to 50% of patients who stopped the use of antidepressant drugs developed had adverse symptoms (Fava, 2006, p. 18). With planned treatment termination of such patients, ongoing antidepressant medication must be addressed as part of long-term care. The team-based scenario above illustrates one possible solution; transfer-of-care considerations are addressed in the Appendix.

demographic variables were not considered). The authors highlighted a few at-risk groups for whom the reduction of premature termination should be a priority (Swift & Greenberg, 2012).⁸

Susceptibility to tort claims for patient abandonment is another consideration with patient-initiated premature termination. If psychologists do not formally recognize that their obligations have ended, it may appear as though they tacitly approve clinical decisions made by the patient, including treatment termination (Vasquez, Bingham, & Barnett, 2008, p. 661). However, it is also important to take into account the role the psychologist may have played in the decision of the patient to terminate. A recent study examined the results of 332 patients (of whom 177 self-identified as White and 155 as racial or ethnic minorities) treated by 44 therapists in a university counseling center (Owen et al., 2012). The authors found that the therapists “accounted for a significant proportion of the variation in patients’ unilateral termination,” and that “racial and ethnic minorities were more likely to report unilateral therapy termination compared to White [patients]” (Owen et al., 2012, p. 314). Other patient groups, such as those suffering from personality disorders, pose additional considerations. Patients with personality disorders often have difficulty with treatment adherence and high therapy dropout rates. In fact, some 30% to 70% of patients receiving inpatient mental healthcare terminate before treatment is completed (Ingenhoven et al., 2012, p. 173). These high attrition rates can be predicted by personality functioning or psychodynamic variables but not by symptom severity or diagnostic class (Ingenhoven et al., 2012, p. 172), so the psychologist—and by extension all members of the

⁸ Those groups included patients who were younger, had personality or eating disorders, or had been seen by trainee clinicians (Swift & Greenberg, 2012, p. 547). In another article, the authors provided a series of strategies to decrease premature termination, including “providing education about duration and patterns of change, providing role induction, incorporating patient preferences, strengthening early hope, fostering the therapeutic alliance, and assessing and discussing treatment progress” (Swift, Greenburg, Whipple, & Kominiak, 2012, p. 379).

patient's healthcare team—must understand the root causes of premature termination and take appropriate steps to maintain the health of the patient and the integrity of the therapeutic process.

The impact of theoretical perspective

For the past century, termination of psychological treatment has been examined from many theoretical perspectives, including analytical, behavioral, and relational orientations (Feller, 2009). In a panel discussion at the American Psychoanalytic Association meeting in 2007, the panelists were posed the question, “How do we know it is time to end?” (Feller, 2009, p. 1185). Alice Jones suggested that a “signal to end would emerge organically out of the patient's material” — “a plan germinating on its own” (as cited by Feller, 2009, p. 1186). Jack Novick framed termination from an analytical perspective based on when the patient's capacity to choose has been restored (as cited by Feller, 2009, p. 1186). Glen Gabbard, using a behavioral approach, noted that “model termination,” where patient and analyst have shared agreement on termination, is rare (as cited by Feller, 2009, p. 1187). Notably, Freud held the relational belief that “whatever one's attitude to the question may be, the termination of analysis is, I think a practical matter” (Freud, 1937, p. 249). Because treatment termination theory carries within it the influence of these varying orientations and their differing perspectives on what termination means in the clinical environment, a standard definition of team-based termination should be part of the patient's overall treatment plan and agreed upon by all team members at the commencement of treatment. However, the prescribed definition must be comprehensive and flexible enough to both incorporate multiple orientations and accommodate changes to the course of therapy as it progresses. In John's case, his inpatient team instituted efforts to control the acute, suicidal episode, which could encompass many different theoretical perspectives, each with a potentially major impact on termination. For example, perhaps his psychologist's

orientation (or treatment approach), might have contributed to the psychologist not establishing a formalized team-based plan for termination and transfer of care. A better approach might have taken into account that John was in an environment (medical school) where such a plan would be necessary due to the seasonal episodic nature of medical school (see Appendix: team-based transfer of care).

Practical and Social Challenges to Adequate Treatment Termination

In addition to the obstacles outlined above, psychologists and patients may face a series of practical, clinical, and social challenges to effective ethical termination. First, the same inequities and social justice dynamics that affect all mental health services also impact termination. Differential access to treatment, implicit and explicit biases on the part of providers, and geographic and economic disparities in the availability and quality of services may all impact the termination process. Insured patients are bound by the specific provisions of their insurance company or managed care organization's contract that may dictate which facilities and practitioners will be reimbursed at any given time; the better prepared, informed, and coordinated patient healthcare teams are, the better the chances for successful and complete continuity of care in the event of treatment termination or referral/transfer.

Second, not all treatment courses follow the theoretically typical schedule of weekly (or more frequent) sessions for X months or years, with the client adhering to treatment protocols and consistently improving. In some cases, time-limited or episodic care may be warranted. Even the best-laid treatment plans must adapt to logistical considerations (e.g., students in different physical locations during school breaks), and to practical issues such as which provider(s) have responsibility for patient recordkeeping and documentation, and for communications between the treatment team and former patients. In addition, client behavior

that constitutes a danger to the client or others presents unique challenges to any treatment plan and to the termination process. Finally, even well-intended and informed psychologists may disagree as to what constitutes ethical termination practice. For example, some psychologists may feel that it is not ethical to reveal all of the patient's information to all members of the involved team. Regardless of theoretical orientation or personal preferences, it is recommended that all psychologists think proactively about termination just as they would about other aspects of treatment planning.

Conclusion

The advent of team-based healthcare has created a need for comprehensive team-based treatment termination protocols. As providers ranging from psychologists, trainees, psychiatrists, social workers, case managers, nurses, primary care physicians, and other parties continue to contribute to the design and implementation of patient treatment programs, team-based termination processes will continue to take on greater importance. A team-based approach to treatment termination holds all members of the patient's treatment team accountable for patient care. By facilitating thorough information sharing among team members throughout the treatment process, including treatment termination, psychologists create shared risk for the responsibility of care and full spectrum continuity of care for the patient. In John's case, this best possible sharing of information would have begun with his inpatient treatment team collaborating to provide John and his new treatment team a written record of his medical history and current treatment plan to the outpatient providers (see Appendix, team-based termination, step four). Optimally, a collaborative team approach might have involved coordinating and creating bridge care, which might have been as simple as outreach calls to the patient until outpatient treatment was established. Regardless, a standardized team-based termination practice

instituted by the inpatient service should have made clear to all providers the need to establish and determine the type of care (with a clear beginning and end to treatment) this patient required (see Appendix: team-based transfer of care).

Further research and evaluation is required to elucidate in greater detail the benefits of team-based termination of care and to build standard working definitions of termination, team-based termination, and premature termination. Areas of proposed future study should include a comprehensive survey of treating psychologists to gather baseline data regarding the current practices for treatment termination, whether team-based or individual. Secondary surveys to gather termination perspectives from provider participants would be helpful as well, and would allow researchers to validate the best practices proposed in the Appendix to this paper.

Other focus areas could include the reasons for strengthening education and training requirements regarding treatment termination. To date, studies on treatment termination training are sparse and indicate a lack of awareness of the requirements for proper termination, inadequate planning for the termination phase, and insufficient supervision of trainees in the termination process (Kapoor et al., 2000). Unfortunately, supervisors themselves may not understand the complexity of the termination process because of their own inadequate training, which might lead to missed important therapeutic and teaching opportunities (Kapoor et al., 2000). In any case, current training in treatment termination and its benefits, whether individual or team-based, is not well quantified and requires further study.

Still more studies could offer further evaluation of clinical considerations such as: (a) whether the termination style matches the theoretical orientation, (b) whether the termination style incorporates and respects the clinical issues at work (Younggren & Gottlieb, 2008), (c) whether the termination practice is clinically pragmatic given the treatment setting and patient

population, and (d) whether there is a need to consult or seek supervision regarding termination.

In-depth study in any or all of these areas will hasten the adoption of standard best practices for team-based treatment termination and ensure better patient safety and quality of care.

Although John Doe is fictional, the challenges faced by patients and providers are infinite and varied, and the suggestions outlined here will assist treatment teams in providing best possible termination outcomes that account for a variety of different patient scenarios and treatment settings.

Appendix: Best Practices for Team-Based Treatment Termination⁹

The two primary methods for a treatment relationship to end are termination and transfer of care. With termination, the therapeutic alliance ends. With transfer of care, either the patient or the psychologist chooses to continue treatment using a different provider or a different facility. Both options present ethical, legal, clinical, and social considerations, so psychologists must use their judgment to determine the best way of terminating treatment to minimize the risk of disrupting patient care.

Team-Based Termination

There are several termination protocols that psychologists can follow to build a foundation of best practices for team-based treatment termination regardless of provider, setting, or third-party mandate:

1. The first step is to determine whether treatment termination or a transfer of care is the recommended course of action and include that recommendation in the patient record.
2. The second step is to determine and record the reasons for treatment termination and to specify whether it is the decision of the psychologist, the entire team, the patient, a third party (i.e., reimbursement influences treatment setting or duration), or a combination of these factors. In some cases, not all of the team members may agree with the decision.

⁹ Several literature sources are referenced to develop best practices for team-based treatment termination. These include excellent summaries with practical advice and concrete steps by: Melonas “Terminating the treatment relationship” (Melonas, 2010) with follow-up commentary by Hessler “Regarding terminating the treatment relationship” (Hessler, 2010); Mossman, Farrell and Gilday (2010), “‘Firing’ a patient: May a psychiatrist unilaterally terminate care?” (Mossman et al., 2010). Other sources and examples are “Psychotherapy Termination: Clinical and Ethical Responsibilities” which includes 12 practical recommendations and sample letters from the clinician to the patient for termination (Vasquez et al., 2008, p. 661) and “Ending a Physician/Patient Relationship: Eight Tips for Writing a Termination Letter” (Mago, 2013, p. 47).

In this case, the most senior responsible person on the team will in most cases make the final decision. However, it will be important to record in the patient's record, and, as appropriate, communicate to the patient, the different opinions about the termination decision. Clearly, if there are strong disagreements about the decision, it is logical to involve a neutral party to help make the decision and then to record this fact in the patient's record and communicate the decision process to the patient.

3. The third step is to outline, follow, and record an accepted process for treatment termination. The process should be designed in a manner that protects the interests and well-being of patients, psychologists, and participating team providers. This process involves:
 - a. Discussing termination with the patient in person (if possible).
 - b. Providing termination information to the patient in writing.
 - c. Educating members of the patient's treatment team (including other psychologists, trainees, psychiatrists, social workers, case managers, nurses, primary care physicians, or other parties as applicable) of all actions taken and recommendations for termination as recorded in the patient record.
4. The fourth step is to document that termination was properly handled by:
 - a. Providing reasonable written notice. Generally, 30 days is considered reasonable notice from a legal standpoint, but notification periods may vary by state. Once the notice period has been determined, the psychologist must provide the patient with a specific end date, after which the psychologist will no longer be available to treat the patient (Mago, 2013, p. 47; Melonas, 2010, p. 40).

- b. Providing treatment recommendations and education (Melonas, 2010, p. 40). The psychologist must inform the patient of the recommended course of action including whether or not the patient should continue treatment, any potential risks of not continuing treatment, and what resources are available to the patient to ease the transition. This information should be documented in the patient's medical record.
- c. Identifying treatment medications and prescriptions. The medical doctors on the patient's care team must be specific in their disclosure of treatment medications and prescriptions. Whether and how psychiatric medications should be continued is of significant importance, as is an understanding of the risks associated with discontinuing medication. The most conservative approach dictates that the treating provider should not prescribe any medication beyond the treatment termination date, if for no other reason than because prescribing or refilling medications is typically considered strong evidence of an extant treatment relationship. Additionally, the risk of adverse pharmacological events occurring before a new provider is engaged represents a potential liability to the original psychologist even if all of the other termination steps are followed. As a result, decisions regarding the timing of necessary medications should be factored into the team-approved termination plan and date of treatment cessation to ensure the patient is adequately provided for and the psychologist is adequately shielded from undue risk. Nevertheless, it is important to state that licensed prescribers are liable for adverse events associated with the use or discontinuation of medications. It is inappropriate for the treatment team to dictate the parameters of

prescribing. They may inform the prescriber, but the ultimate decision to prescribe or not, and for how long, will be determined by state or facility policy or the comfort level of the prescriber. In any event, decisions must be communicated clearly and completely to the patient and team, including possible changes to an original termination date or the beginning of a new course of treatment to bridge the gap between providers.

- d. Helping the patient find additional resources for treatment (Melonas, 2010, p. 40; Mossman, 2010, p. 22). In many cases, finding resources can be as easy as instructing patients to review their insurance plans, identifying readily available community health services, offering psychologist referrals, and providing emergency hospital information. Some patients may require more assistance with these tasks.
- e. Facilitating transfer of records. Psychologists should instruct patients on the steps they need to take to request a copy of their patient records and to let patients know that all relevant records will be transferred to the new provider once all required steps are completed (Melonas, 2010, p. 41; Mago, 2013, p. 47; Mossman, 2010, p. 22).
- f. Following up. The original psychologist should provide a follow-up letter via certified mail to the patient that includes written documentation of all instructions, recommendations, and resources for continuing care.¹⁰ A copy of the letter

¹⁰ The letter becomes critical when attempts to reach a patient or telephone contact fails. Once the patient is contacted in writing, the letter becomes a formal termination document for the patient record. This letter should include the psychologist's "assessment of the patient's treatment needs as of the date of their last contact; an offer to resume treatment in the future; recommendations for ongoing care such as for continuing psychotherapy and supervision of

should also be placed in the patient file and made accessible to the larger treatment team (Melonas, 2010, p. 41).

Team-Based Transfer of Care

The transfer-of-care process closely resembles the process for treatment termination. Transfer of care can be outpatient-to-outpatient or outpatient-to-facility, but in either case the type of care needs to be specifically identified and all steps need to be coordinated and communicated to participating providers on the care team. Important components of best practices include:

1. Determine the type of care (outpatient-to-outpatient or outpatient-to-facility).
2. Provide a smooth or “warm” transfer from one psychologist or provider to another. To ensure effective information transfer, this would include written and oral communication to the next care provider on the patient’s condition and prior treatment plan.
3. Ensure there is no gap in treatment (i.e., provide bridge care as necessitated).
4. Ensure that the new psychologist, provider, or facility can meet the patient’s clinical needs.

Additional considerations for team-based outpatient-to-outpatient transfer of care include:

1. Verify and document that the patient will receive appropriate continuing care and how it will be delivered.
2. Identify and document the reason(s) for the transfer.
3. Confirm that there is a psychologist and treatment team ready to receive the patient, that the patient agrees to the transfer of care, and that relevant patient information is given to

prescribed medications; recommendations should emergencies arise; and an offer to assist with the referral process if the patient cannot or will not continue treatment with the practitioner” (Vasquez et al., 2008, p. 661).

the new psychologist with the patient's consent. It is also advisable for the referring treatment team to ensure that the patient has properly initiated treatment with the provider(s) to which the care was transferred. Pragmatically speaking, however, this may not always be possible.

4. Communicate to the patient verbally and in writing when and how to contact the new psychologist and other relevant resources for treatment.

Additional considerations for team-based outpatient-to-facility transfer of care and for subsequent discharge from the facility include:

1. Provide documentation of the emergency or crisis event that triggered the transfer as applicable; confirm that all parties understand that the change represents a transfer only and not a termination of treatment.
2. Share all ethically permissible patient information with providers at the new facility to enable them to provide appropriate and effective care.
3. Determine the best provider for the patient to see on an outpatient basis upon discharge from the facility and ensure all parties understand who will—and will not—provide ongoing care.
4. Communicate with the facility, provider, and new outpatient psychologist to ensure psychologist availability and determine the best ways to meet the patient's clinical needs at discharge.

Considerations for Team-Based Termination in the Absence of the Patient

There are additional considerations to evaluate when the patient self-initiates treatment termination and unilaterally discontinues therapy prior to recovering from the problem that led

the patient to seek treatment in the first place (Swift & Greenberg, 2012, p. 547). The steps below propose best practices for a team-based approach:

1. Determine whether the patient has the proper state of mind and understanding to make an informed and rational termination decision. If the patient terminates care during a crisis event, the psychologist should engage treatment team members immediately to ensure the patient's safety, which may include following the state's protocols regarding civil commitment.
2. Complete all of the same steps required when a psychologist terminates treatment except the notice period, as the patient rather than the psychologist will determine notification.
3. Communicate recommendations in writing to the patient for continuing treatment, resources for finding care, requesting patient records, and other relevant information.

Document all activities for inclusion in the patient record and ongoing accessibility to treating team members.

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