Learning objectives

- Describe five primary purposes of the codes of ethics for mental health practitioners.
- Explain the five professional values and related principles that inform ethics for social work practitioners.
- Recognize and discuss problematic nonprofessional behavior that could lead to ethics violations.
- Describe ethical best practices that mental health practitioners use each day to avoid unethical or illegal behaviors.
- Identify issues of multicultural diversity in mental health practice.
- List examples of informed consent as applied to clients, supervisees and other professionals.
- Identify four factors in an ethical decision-making model.
- Explain the impact of technology and a protocol for ethical use in mental health practice.
- Identify five ethical guidelines to follow when filing, managing and storing client data covered by HIPAA.
- Describe confidentiality and privileged communication as it affects ethical practice.
- Describe two current issues that involve the ethical decision-making process in counseling.

Introduction

Those who pay attention will often see ethics violations reported in the media. Teachers, politicians, coaches, physicians, nurses, college presidents and clergy, all professionals in their field, are a few who have made national headlines recently. Ethics violations occur in all professions, making the study of ethics a critical issue for all professionals.

Today, professionals in the field of mental health face many complex ethical considerations. Managed care requires practitioners to consider issues of confidentiality, informed consent and multiple relationships with clients in a constantly changing culture with many diverse populations.

In an increasingly litigious society, strict adherence to a code of ethics by all mental health professionals and their staffs is essential.

Ethics refers to the beliefs individuals hold about what is “right.” Ethical conduct refers to the behaviors exhibited by the counselor and social worker. Good ethical conduct is grounded in sound moral principles, understanding the ethical codes, and having the desire to do what is right. Morality informs proper ethical conduct and involves an evaluation of behavior based on standard expectations often influenced by culture and religion.

Laws and ethical codes regulate the practice of social workers and counselors. Professional organizations do not enforce the law; instead, laws are enforced by government definitions of the minimum standards acceptable to society.

To guide professional counselors and social workers, their professional organizations have developed guidelines in the form of a code of ethics. Recent revisions to these codes of ethics will be discussed.

The Standards for Privacy of Individual Identifiable Health Information, (the Privacy Rule) establishes a set of national standards for the protection of health information. The U.S. Department of Health and Human Services (HHS) issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule standards address the use and disclosure of individuals’ health information by organizations subject to the rule (HHS, 1996).

The major goal of the Privacy Rule is to assure that health information is properly protected, while allowing the flow of information to promote quality health care and protect the public health.

The HIPAA Privacy Rule and the codes of ethics for mental health practitioners compliment each other, as both were developed to ensure privacy, confidentiality and the well-being of individuals and society.

Historical perspectives

Standards of practice and the idea of accountability can be traced back to ancient Egypt around 2000 BC as found in the code of Hammurabi (American College of physicians, 1984), which contained a description of physician responsibilities and the consequences and punishments if the patient’s health did not improve.
Later, around 400 BC, the Hippocratic oath was an early example of a code of ethics to guide the practice of medical professionals and highlighted obligations to their profession, practice and patients. This oath contains many of the same values and ethical principles that we see today in current codes of ethics (Sinclair et al., 1996).

The writings of Aristotle concluded that ethics provide guidelines for virtuous action. In his rule the “Gold Mean,” Aristotle defined ethical choice as one that falls between two extremes. For example, Aristotle believed that trust is a virtue that lies between suspicion and foolish faith (Stanford, 2010).

After World War II, the American Psychological Association (APA) saw the need to develop a code of ethics because of a change in the type of professional activity requested of their members. Psychologists were called upon to address the mental health needs of many soldiers returning home from the war and responsible for developing psychological assessments that would be used to determine eligibility for the draft. A committee was formed to identify ethical issues that would be effective in guiding psychologists’ practice as well as their behavior. It covered such concepts as the psychologists’ responsibilities when treating clients, their relationships with their clients, students and colleagues and ethical research practices (Hobbs, 1948).

Through the years, the APA and other mental health organizations developed codes of ethics and subsequent revisions to address changes in society and the needs of their clients.

One shared belief among social workers and counselors is that professionals will do the right thing or make the right decision in the best interest of the client.

Trust appears to be the common thread throughout ethical counseling and social work practice. Tremble and Fisher (2006) note that it is not an external force that directs ethical practice; instead the focus is on internal resources such as trust and respect as a foundation for the counselor/client relationship. Ridley (2001) provides an ethical decision-making model based on trust and respect in an effective counseling relationship which is referred to as “goodness of fit.” The counselor/client relationship affects ethical decision-making that considers the cultural context of the relationship as applied to general ethical principles.

Confidentiality is essential in developing an effective relationship between mental health practitioners and clients. Some researchers have noted that therapy may not be effective at all without the trust that comes from confidentiality between therapist and client (Epstein, Steingarten, Weinstein and Nashel, 1977). They proposed the ideas that the therapeutic relationship must be based on confidence and trust so clients are willing to openly and honestly communicate emotions, fears, perceptions and actions. The complex, sensitive and serious nature of the information that is shared may be painful or shameful for the individual. If the client believes that this information will be kept confidential, there is a greater possibility of developing an effective relationship with the therapist and therefore a positive outcome for the client.

Over the last decade, ethical issues faced by counselors have received increased attention in counseling literature (Corey, Corey, and Callahan, 2003). Counselors are often faced with situations that require sound ethical decision-making. Determining the appropriate course of action to take when faced with a difficult ethical dilemma can be a challenge.

Codes of ethics were developed by professional associations to provide guidelines for practice by counselors and mental health professionals. These codes are designed to protect the professional practitioner, client and public. In their practice, counselors constantly encounter ethical issues and dilemmas that require decisions and should be not only familiar with ethics codes for their organization but also should know the areas and issues that are problematic for counselors.

Overview

Ethical professional behavior includes (Meara, Schmidt and Day, 1996):
- Understanding and implementing ethical codes.
- Always doing what is best for the client.
- Practicing the four core virtues: prudence, integrity, respectfulness and benevolence.
- Realizing the importance of intuition, integrity, honest self-evaluation and ethical decision-making models.
- Placing client welfare as paramount in all ethical decisions.

Moral principals

Kitchener (1984) identified five moral principles that are viewed as foundations of components that make up ethical decision-making. The guiding moral principles described by Kitchener and adopted by other researchers include the following:

- **Autonomy** – The concept of freedom of choice for the client is stressed. Counselors encourage the client to make decisions that are consistent with their values and to think and act in autonomous ways. The counselor must consider whether the client is capable of making sound choices. If the client is incapable of making sound choices, the counselor will help the client as much as possible.
- **Beneficence** – The concept of “do no harm.” Though this language has been recently revised, it reflects the concept of not inflicting pain on others and refraining from actions that risk harm to others.
- **Justice** – The principle of providing equal treatment for all clients.
- **Fidelity** – Honoring commitments. Counselors must guard clients’ trust and therefore not threaten the therapeutic relationship.
- **Non-malefeasance** – The concept of “do no harm.” Though this language has been recently revised, it reflects the...
and their relationships with clients rather than on solving a specific ethical or legal dilemma. Although ethics codes speak to many issues, counselors must recognize that these codes are broad and do not cover all ethical issues faced by counselors. Professionals’ ethical awareness and problem-solving skills will determine how they translate these general guidelines into professional day-to-day behavior. Welfel (2002) concludes that “ethical codes are not cookbooks for all ethical problems, and in fact, the codes are silent on many ethical issues.”

Client focus
Counselors need to be aware that their focus must be on putting the client’s needs before their own. Counselors must understand their own needs, areas of unfinished business, potential personal conflicts and defenses, and how this may affect the client. Professionals have a responsibility to work actively toward expanding self-awareness and recognizing areas of bias, prejudice and vulnerability.

Right of informed consent
Informed consent is an ethical and legal requirement and is an integral part of both therapeutic processes. Providing clients with information they need to make informed choices promotes the active cooperation of clients in their counseling plan. By educating clients about their rights and responsibilities, the counselor builds empowerment and a trusting relationship.

Confidentiality
Cullar (2001) conducted a study in which clients were questioned to determine what was most important to them in a therapeutic relationship. The survey revealed that the two most critical were “a feeling of safety and security” and “the chance to talk to the therapist in a safe environment without fear of repercussion.” Aspects of informed consent and confidentiality included in the in HIPAA Privacy Rule will be discussed later in this course.

Today the social stigma surrounding mental illness and seeking therapy has decreased – but those perceptions still exist in some areas. In the 1996 decision by the U.S. Supreme Court in Jaffe v. Redmond (1996, p.8), the court said, “Disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace,” and “the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.” Confidentiality is also based on our society’s belief that individuals have a right to privacy and the right to decide what information they will share and with whom. Confidentiality is an ethical principle, which holds the practitioner responsible for respecting the client’s privacy and protecting information disclosed during therapy. Both the code of ethics and the HIPAA Privacy Rule provide explicit, detailed provisions that cover client consent for disclosure of information and which entities can receive information. Privileged communication resulting from a therapy session is a legal concept that protects clients from having confidential information disclosed without their consent.

Confidentiality is the foundation of the professional-client relationship and is consistent with the mission to serve as an advocate for the client and the greater society. Confidentiality as it is addressed in ethics codes and case study examples of violations of confidentiality, will be presented here. The Tarasoff vs. University of California case and the legal action that resulted led to the revisions in the American Counseling Association (ACA) Code of Ethics in 2005.

Some research found that only 1 percent to 5 percent of complaints registered with ethics committees and state licensing boards of counselors and psychologists involved confidentiality violations (Pope and Vasquez, 1998). However, a national study that interviewed psychologists reported that 69 percent revealed they had violated client confidentially unintentionally, and clients may not have known (Tabachnik, & Keith-Spiegel, 1987).

Today, codes of ethics and the HIPAA Privacy Rule must address the use of new technology to prevent unintentional and intentional breaches of confidentiality that may occur in managing therapy notes and patient files electronically.

Multicultural issues
A major focus of the ACA Code of Ethics revision of 2005 was multicultural diversity competency. Cultural bias is an ethical dilemma facing many counselors today. Our culture influences our lives and defines reality for us in many ways. A culturally centered approach recognizes that culture is central, not marginal, to effective counseling relationships. Cultural issues have given rise to a variety of counseling styles that are complex and ever changing.

An ethical dilemma in multicultural diversity may begin with the difficulties with assessment because appropriate evaluation tools may not be available. It is difficult, if not impossible, to locate a culture-fair or culture-free test for all specific cultural contexts. The counselor must be trained to interpret data from tests in ways appropriate to the client’s cultural context (Paniagua, 2001).

The counseling theory or methodology must provide a valid explanation for the origin and maintenance of the behavior to inform the counseling process. The racial or cultural identity of both the counselor and the client influences how problems are defined and influences counseling goals and methods.
Counselors must expand their repertoire of helping responses to be effective in a variety of cultural contexts.

Problems may also arise when making a diagnosis in a multicultural context when using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). There are many cultural beliefs and experiences that are normal for the client’s culture, but viewed from a “western” perspective, may seem pathological (Pedersen, 2007).

### Revised ethical codes

The American Counseling Association (ACA) developed a professional code of ethics that has been adopted by licensing boards in 22 states that use the code as the basis in counseling decision-making on ethical issues.

A major revision of the ACA Code of Ethics was completed in October 2005 and contains significant changes that will impact professional counselors across all settings and specialties. The code contains new ethical directives in the areas of confidentiality, dual relationships, multiculturalism and diversity, technology, end-of-life care, and the selection of counseling interventions.

Revisions in the ACA code also include obligations for protecting the confidentiality of a deceased client, ethical use of technology in the practice of counseling, permission to refrain from making a new diagnosis and mandates for selecting new or innovative interventions, and the importance of always consulting professional colleagues in the ethical decision-making practice.

A review of the Code of Ethics for the American Mental Health Counseling Association (AMHCA), American Counseling Association (ACA), the American Psychological Association (APA), American Association of Marriage and Family Therapists (AAMFT), and the National Association of Social Workers (NASW) reveals similarities in the values, principals and standards that guide their professions.

All have the mission to enhance human development and well-being, recognize diversity and promote the worth, dignity, potential and independence of all people within their social and cultural contexts. All of these associations have ethics codes that apply to their scientific, educational, and professional roles. They share common terms and definitions and are based on the foundational premise that the client’s welfare always has the highest priority.

These codes clarify the ethical responsibilities of the practitioner and identify relevant considerations when professional obligations conflict or ethical uncertainties arise. The code for each organization includes information in the following areas:

- The client relationship.
- Communication and privacy, and confidentiality.
- Professional responsibility.
- Evaluation, assessment and interpretation.
- Training, teaching and supervision.
- Research and publication.
- Relationships and ethical responsibilities to colleagues and other professionals.
- Ethical responsibilities to society.
- Resolving ethical issues, complaints or inquiries.

This course will review and discuss key elements of the codes of ethics for social work and counseling and the application of an ethical decision making process. It is not a comprehensive guide to compliance or a source of legal information or advice.

### Terms and definitions

Counseling and social work organizations, including ACA, NASW, APA, AAMFT and AMHCA, have terms and definitions in common, and these are seen throughout their ethics codes. Some of the most commonly used terms and their definitions are:

- **Advocacy** – Promotion of the well-being of individuals, groups and the profession within systems in organizations. Advocacy seeks to remove barriers and obstacles that inhibit access, growth and development.
- **Assent** – To demonstrate agreement when a person is otherwise not capable or competent to give formal consent or informed consent to a plan of service.
- **Client** – An individual or group of individuals seeking services or referred for professional services to help with problem resolution or decision-making.
- **Competency** – Only services that are within the boundaries of social workers’ and counselors’ education, training, license and certification shall be offered.
- **Culture** – Membership in a socially constructed way of living that incorporates collective values, beliefs, norms, boundaries and the lifestyles that are co-created with others who share similar world views on biological, psychosocial, historical, psychological and other factors.
- **Diversity** – The similarities and differences that occur within and across cultures, and the intersection of cultural and social identities.
- **Documents** – Any written, digital, auditory, visual or artistic recording of the work within the counseling relationship between counselor and client.
- **Multicultural/diversity competence** – A capacity whereby practitioners possess cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge is applied effectively in practice with clients and client groups.
- **Psychosocial** – Involves aspects of social and psychological behavior and development. Related to the influences of life experiences combined with cognitive and behavioral processes.
- **Student** – An individual engaged in formal educational preparation to be a counselor or social worker.
- **Supervisee** – A professional counselor or counselor in training who is being supervised by a qualified professional in a formal supervisory relationship.
Code of Ethics of the National Association of Social Workers

The NASW approved a Code of Ethics in 1996 at its Delegate Assembly, and the same group revised it in 2008. The Code is based on a set of core values that are the foundations for the principals and standards of the profession. The core values are:

- Service.
- Social justice.
- Dignity and worth of the person.
- Importance of human relationships.
- Integrity.
- Competence.

The NASW Code of Ethics proposed these values, principles and standards to guide social workers’ conduct. The code is relevant to all social workers and social work students regardless of the type of work, setting or population they serve.

The NASW Code of Ethics was developed to:

- Identify core values on which social work is based.
- Summarize broad ethical principals that reflect the profession’s core values and establish a set of specific ethical standards that guide the social work practice.

Ethical principles

The following principles are based on the six core values identified by the NASW and set forth ideals to which all social workers should aspire and are the foundation of the NASW Code of Ethics:

- **Value: Service.**
  **Principle:** Social workers’ primary goal is to help people in need and address social problems. Social workers elevate service to others over self-interest. Social workers are encouraged to volunteer their professional skills with no expectation of significant financial return (pro bono).

- **Value: Social justice.**
  **Principle:** Social workers pursue social change on the behalf of vulnerable oppressed individuals and groups of people. Efforts of social change may be focused on poverty, unemployment, discrimination and other forms of social injustice. Social workers promote sensitivity and knowledge about oppression and cultural and ethnic diversity.

- **Value: Dignity and worth of the person.**
  **Principle:** Social workers respect the inherent dignity and worth of the person. Social workers treat each person with care and respect, aware of individual differences and cultural and ethical diversity. They promote clients’ social responsibility and self-determination to change and address their own needs.

- **Value: Importance of human relationships.**
  **Principle:** Social workers recognize the central importance of human relationships. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain and enhance the well-being of individuals, families, social groups, organizations and communities.

- **Value: Integrity.**
  **Principle:** Social workers behave in a trustworthy manner. Social workers act honestly and responsibly to promote ethical practices on behalf of their organization.

- **Value: Competence.**
  **Principal:** Social workers practice within their areas of competence and enhance their professional expertise. Social workers strive to increase their professional knowledge and skills to apply them in practice. They should aspire to contribute to the knowledge base of the profession.

Ethical standards

Ethical standards concern social workers’ ethical responsibilities to their clients, colleagues, the profession as a student or professional, and to the broader society.

These standards cover the following general areas. Contact the NASW for the code of ethics for each section below and procedures for enforcement.

- **Section 1:** Ethical responsibilities to clients.
- **Section 2:** Ethical responsibilities to colleagues.
- **Section 3:** Ethical responsibilities in practice settings.
- **Section 4:** Ethical responsibilities as professionals.
- **Section 5:** Ethical responsibility to the social work profession.
- **Section 6:** Ethical responsibility to the broader society.

Each of the six sections includes extensive and specific details that cover such topics as:

- Privacy and confidentiality.
- Informed consent.
- Competence.
- Multicultural diversity.
- Conflict of interest.
- Disputes, referrals, termination of service.
- Records.
- Supervision.
- Unethical conduct.
- Evaluation and research.
- Education and training.
Counselor Code of Ethics

The American Counseling Association (ACA) Code of Ethics was approved by the ACA governing council in 2005. Every section of the code was revised during the three-year process. Since it was first adopted in 1963, the ACA Code has been revised every seven to 10 years. It is currently under revision, and a revised code is planned for publication in 2014.

The American Mental Health Counseling Association (AMHCA) governing board revised its Code of Ethics in 2010. The mission of both counseling associations is to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the practice of counseling to promote respect for human dignity and diversity.

The ACA and AMHCA serve as educational, scientific and professional organizations whose members work in a variety of settings and serve multiple capacities. Members are dedicated to the enhancement of human development and serve individuals of all ages. Association members recognize diversity and embrace a cross-cultural approach in support of the worth, dignity, potential and uniqueness of people within their social and cultural context.

Professional values represent the ethical commitment of the counseling profession and are the foundation for principles that guide professional behavior and the counseling practice. The practice of the counselor is developed out of personal dedication rather than mandatory requirements of an external organization or legal system.

The codes of ethics for the two counseling associations mirror each other and in purpose and content and will be summarized.

Purpose

The ACA Code of Ethics and AMHCA Code of Ethics outline the following purposes:
1. The code enables the association to clarify to current and future members and to those served by the members the nature of the ethical responsibilities held by all counselors.
2. The code supports the mission of the association.
3. The code establishes principles that define ethical behavior and best practices for counselors.
4. The code serves as an ethical guide to help counselors construct a professional course of action that best serves the client and best promotes the values of the counseling profession.
5. The code serves as a basis for processing ethical complaints and inquiries initiated against members in the counseling profession.

The complete ACA Code of Ethics and the AMHCA Code of Ethics must be reviewed to study the specific guidelines for each section:
- Counseling relationship.
- Confidentiality, privileged communication and privacy.
- Professional responsibility.
- Relationships with other professionals.
- Evaluation, assessment and interpretation.
- Supervision, training and teaching.
- Research and publications.
- Resolving ethical issues.

The ethics code sections above contain specific details covering the following topics:
- Informed consent.
- Professional competence.
- Cultural sensitivity/diversity.
- Advocacy.
- Group work.
- End-of-life care.
- Fees and bartering.
- Termination and transfer.
- Technology services.
- Privacy and confidentiality.
- Shared information.
- Records.
- Parents and guardians.
- Research and publication.
- Continuing education.
- Assessment and evaluation.
- Supervision and training.
- Standards and the law.

American Nurses Association: Code of Ethics for Nurses

The following summary is from the American Nurses Association Code of Ethics for Nurses with Interpretive Statements, published in 2001. Please refer to this document for specifics of the code.
- Nurses’ primary commitment is to the patient, regardless of the setting for treatment of their health problems.
- The nurse always advocates for the health and safety of the patient.
- The nurse is responsible and accountable for nursing practice to provide optimal patient care.
- Nurses are responsible to maintain competence and personal and professional growth.

- Nurses in all professional relationships have respect for the uniqueness of every individual, regardless of social or economic status.

- Nurses in all professional relationships have respect for the uniqueness of every individual, regardless of social or economic status.
• The nurse strives to maintain and improve health care environments and conditions conducive to quality care.
• The nurse participates in the advancement of the profession.
• The nurse collaborates with other health professionals to meet health needs throughout the community.
• Those in the profession of nursing are responsible for articulating nursing values to maintain integrity of the profession, its practice and for shaping social policy.

Public education code of ethics

Most states and local school systems throughout the states have a code of ethics for teachers and counselors. The American School Counselor Association (ASCA) is a professional organization whose members are school counselors, certified or licensed in school counseling with unique qualifications and skills to address all students’ academic, personal, social and career development needs.

In their role as school counselors, they are advocates, leaders, collaborators and consultants who work to ensure equity in access and success in educational programs. In all situations, the educational professionals must align their programs with the mission of the school and school district. As with other codes of ethics, the ASCA Ethical Standards were developed to:

- Specify the principles of ethical behavior.
- Maintain high standards.
- Clarify the nature of ethical responsibilities.
- Serve as a guide for ethical practice.
- Provide self appraisal and peer evaluation.
- Inform others, including students, parents, guardians, teachers, administrators, community members and courts of justice, of the best ethical practices in the profession of school counseling.

The following major sections are included in the ethical standards for school counselors. Specific details for each section are included in the document last revised by ASCA in 2010. The sections are:

• Responsibilities to students.
• Confidentiality academic, career/college, post-secondary and personal/social counseling plans.
• Appropriate referrals.
• Danger to self or others.
• Student records.
• Evaluation, assessment and interpretation.
• Technology.
• Student peer support.
• Responsibilities to parents/guardians.
• Parental rights and responsibilities.
• Responsibilities to colleagues.
• Sharing information.
• Collaborating and educating as the counselor.
• Responsibilities to school communities and families.
• Responsibilities to self.
• Multicultural and social justice advocacy.
• Responsibilities to the profession.
• Supervision of school counseling candidates.
• Maintenance of standards.
• Resulting ethical conflicts.

An ethical decision-making model

Ethical decision-making is a process and involves the informed judgment of the social worker or counselor. There are many situations in which simple answers are not available for ethical issues. The practitioner should consider how the issues would be judged in a peer review process where the ethical standards would be applied.

In all cases, practitioners must review all values, principles and ethical standards that are relevant to the situation. They must have thorough knowledge of the code of ethics for their organization or employer.

When codes do not contain information on a particular issue, the practitioner is still responsible for making correct ethical decisions. If practitioners are faced with ethical dilemmas that are difficult to resolve, they are expected to engage in a carefully considered ethical decision-making process. Reasonable differences of opinion can and do exist among individual counselors or social workers about values, ethical principles and ethical standards to be applied when they conflict.

Because there is no specific ethical decision-making model that is most effective, professionals are expected to be familiar with credible models of decision-making that involve the professional team and will stand public scrutiny. In the absence of a clear answer in the particular ethics code or conflicts arise among the team concerning interpretation, they must implement an ethical decision-making model. Through an ethical decision-making process and evaluation of the context of the situation, counselors are empowered to make decisions that help expand the capacity of people to grow and develop.

Cottone and Claus (2000) described nine decision-making models. These models are grounded in Kitchener’s five ethical principles. The model that is used most frequently and complements most of the professional codes of ethics is an eight-step model (Corey, Corey, and Callahan 2004). The eight steps are:

1. Identify the problem or dilemma.
2. Identify the potential issues.
3. Look at relevant codes of ethics for general guidance.
4. Consider applicable laws and regulations, and determine how they may have bearing on an ethical dilemma.
5. Seek consultation from more than one source to gain multiple perspectives on the dilemma.
7. Enumerate consequences of various decisions.
8. Implement the course of action.

School counselors must become familiar with an ethical decision-making model such as Solutions to Ethical Problems in Schools (STEPS) (Stone, 2001). This model follows nine steps to help the school counselor work through solutions to ethical problems in schools. It includes the following steps:
The counselor informs the client that although she asks appropriate questions and engages in a clinically appropriate reparative/conversion therapy and has researched this approach on the Internet is convinced this is the route he wants to take. At the suggestion of a friend, the client had read about reparative/conversion therapy and has researched this approach on the Internet. He then asks for a referral to another counselor or therapist who will help him to change his sexual orientation. The ethical question is whether the counselor should make a referral for this practice in accordance with professional codes of conduct, the models provide a means for counselors to consult with others and reflect on the process, which minimizes the likelihood of an arbitrary decision. The model will help counselors to be sure it is appropriate. The three tests are:

1. **Justice** – In this test, you assess your own sense of fairness and whether you would treat other people the same way in this situation.
2. **Publicity** – Ask yourself if you want your ethical decision or course of action to be reported by the press.
3. **Universality** – Could you recommend the same decision and course of action to another counselor in the same situation?

If the course of action or decision seems to present new ethical issues, then the counselor will go back to the beginning and re-evaluate each step of the process. The course of action or decision may be incorrect, or the problem, situation or context may have been identified incorrectly.

If the counselor can answer in the affirmative to Sadler’s three tests questions above and is satisfied with course of action they selected, he or she is ready to move to implementation.

After implementation the counselor would follow up to assess whether the course of action had the anticipated effect and consequences.

### Evaluating ethical practice

Van Hoose and Paradise (1979) suggest practitioners are probably acting in an ethically responsible way with a client if they:

- Define the problem emotionally and intellectually.
- Apply the code of ethics for the school system and any school law that applies.
- Consider the student’s chronological and developmental level.
- Consider the setting, parental rights and minors’ rights.
- Apply the moral principles.
- Determine potential courses of action and their consequences.
- Evaluate the selected action.
- Consult with other professionals and administrators within the school system.
- Implement the course of action.

The implementation of the decision-making model provides a means by which the counselor can implement a standard of care in making ethical decisions (Grant, 2010).

It is important to realize that different professionals may implement different courses of action in the same situation. There is rarely one right answer to complex ethical dilemmas, but if practitioners follow a systematic model, they will be able to give a professional explanation for the course of action they choose.

The decision-making model presents a format for balancing risks and benefits of a course of action. In accordance with professional codes of conduct, the models provide a means for counselors to consult with others and reflect on the process, which minimizes the likelihood of an arbitrary decision. The model will help counselors to be sure it is appropriate. The three tests are:

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### Current ethical issues

Many counselors have consulted ACA staff and leaders about ethics in the practice of conversion therapy. The ACA ethics committee shared its formal interpretation of specific sections of the Code of Ethics concerning the practice of conversion therapy and the ethics of referring clients for this practice in (Whitman, Glosoff, Kocet & Tarvydas, 2011).

**Ethics case study 1: Reparative/conversion therapy**

During the third session of counseling, a client reports that he is gay and states, “I want to change my way of life and not be gay anymore. It’s not just that I don’t want to act on my sexual attraction to men. I don’t want to be attracted to them at all except as friends. I want to change my life so I can get married to a woman and have children with her.”

At the suggestion of a friend, the client had read about reparative/conversion therapy and has researched this approach on the Internet. He then asks for a referral to another counselor or therapist who will help him to change his sexual orientation. The ethical question is whether the counselor should make a referral for conversion therapy.

**Interpretation**

The ACA Ethics Committee considered many factors and derived a consensus opinion that addresses several sections of the Code of Ethics and moral principles of practice presented in this scenario.

Members started with the basic goal of reparative/conversion therapy, which is to change an individual’s sexual orientation from homosexual to heterosexual. Counselors who conduct this type of therapy view same-sex attractions and behaviors as abnormal and unnatural, and therefore in need of “curing.”
The belief that same-sex attraction and behavior is abnormal and in need of treatment is in opposition to the position taken by national mental health organizations, including ACA, APA and the AMHCA. The ACA Governing Council resolution of 1998 specifically notes that the ACA opposes the portrayals of lesbian, gay and bisexual individuals as mentally ill due to their sexual orientation.

In addition, the resolution supports dissemination of accurate information about sexual orientation, mental health and appropriate interventions and instructs counselors to report research accurately and in a manner that minimizes the possibility that results may be misleading.

In 1999, the ACA Governing Council adopted a statement “opposing the promotion of reparative therapy as a cure for individuals who are homosexual.” In fact, in 1973, the American Psychological Association Diagnostic and Statistical Manual (DSM–IV-TR) stated that homosexuality is not a mental disorder in need of being changed (APA, 2011).

The ACA found the majority of the studies on this topic have been expository in nature with no scientific evidence published in psychological peer-reviewed journals that state the effectiveness of conversion therapy. They did not find any longitudinal studies conducted to follow the outcomes of those individuals who have engaged in this type of treatment. They did conclude that research published in peer-reviewed counseling journals indicates that conversion therapy may harm clients.

**Ethical questions**

These findings bring several questions to the forefront:

- Is a counseling professional who offers conversion therapy practicing ethically?
- Since ACA has taken the position that it does not endorse reparative therapy as a viable treatment option, is it ethical to refer a client to someone who does engage in conversion therapy?
- If the client insists on obtaining a referral, what guidelines can a counselor follow?
- If professional counselors do engage in conversion therapy, what must they include in their disclosure statements and informed consent documents?

**Ethical decision**

- ACA committee members agreed that it is of primary importance to respect the client’s autonomy to request a referral for services not offered by counselor.
- If counselors determine an inability to be of professional assistance to clients, they must avoid entering or continuing the counseling relationship.
- Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest alternatives (ACA, 2005).

**The use of technology**

Today, computer networks are used to manage records concerning assessment and evaluation, treatment, billing and payment, and communications between therapist and client. The use of these systems may lead to breaches in confidentiality given the rising use of new technologies such as the computer, e-mail, faxes and cellular phones. Technology in counseling settings requires special security considerations to avoid new

The ACA Code reminds the counselor “to be respectful of approaches to counseling services that differ from their own” (ACA, 2005).

- “The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients” (ACA, 2005).
- “Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm” (ACA, 2005).

Referring a client to a counselor who engages in a treatment modality not endorsed by the profession and that may in fact cause harm does not promote the welfare of clients and is opposition to the basic purpose of the code.

The ACA Code clearly states that counselors “practice only within the boundaries of their competence based on the education, training, supervised experience, state and national professional credentials, and appropriate professional experience.”

It continues, “Counselors practice in specialty areas new to them only after appropriate training, education, and supervised experience. While developing skills in a new specialty area, the counselor takes steps to ensure the competence of their work and to protect others from possible harm” (ACA, 2005).

Any professional engaging in conversion therapy must have received appropriate training in such a treatment modality with the requisite supervision. There is no professional training condoned by ACA, APA, AMHCA or other prominent mental health associations that would prepare counselors to provide conversion therapy.

The ACA Code requires counselors to “recognize history and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment.”

Historically, mental health professions viewed homosexuality as a mental disorder. But with the revision by the APA, removing it from the Diagnostic and Statistical Manual as a mental disorder, professional communities of counseling, social work and psychology no longer diagnose the client who has an attraction to people of the same sex as mentally disordered.

However, within some religious and cultural communities, same-sex attractions and behaviors are still viewed as pathological.

Referring a client to someone who engages in conversion therapy communicates to the client that same-sex attraction and behaviors are disordered and need to be changed. This contradicts the dictates of the 2005 ACA Code of Ethics and APA Diagnostic Manual, so the ethical decision in this case would be to refuse the referral request.
risks for unintentional confidentiality breaches. Gelman et al. (1996) advise that secure computer systems be developed that:

- Block unauthorized users from accessing information.
- Provide ongoing security of data to prevent alteration or lost.
- Verify the source of information to confirm authenticity.
- Keep a record of communications to and from the system.
- Recover quickly and effectively from anticipated disruptions.

Koocher and Keith–Spiegel (2008) suggest the following safeguards to manage electronic records:

- Apply encryption software to protect data transmission.
- Protect stored information with complex passwords.
- Apply Internet firewalls.
- Discuss security measures with professionals when storing files with the common server or backing them up on an institutional system.
- Keep removable data storage media in secure places or use complex passwords to encrypt them.
- Protect passwords, changing them frequently and never share passwords with others.
- Be knowledgeable about security measures when using wireless devices.
- Never reveal confidential information in an e-mail or instant messaging without encryption.
- Always use privacy screens to shield monitors or other screens from view.
- Protect the physical security of portable devices such as laptops, small computers, personal digital devices and smartphones.
- Update virus protection software and other security systems.
- Remove all information when disposing of computers or other electronic devices because information may remain after erasing files.
- Consult technology specialists when disposing of information electronically.

Practitioners must always consult their organizations’ code of ethics, which address the maintenance, dissemination and disposal of confidential records of professional and research work stored or communicated electronically.

The following cases concern confidentiality issues using modern technology as described by Koocher and Keith–Spiegel (2008).

**Ethics case study 2: Technology breach of confidentiality**
A therapist sent a third billing notice to a slow-to-pay client’s fax machine in her office. On that day, however, the client did not report to work. The bill was titled “Psychological Services Rendered” and handwritten in large print was “Third Notice – Overdue!!” with the client’s name also on the cover. This notice sat in an open access mail tray of the busy office all day.

**Analysis:** The therapist should have considered that many people would have access to a common fax machine in a business office. Private material should not be faxed unless it is known that the intended recipient will be there to immediately receive the information. In fact, a message relating to billing or payment sent to a client’s office might violate debt collection laws as well as confidentiality (Koocher and Keith-Spiegel, 2008).

**Ethics case study 3: Technology breach of confidentiality**
A therapist updated numerous cases on her laptop computer while on a flight. As she completed a treatment summary on a client, she was directed to turn off all electronic equipment and prepare for landing. She saved the file to a hard disk, backed it up on a removable drive, put the stick in the seat back pocket, and packed up her computer. At that moment, the plane hit some turbulence, which caused her to become anxious and confused. She left the plane without the removable drive and though she called the airline, the drive was not recovered and the confidential material was not retrieved.

**Analysis:** The use of readily available encryption technology for confidential files would have protected the contents.

**Ethics case study 4: Technology breach of confidentiality**
A therapist who managed an office bought new desktop computers and donated the old computers to a local community center. She deleted all of the word processing and payment files before donating the computers.

**Analysis:** Just deleting files on a hard drive will not permanently remove the information, so the confidential files remained on the donated computers. In some cases, reformating a drive may not prevent some information from being recovered. Professional computer consultation must be considered when disposing of computer equipment containing client data. The counselor must consider special confidentiality issues when using modern technology. The use of encryption technology for confidential files would have protected the contents also.

**Ethics case study 5: Technology breach of confidentiality**
A mental health practitioner received a faxed complaint release of information form from a counselor in another city. The form requested information about one of the practitioner’s former clients. The practitioner noticed an e-mail address indicated on the new counselor’s letterhead to which he transmitted the requested files. During the e-mail transmission, the practitioner was interrupted by a phone call that resulted in him sending the confidential material to the wrong e-mail address – and 3,500 subscribers on the International Poodle Fanciers list server received the confidential client files.

**Analysis:** When sending information by e-mail, the practitioner must always determine the security and accuracy of the recipient e-mail address and carefully execute the transmission of confidential material by e-mail, fax or any electronic means. Ethical principles and codes and the HIPAA Privacy Rule remain in place even though technology is constantly changing. Therapists are always responsible for protecting client privacy and information disclosed to them in confidence. They must be especially careful when using electronic communication methods to protect client welfare.

Extra precautions must be taken to ensure confidentiality of information transmitted through the use of computers, electronic mail, fax machines, telephones, voice mail, answering machines, video and audio recording devices, and other electronic or computer technology.
When reviewing revised codes of ethics, considerable information relates to dual relationships that counselors may have with a client. Gabbard (1994) discussed the need for maintaining boundaries, which requires therapists to set aside their own needs in the service of addressing the patient’s needs. Mental health professionals must have guidelines, often referred to as boundaries, that are designed to minimize the opportunity for therapists to use clients for their own gain.

These boundaries can identify a set of roles for those involved in the therapy process and serve as a “limit that promotes integrity” (Katherine, 1991).

Boundaries serve to ensure the well-being of clients who disclose confidential information to their therapist. Dual relationships are sometimes referred to as multiple-role relationships, which occur when the counselor assumes two or more roles concurrently or sequentially that involve the client (Herlihy and Corey, 1997).

The dual relationship may include a second role that could be social, financial or professional. The practitioner may also be a friend, supervisor, teacher, associate or employer.

In all codes of ethics there are key elements in the guidelines relating to dual relationships as summarized below:

- A dual relationship exists when a mental health practitioner is in a counseling relationship at the same time he or she is in a relationship with the client.
- Guidelines also govern a promise or agreement to enter into another relationship in the future with the client or a person associated with the client.
- Mental health practitioners should not take on a dual role with the client if it would impair their assessment, objectivity, competence, effectiveness, communication or confidentiality as a therapist.
- Mental health practitioners should not enter into a dual relationship if the possibility exists that it could exploit or harm the client.
- Mental health practitioners are responsible for establishing clear, appropriate, sensitive and ethical boundaries before entering into any dual relationship with a client.
- If a mental health practitioner becomes aware that potential harm may occur or that unintentional harm has occurred because of a multiple relationship, the practitioner must take immediate action and show evidence of attempting to remediate the harm.

Kitchener and Harding (1990) identified three risk factors that may result in harm to clients involved in multiple or dual relationships with their therapist:

- The more incompatible the expectations in the roles within the dual relationship, the greater the potential harm.
- The greater divergence of responsibilities and obligations associated with the dual roles, the more potential for divided loyalties and loss of objectivity.
- The larger power and prestige differential between a therapist and client in a dual relationship culminates in greater potential for client exploitation because power is generally assigned to the therapist in most societies.

Herlihy and Cory (1997) outlined four problematic and complicated characteristics of dual relationships:

- Dual relationships can be difficult to identify because they develop in a subtle fashion without a clear danger sign alerting the therapist that the behavior in question might lead to an unprofessional relationship.
- The potential for harm broadly ranges from extremely pernicious to neutral or even beneficial. Sexual dual relationships can be extremely harmful to the client, whereas attending a client’s graduation may be benign or therapeutic.
- Except for dual sexual relationships, there is little consensus among mental health practitioners concerning the appropriateness of dual relationships.
- Some dual relationships cannot be avoided, such as those facing clinicians living in rural areas and small towns where they are more likely to have social and other relationships with clients.

Within an urban environment, political affiliations, ethnic identities, pastoral counseling and substance abuse status can promote dual relationships because clients may seek a therapist with similar values (Lerman and Porter, 1990).

Borys and Pope (1989) surveyed 1,600 psychiatrists, 1,600 psychologists, and 1,600 social workers with a 49 percent return rate. They examined a number of the beliefs and behaviors related to dual relationships, such as the practitioners' gender, type of profession, area of residence, marital status, experience, practice setting, practice location, size of the community, therapeutic orientation, and clients' ages. Their results found:

- There was not a significant difference between the three professions relative to sexual intimacy with clients before or after termination, nonsexual dual professional roles, social involvements, or financial involvements with clients.
- More therapists rated each dual relationship behavior as “never ethical” or “ethical under only some rare conditions” than a rating of “ethical under most or all conditions.”
- Psychiatrists, as a whole, rated such dual relationships as less ethical than psychologists or social workers.

Herlihy and Corey (1997) developed a decision-making model for therapists faced with a potential dual or multiple relationship. Their model gives following guidelines:

- Determine whether the dual relationship is avoidable or unavoidable.
- If avoidable, the practitioner should explore potential problems and benefits with the client.
- The practitioner must judge whether benefits outweigh the risk or vice versa by assessing issues that establish potential harm.
- The differences in the client’s expectations of the therapist in the two roles must be examined.
- The therapist’s divergent responsibilities in the two roles must be determined.
- The power differential in the therapist and client relationship must be considered.
- If the practitioner’s assessment concludes that client risk of harm is greater than the potential benefits, the counselor...
should not enter the dual relationship, and if necessary, refer
the client to another therapist.

- The client should be informed of the rationale for not participating in the dual relationship.
- If the therapist feels that client benefits are substantial and the risk of harm is minimal or that the dual relationship is unavoidable, then the dual relationship can exist with the following safeguards:
  - Obtain the client’s informed consent and initiate the dual relationship. The practitioner and client should discuss potential problems and possible methods of resolution.
  - Seek ongoing consultation because the therapist can lose objectivity in managing a dual relationship’s potential for harm to the client.
  - Maintain ongoing communication and monitoring with the client about potential problems and potential resolutions. This step reflects the dynamic and ongoing, rather than static, nature of informed consent.
  - Document the dual relationship and self-monitor throughout the process. If the dual relationship becomes a complaint before a licensure board or court of law, those adjudicating the complaint will expect an open reporting of all information.
  - The practitioner is advised to document the dual relationship, providing evidence of vigilance toward client risks, benefits and protection.
  - Obtain ongoing supervision, beyond simple consultation, during the dual relationship if risks are high, the relationship is complex, or if practitioners are concerned about maintaining objectivity.

Ethics violations related to dual relationship comprise the majority of ethics complaints and licensing board actions (Montgomery and Cupits, 1999; Neukrug, Millicen, and Walden, 2001). Lawsuits and the cost of defending licensing board complaints led to increased liability insurance rates, which affect everyone in the mental health professions.

This would explain the number of revisions and the specificity in the detailed descriptions of dual relationships in mental health organization’s current codes of ethics. The above section represents only a brief view of complex dual relationships. Practitioners must carefully study their organization’s code of ethics in its entirety.

Ethics case study 6: Dual relationships
A client worked as a records clerk for a community mental health center and a therapist supervised her work. The client experienced some personal problems that she asked the therapist to treat, and he agreed. The client ultimately filed an ethics complaint against the therapist, charging that he blocked her promotion based on the evaluation of her as a client rather than an employee.

Analysis: It is difficult to determine exact cause and effect in this situation, but the client can now interpret the cause of any work-related negative outcomes as related to the therapy. Dual relationships with a client/employee can become problematic in many ways and can produce career and economic hardships for the client. The therapist violated ethical standards because of the clear and foreseeable risk of harm to the client (Koocher and Keith-Spiegel, 2008).

Ethics case study 7: Dual relationships
A professional artist complained to an ethics committee that the therapist did not carry out her promises. The therapist had treated the artist for more than one year, during which the therapist complemented the client’s art work, attended art shows with him and promised to introduce his art gallery contacts to the client. The client stated he began to feel so self-confident that he terminated therapy and expected the therapist’s interest in his career to continue. The therapist stopped returning the ex-client’s phone calls, which left the client frantic. An ethics committee contacted the therapist, who explained that she always provided unconditional positive regard to her clients, but since this particular individual was no longer a client, she felt no further obligation to him.

Analysis: The ethics committee found in favor of the client. The therapist maintained a dual relationship by entwining their lives together, rendering confusion in the client. The therapist did not resolve the potential consequences of the dependency she established and maintained with the client Koocher and Keith-Spiegel, 2008).

Ethics Case Study 8: Dual relationships
A therapist and her ex-client decided they would become friends because the past therapeutic relationship was very harmonious. Unexpectedly, the ex-client perceived the therapist to be controlling and overbearing in the new relationship. She then questioned the therapist’s overall competence to the point of distancing herself from the post-therapeutic friendship. The ex-client decided that the therapist was incompetent, causing her to feel exploited and confused. She then consulted another therapist, who told her to press charges against the previous therapist.

Analysis: An ethics committee determined that incompetence could not be conclusively proven, but both the complainant and respondent were surprised at the findings on a dual role violation.

The investigation uncovered that the therapist mistakenly planned their developing relationship and its longer-term continuation while the client was still in active therapy. The therapist had actually presented these facts as a defense against the client’s accusations.

This case shows how personas may change from one context to another, and the change may be viewed as negative. The client responded well to the therapist’s authoritative personality in therapy but not socially. Also, ex-clients may choose to reenter therapy, and a neutral relationship combined with the positive effects of continuing transference is advised (Koocher and Keith-Spiegel, 2008).

Bartering: A common boundary issue
Bartering with the client for goods or services is not ethically prohibited but is not recommended as a customary practice. All codes of ethics for mental health practitioners include major sections on regulations surrounding bartering.
There is much disagreement among practitioners regarding whether bartering is ethical as evidenced by Gibson and Pope’s (1993) survey finding that 53 percent judged accepting accepting services and 63 percent rated accepting goods instead of payment as ethical. Therapists generally enter bartering arrangements with clients with the good intention of offering services to those with limited finances. However, potential problems exist. Often, client services do not equal the monetary value, on an hourly basis, to that of therapy (Kitchener and Harding 1990). Therefore clients fall further behind in the amount owed and may feel trapped or resentful.

The quality of barter services might also become problematic as therapist or client may feel short-changed, resulting in resentment and therapeutic damage.

The exchange of goods instead of payment may elicit the same quality issues inherent in service exchange, and negotiating the equivalent number of therapy sessions for the bartered goods can become an issue.

The following list provides general guidelines that are summarized and held in common from the various codes of ethics for mental health practitioners:

- Bartering arrangements create the potential for conflicts of interest and inappropriate boundaries with clients.
- Bartering should occur only in limited circumstances and if it is an accepted practice in the community.
- The mental health practitioner assumes the full burden of demonstrating that this arrangement will cause no harm to the client.
- Bartering arrangements should not put the mental health practitioner at an unfair advantage.
- Bartering agreements should be discussed and a clear written contract should be signed by the counselor and client.

**Sexual dual relationships**

One of the oldest ethical mandates in the health care profession is the prohibition of sexual intimacies with health seekers, and it predates the Hippocratic Oath. The ethics codes of mental health professions, however, did not address this behavior until research revealed its prevalence and harm to clients (Pope and Vasquez, 1998). It is estimated that 7 percent of male counselors and 1.6 percent of female counselors reported sexual relationships with former or current clients (Salisbury & Kinnier, 1996; Thoreson, Shaughnessy, & Frazier, 1995).

Holroyd and Brodsky (1997) discovered that 80 percent of psychologists who reported sexual contact also reported sexual intimacy with more than one client.

Approximately 90 percent of clients who experienced sexual intimacies with their therapist are damaged by the relationship (Bouhoutos, Holroyd, Lerman, Porter, & Greenberg, 1983). Clients are likely to suffer reactions similar to victims of rape, spouse abuse, incest and post-traumatic stress disorder. Feelings of guilt, rage, isolation, confusion and impaired ability to trust often ensue. Other clients have symptoms of post-traumatic stress disorder, including attention and concentration issues, overwhelming emotional reactions upon sexual involvement with the partner, nightmares and flashbacks.

Such harm is currently well recognized, and there are no credible opinions in the profession that defend therapist-client sexual relationships.

The codes of ethics for all mental health organizations include established moratorium time frames and strict regulations concerning sexual contact with clients. Mental health practitioners must review the sections of their organization’s code of ethics that govern sexual contact with clients in their entirety.

The following list contains information held in common among major codes of ethics regarding regulations for sexual contact between mental health practitioners and clients:

- Mental health practitioners do not engage in sexual intimacies with current therapy clients.
Mental health practitioners do not engage in sexual contact with former clients that according to the limits set in their organization’s code of contact.

Sexual intimacy with former clients is likely to be harmful.

Even after the appropriate time period allowed in the professional’s code of conduct, the burden shifts to the therapist to demonstrate there has been no exploitation or injury to the client or the client’s immediate family.

Whether such contact is consensual or forced, under no circumstances will the counselor engage in sexual activities or sexual contact with current clients.

Mental health practitioners should not engage in sexual activity with anyone associated directly with a client, such as friends, family members or colleagues.

The inadequacy of sexual conduct with clients is widely acknowledged, and clients who sue for damages have an excellent chance of winning their lawsuits if allegations are true.

Jorgenson (1995) lists the broad array of causes of action that victimized clients may allege in their civil lawsuits:

- Malpractice.
- Negligent infliction of emotional distress.
- Battery.

### Confidentiality and duty to warn

Anyone familiar with the previous 1995 ACA Code of Ethics will notice the omission of “clear and imminent danger” and the substitution of “serious and foreseeable harm” in the 2005 revisions. This was a direct outcome from the legal case Tarasoff vs. the University of California.

This case from 1969 concerned a counselor working with a client who confessed an intention to kill a partner (Grant, 2011).

#### Ethics case study 10: Duty to warn

In this case study, a student named Prosenjit Poddar came from India, where he had been born into the Harijan “untouchable” caste. He came to UC Berkeley as a graduate student in September 1967, and he briefly dated a fellow student named Tatiana Tarasoff.

She was not interested in a serious, exclusive relationship, and during the summer of 1969, she went to South America. Poddar felt betrayed, became depressed and went to a psychologist for counseling at UC Berkeley University’s Health Service Department. During counseling, Poddar confided his intent to kill his former girlfriend to his counselor.

The psychologist requested that the campus police detain Poddar, writing that, in his opinion, Potter was suffering paranoid schizophrenia, acute and severe. The psychologist recommended the defendant be civilly committed as a dangerous person.

Poddar was detained, but then quickly released, because he appeared rational. The psychologist’s supervisor then ordered Poddar not to be subject to further detention.

Poddar then befriended Tatiana’s brother and even moved in with him. In October, after Tatiana had returned, Poddar stopped seeing his psychologist. Neither Tatiana nor her parents received any warning of the threat he had made as revealed to the counselor. Several months later, on October 27, 1969, Poddar carried out his plan, killing Tatiana Tarasoff by stabbing her with a kitchen knife.

Tatiana Tarasoff’s parents sued the psychologist and other employees of the university. Poddar’s original sentence was overturned, and he was allowed to avoid a second trial by agreeing to return to India. Some reports indicate he is married and living happily in India today.

#### Ethical questions

This case brings several ethical questions to mind:

- Should the counselor have informed the police or Tarasoff or her family?
- Does the counselor have a duty to warn or to protect?
- What information concerning cultural contexts existed, and should they have been reviewed?
- Was the counselor competent to deal with the cultural aspects and the mental health diagnoses?
- Was the counselor competent to deal with dangerous or violent clients?
- If confidentiality is the cornerstone of patient-counselor relationships, can the counselor violate this ethical standard if he is no longer seeing the client?
- In what circumstances is breaching the sanctity of confidentiality necessary or allowed?

#### Interpretation

Resulting court opinions form the basis for general acceptance of the notion that treating professionals have a duty to protect known intended victims. This is important and relates to the general principles of beneficence, meaning “strive to benefit,” and non-malfeasance, or taking care to “do no harm.”
In Tarasoff v. Regents of the University of California it was ruled that if the patient poses a significant risk of violence to another party, the therapist “bears a duty to exercise reasonable care to protect the foreseeable victim of the danger.” States differ in their requirements for identifying foreseeable danger or intended victims and the scope of possible danger. These are important factors to be considered and acted upon to protect individuals and society.

**Ethical decisions**
Key points resulting from the Tarasoff case (Grant, 2011):
- A belief that therapists have special knowledge that, when coupled with the “special relationship” of therapist and client, gave rise to the duty to protect in such cases.
- The Tarasoff case and the line of cases that followed do not stand for that proposition that psychotherapists have a duty to warn unknown, intended victims. Instead they have a duty to protect the intended victim.
- Counselors must keep current in methods and procedures to handle violent clients and evaluate the level of danger.
- If a patient poses a significant risk of violence to another party, the therapist “bears a duty to exercise reasonable care to protect the foreseeable victim of danger.”
- One standard by which the breach of confidentiality and the duty to warn will be judged is the standard of what a reasonable professional in the community under the circumstances would do.
- Counselors must be competent to work with clients with those diagnoses that may include violent behavior.
- Thorough records are critical to document that the therapist understood the nature of the situation in relation to the client’s diagnosis.
- Counselors must take reasonable steps in light of the facts.
- Counselors should consult with colleagues if they unsure of how to proceed according to their code of ethics and the law of their state.
- A therapist is liable for a negative outcome if their actions fall below the expected level of care.

Therapist liability either to the client for slander or defamation or to the person warned for intentional infliction of emotional distress is extremely unlikely under the doctrine of “qualified privilege” (Grant, 2011). Elements of this doctrine are:
- Good faith.
- Legitimate interest in their duty to “protect from harm” to be furthered by statement or action.
- Statements limited in scope to that purpose.
- Proper location and communication in a proper manner and to proper parties.

**Subsequent cases**
- Some cases have recognized the duty to warn all foreseeable victims, not just those clearly identified.
- Legislative and regulatory bodies have attempted to clarify and define this duty across numerous states.
- In child abuse cases, parents must be notified despite client confidentiality rules.
- All 50 states have mandatory reporting requirements for child abuse.
- In cases of communicable diseases, HIV in the relevant case, the counselor may attempt to diffuse the risks before making an exception to the confidentiality rule if the levels of risk or foreseeable harm allow it. Examples would be to:
  - Have the client present when the partner is notified.
  - Including this in part of the therapy.
  - Have the partner or client voluntarily divulge.
- Other circumstances dictate the counselor MUST legally report information in the following cases as outlined by law:
  - Counselors believe a client under 16 is a victim of incest, rape or some other crime.
  - Counselors believe the client needs hospitalization to prevent harm to self or others.
  - When information is required as an issue in a court action.
  - When clients request that their records be released to themselves or to a third party (HIPAA, 1996).

**Discussing confidentiality laws with a minor or incapacitated client**
Federal and state laws mandate reporting of suspected child abuse or neglect, and statutes require the protection of others who may not have the ability to protect themselves, such as elderly individuals or those who reside in institutions.

A report by Taylor and Alderman (1995) included a statement to inform minor clients about the counselor’s obligations to report information that may breach confidentiality between the counselor and client. Taylor and Alderman provided an example of the type of statement that could be used in this situation:

“Most of what we talked about is private, but there are three kinds of problems that you might tell me about that we would have to share with other people. If I find out that someone has been hurting or abusing you, I would have to tell the police about it. If you tell me you plan to hurt yourself, I would have to let your parents know. If you tell me you have made a plan to hurt someone else, I would have to warn that person. I would not be able to keep these problems just between you and me because the law says I can’t. Do you understand that it is okay to talk about things here, but that these are things we must talk about with other people?”

They further suggest adding a buffer statement along the lines of the following:

“Most of what we talked about is private. If you want to talk about any of the three problems that must be shared with others, we will also talk about the best way for us to talk about the problem with others. I want to be sure I’m doing the best I can to help you.”
As previously outlined, the confidentiality requirement does not apply when imminent danger to the client or others exists. This duty to warn from the Tarasoff case in California has been added to many states’ laws across the nation. The laws on therapists’ obligation vary. Variations across the states include:

- Language such as whether the therapist must warn of imminent danger or may warn of imminent danger.
- Information about which individuals must be given a warning of imminent danger.
- What circumstances warrant the therapist’s obligation to warn of imminent danger.

Therapists must know their state laws on their duty to warn, and if they are communicating across state lines in the course of therapy, they must also be knowledgeable of the laws of that state or country.

The requirement that counselors keep information confidential as defined in the code of ethics governing their organization must also be reviewed in relation to state and federal laws, including HIPAA, governing disclosure.

According to the APA, psychologists should disclose confidential information without the consent of the individual only as mandated by law or where permitted by law for a valid purpose such as to:

- Provide needed professional services.
- Obtain appropriate professional consultations.
- Protect the client/patient, psychologist or others from harm.
- Obtain payment for services from a client/patient, in which disclosure is limited to the minimum necessary to achieve the purpose (APA, 2002).

To have thorough knowledge about the above situations, the complete APA Code of Ethics and HIPAA Privacy Rule must be studied.

NASW (1999) highlights on duty to warn include:

- Social workers should protect confidentiality of all information obtained in the course of professional service, except for compelling professional reasons.
- The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, imminent harm to a client or identifiable person.
- In all instances, a social worker should disclose the least amount of confidential information necessary to achieve the desired purpose.
- Only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

This summary above is not complete information, and contains concepts that cannot be fully understood without studying NASW Code of Ethics in its entirety.

The ACA (2005) general requirement that counselors keep information confidential does not apply when:

- Disclosure is required to protect clients or identified others from serious and foreseeable harm.
- When legal requirements demand that confidential information must be revealed.
- The counselor is in doubt as to the validity of the exception and must consult other professionals.

- Additional considerations apply when addressing end-of-life issues (ACA, 2005).

The statements above are addressed in detail in the ACA Code of Ethics, which must be studied in its entirety to understand the complexities of confidentiality between the client and the counselor.

**Case study 11: Duty to warn**

A PhD and MFT therapist had treated a client, who was a former policeman, for three years. Therapy centered on work-related injuries and the breakup of a 17-year relationship with a woman who had begun to date someone else.

On June 21, 2001, the client allegedly told the therapist that he was having suicidal thoughts. The therapist recommended hospitalization, and he asked for permission to speak with the client’s father. The father told the therapist that his son was deeply depressed, had lost his desire to live, and contemplated harming the new man his former partner was dating.


The therapist received a phone call from the client’s father the next morning, who said the hospital would soon release his son. The therapist then called the admitting physician and urged him to maintain the client’s hospitalization for further observation through the weekend. The psychiatrist disagreed and released the client, who did not contact his therapist after he was released from the hospital.

On June 23, 2001, the client shot the boyfriend of his ex-partner and then killed himself with the same handgun.

The parents of the new boyfriend filed a wrongful death lawsuit naming the therapist as one of the defendants (Ewing v. Goldstein, 2004), claiming he had a duty to warn their son of the risk from the client.

A judge dismissed the case against the therapist, who asserted that his client did not disclose a threat to the new boyfriend directly to him.

Ultimately, the California Court of Appeals reinstated the case, explaining, “When the communication of a serious threat of physical harm is received by a therapist from the patient’s immediate family, and is shared for the purpose of facilitating and furthering the patient’s treatment, the fact that the family member is not technically the ‘patient’ is not crucial.” The court expressed that psychotherapy does not occur in a vacuum, and that for therapy to be effective, therapists must be aware of the context of a client’s history and personal relationships. The court advised that communications from clients’ family members in the context comprised a “patient communication.”

When therapists must testify in court and their clients request that they not disclose information revealed in therapy, therapists may ask the court not to require the disclosure and explain the possible harm to the therapeutic relationship if such a disclosure is made. If the judge requires the therapist disclose the information, the therapist should only reveal information...
Confidentiality in group counseling

When counseling groups or families, confidentiality cannot be guaranteed because the counselor cannot control the behavior of group members. In all codes of ethics there are statements that guide the counselor to:

- Inform all clients in the group of the rules of confidentiality.
- Define the parameters of the specific group.
- Identify who the client is in the counseling setting.
- Discuss how confidentiality matters will be addressed.
- Determine how information provided by one member may be disclosed to other members by the counselor.
- Discuss how to disclose information that was previously held as secret in the group counseling session.
- Explain that confidentiality cannot be guaranteed in the group setting.

The ACA suggests that counselors seek agreement and document in writing agreements among all parties involved in the group counseling setting. These documents should include consent agreements concerning the rights of each individual to confidentiality and any obligation to preserve the confidentiality of the information disclosed (ACA, 2005).

The AAMFT notes that as with other information shared in a counseling setting, marriage and family therapists:

- Do not disclose client confidences except by written authorization, waiver or when mandated by law.
- May accept verbal authorization only in an emergency situation, or when permitted by law.
- Do not disclose information outside the treatment context without a written authorization from each individual competent to execute the waiver.

Confidentiality in research

There are many ethical standards in the code of ethics for mental health practitioners that govern the confidentiality rights of subjects or clients in research projects. The standards also govern research conduct and the differences between the client-therapist relationship and the participant-researcher relationship.

Therapy clients usually realize that they are receiving services. Research subjects may not always know this. The goal of therapy is healing the client. The goal of research is the dissemination of information. The therapist, because of the close relationship, would probably have a better understanding of what would be harmful to the client than a researcher would. Because of the formal, superficial nature of research, a researcher likely would not know the research subject as well as a therapist does. Information obtained about a participant during a research project must be kept confidential unless an agreement has been made in advance (Keith-Spiegel and Koocher, 1985).

Some laboratory ethics don’t translate well to recent research studies outside the laboratory. New ethical dilemmas may occur when social psychologists use what are called nonreactive methods in which research subjects are not aware they are being observed. This would preclude advanced informed consent and voluntary contracts. People may be observed in a social setting, contrived or changed setting. Without consent, ethical principles allow for only minimal-risk research. Yet, minimal risk may be hard to define, because the invasion of privacy and some level of deception may be involved. Both of these situations may be considered sufficient conditions to cause risk. Ethical problems in these cases may be minimized if the data cannot be linked to those observed.

When participants believe they are in a private setting, such as their own homes, added ethical issues arise when a researcher surreptitiously intrudes into the settings.

The responsibility is solely on the researcher to develop research conditions and procedures that engage in compassionate, sensitive work that provides accurate data. A researcher must also be sure that actually being studied has not harmed the group or subject.

As noted above, this information serves as a guideline only. The entire AAMFT Code of Ethics must be reviewed to understand the complex nature of confidentiality in group therapy.

The American Counseling Association offers confidential ethical and professional standards consultation five days a week during business hours. Most inquiries are answered within 24 hours, but may take up to three days when inquiries require specific research.

As noted above, the ACA Code is currently being revised, and one of the newest areas of concern is social media. ACA President Marchetta Evans noted in June 2011, “with Twitter and Facebook, there are some ethical boundary issues just floating out there with counselors.”

Evans continued, “Revising our ethics code periodically is part of our professionalization. We want it to be as extensive and as inclusive as it can be while also looking at issues that pop up in the future. The ACA Code of Ethics helps define who we are, how we operate and who we are as counselors” (Glossoff & Kocet, 2011).
Researchers may deem it necessary to violate the confidentiality of a subject to improve their data to help others. But with sensitive and advanced planning, ethical problems can be minimized. Mental health practitioners are responsible for seeking advice whenever scientific values may cause a conflict and compromise ethical principles. Investigators are also responsible for removing any negative consequences as a result of research-related participation (Keith–Spiegel & Koocher, 1985).

Ethics case study 12: Research violations

A research article was published concerning a child abuse case. It centered on a videotaped discovery of a reportedly forgotten memory in a child sexual abuse case, which was compared to the childhood interview videotaped 11 years before. The woman, known as Jane Doe, had agreed to this publication of the article (Caridad, 2003).

A psychologist on staff with a university and a private investigator discovered the real identity of Jane Doe. They interviewed her mother, brother, stepmother and foster mother. The investigator also tried to contact Jane Doe, but failed. The psychologist and the investigator did not contact the original publisher of the article or Jane for their consent to confirm her identity or to talk to her caregivers.

As a result of their investigation, two articles were published, entitled “Who abused Jane Doe?”

The psychologist did not respond to the university’s Institutional Review Board (IRB) in response to questions about their research of Jane Doe. This was because the psychologist claimed the IRB had given the permission to proceed with the research. The IRB had no record of approval for research in this case. The university decided that the study didn’t fall within its scope.

The psychologist believed she was justified in exposing Jane’s identity because she believed that the secrecy rules used to protect patients or research subjects should not be used to hide the truth about a child abuse case. The psychologist admitted befriending Jane’s mother and that she was largely motivated by the desire to reunite the mother and daughter.

Jane Doe told the IRB that she disagreed with the psychologist’s decision and actions to find her mother and her stepmother for interviews.

Meanwhile, the psychologist’s actions damaged her relationship with the university. Her colleagues questioned the methods she used in her challenge of the initial published research. University officials began a 21-month investigation of the psychologist’s research in this case.

The dean at the university stated that university rules for research on human subjects were primarily written for medical school examinations. The office of scholarly integrity stated that the psychologist would have had to seek the university’s permission to interview people and probably would have been required to give the IRB a list of questions being asked and a form explaining to the subjects the risks of being interviewed. The psychologist would have been required to have the researcher who wrote the initial article get permission to interview Jane Doe and review records. The university cleared the psychologist, but she was required to take an ethics class and to get permission from the IRB before talking to any of the research subjects again.

The psychologist is facing an impending lawsuit filed by Jane Doe. She and several others are accused of defamation, libel, negligent and intentional infliction of distress, emotional invasion of privacy, and damages. Jane Doe alleges that the psychologist’s research disclosed her private information and disclosed her identity. Her lawsuit claims that this has subjected her and her family to additional emotional distress from past events. She also claimed that the psychologist did not plan the research with regard for her safety and welfare, and those procedures were not in place for other researchers, or her, to observe the project and report possible problems. Jane Doe states that the psychologist purposefully mischaracterized the records and information they received.

The psychologist in her defense claims she always called the subject Jane Doe in the publication and that the lawsuit was an attempt to stifle her freedom of speech.

Though the psychologist’s article did not include names, other details were included that could break confidentiality. This information included Jane’s parents’ wedding date, name of the hospital Jane was taken to and the emergency room director’s name, Jane’s age and the date of the incident, details of her injuries and information on a custody case.

This information and other details in the article would make it relatively easy for a researcher to ascertain Jane’s identity.

Analysis: In this particular case, it appears the psychologist may have violated at least three ethical codes: research subject confidentiality, informed consent and dual relationships. Psychologists are only allowed to reveal the information with the consent of the person or their legal representative, with the exception of when this information could cause a clear danger to the person or others.

The code of ethics further states that psychologists who present personal information obtained during their professional work are required to obtain adequate prior consent or adequately disguise the information. The psychologist did not get prior consent or adequately disguise the information (Keith–Spiegel & Koocher, 1985).

The 1992 APA guidelines for disclosure of information say psychologists are only allowed to disclose confidential information without the individual’s consent in the following cases:

- To help provide the client services.
- To get appropriate professional consultation.
- To protect clients or others from harm.
- To get payment for services provided, but disclosure is limited to the minimum information necessary.

The psychologist’s rationale for violating confidentiality was to expose the truth, but this does not fall under one of the APA’s guidelines for violating confidentiality.

However, scientific merit and ethical issues may sometimes conflict. A researcher may deem it necessary to violate confidentiality of the subject to improve the data to help others. But with sensitive advance planning, ethical problems can be minimized.
Psychologists are responsible for seeking advice whenever scientific values may cause a conflict and compromise the APA standards. The investigator is also responsible for removing any necessary negative consequences as a result of research-related participation.

Stricker (1982) defines informed consent as the subject agreeing to participate in research after receiving an explanation of the research and its risks. The elements of informed consent include competency, voluntariness and knowledge.

One issue in the research concerns existing records that were collected for clinical or administrative purposes. Patients may have given initial consent for this data to be collected, but they probably didn’t give consent for the data to be used in research. Many records may be old, and a patient’s permission would be difficult to obtain. In these cases, retaining patient anonymity is crucial. Permission should be obtained from a person acting on the patient’s behalf. The data should not be used in any way beyond that for which permission was granted (Stricker, 1982).

Jane Doe gave consent to the initial study, but she did not give consent for the second study. The psychologist admits she could have contacted Jane Doe to interview her, but chose not to do so. The psychologist did not call the original researcher until the middle of her research of the Jane Doe case.

As previously noted, the psychologist admitted to befriending Jane’s biological mother and that she was largely motivated by the desire to reunite the family. Dual relationships are defined as having two or more roles with the client at the same time. In this situation, the psychologist had two or more relationships with research subjects. The psychologist acted as researcher and friend to the mother.

The psychologist’s objectivity may have been diminished by her friendship with Jane’s mother. The psychologist’s desire to unite mother and daughter may have made her biased to the mother’s perspective.

A major goal of the Privacy Rule is to assure that individuals’ health information is properly protected while allowing the sharing of health information to provide high-quality health care and to protect to public health.

The health care marketplace is diverse, so the rule is designed to be flexible and comprehensive to cover the variety of disclosures that need to be addressed.

The following summary of key elements in the Privacy Rule is not a complete or comprehensive guide to compliance. Covered entities regulated by the rule are obligated to comply with all of its requirements and should not rely on this summary as the source of legal information or advice. To view the entire rule, and for other information about how it applies, review the OCR website included in the resource information section at the end of this course.

Summary of the HIPAA Privacy Rule

The U.S. Department of Health and Human Services (HHS) created the Standards for Privacy of Individually Identifiable Health Information, known as the Privacy Rule, to establish a set of national standards for the protection of certain health information. The Privacy Rule was needed to implement the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Privacy Rule standards address the use and disclosure of individuals’ health information called “protected health information” by organizations subject to the rule, which are called “covered entities.” HIPAA also includes standards for individuals’ privacy rights to understand and control how their health information is used.

Within HHS, the Office for Civil Rights (OCR) has responsibility for implementing and enforcing the Privacy Rule, including voluntary compliance activities and civil money penalties.

Therapists may not need to be as objective as a researcher when trying to come to a conclusion about the data or clients there they are studying. A researcher is merely observing the subject to obtain accurate data, while a therapist is attempting to help the client make a change.

A researcher must also be sure the group or subject has not been harmed by being studied. A case could be made that because of the breach of confidentiality and intrusion into Jane Doe’s private life and the life of her family, Jane’s informed consent before research of this case would be ethically mandated. Jane also alleges she was harmed by the research. As noted, it is a researcher’s ethical responsibility to ensure such harm is not occurring to anyone during the research.

The right to freedom of speech and academic debate does not allow for the kind of ethical breaches that were made in the Jane Doe case. The violation of Jane Doe’s confidentiality without her written consent around such a sensitive issue appears to have been unnecessary and inappropriate.

Furthermore, discussing such a sensitive issue publicly without a person’s consent appears to be extremely insensitive. There may have been other ways to contradict the initial case study that would not have necessitated publishing extremely personal details about Jane Doe without her permission.

The hazards and inconveniences that the research caused Jane and her family were not well mediated. The psychologist admitted having a dual relationship with Jane’s mother, which shows poor judgment on her part.

The psychologist’s excuse that she should reunite the mother with Jane is not strong enough to counteract the possible damage that could result from her dual relationship with the mother (Claridad, 2003).
Background information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996, and sections 261 through 264 required the secretary of HHS to publicize standards for the electronic exchange, privacy and security of health information. These are known as the administrative simplification provisions.

HIPAA required the HHS secretary to issue privacy regulations governing individually identifiable health information if Congress did not enact privacy legislation within three years of the passage of HIPAA. Because Congress did not do so, HHS developed a proposed rule and released it for public comment on Nov. 3, 1999. The department received more than 52,000 public comments. The final regulation, the Privacy Rule, was published Dec. 28, 2000.

In March 2002, the department proposed and released modifications to the Privacy Rule. The department received more than 11,000 comments, and the final modifications were published on Aug. 14, 2002.

Covered entities

The Privacy Rule, as well as all of the administrative simplification rules, applies to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form in connection with transactions that are called “covered entities.”

- Health plans
  - Individual and group plans that provide or pay the cost of medical care are covered entities. The plans include health, dental, vision, prescription drug insurers and health maintenance organizations (HMOs).
  - Medicare, Medicaid, Medicare Plus Choice, and Medicare supplement insurers, and long-term care insurers are covered entities.
  - Health plans also include employer-sponsored group health plans, government- and church-sponsored health plans, and multi-employer health plans.
  - There are exceptions; a group health plan with less than 50 participants that is administered by the employer that established and maintains the plan is not a covered entity.
  - Two types of government-funded programs are not health plans:
    1. Those whose principal purpose is not providing or paying the cost of health care, such as food stamp programs.
    2. Those programs whose principal activity is directly providing health care, such as a community health center, or to provide grants to fund the direct provision of health care.

- Health care providers
  - Every health care provider, regardless of size, who electronically transmits health information in connection with certain transactions is a covered entity. These transactions include claims, benefit eligibility inquiries, referral authorization requests and other transactions for which HHS has established standards under the HIPAA Transaction Rule.
  - The Privacy Rule covers a health care provider regardless of whether it electronically transmits these transactions directly or uses a billing service or other third party to do so on its behalf. Health care providers include “all providers of services” and “providers of medical or health services” as defined by Medicare and any other person or organization that furnishes, bills or is paid for health care.

Protected information

The Privacy Rule protects all “individual identifiable health information” held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper or oral. The Privacy Rule calls this information “protected held information (PHI).”

“Individually identifiable health information” is information, including demographic data, that relates to:

- The individual’s past, present or future physical or mental health condition.
- The provision of health care to the individual.
- The past, present or future payment for the provision of health care to an individual.
- Identification of the individual or information for which there is a reasonable basis to believe can be used to identify the individual.
- Individually identifiable health information that includes many common identifiers such as name, address, birth date and Social Security number.

The Privacy Rule excludes from protected health information employment records that a covered entity maintains in its capacity as an employer, and education and other records subject to or defined in the Family Educational Rights and Privacy Act, 20 U. S. C. 1232G.

De-identified health information

There are no restrictions on the use or disclosure of de-identified health information. De-identified health information neither identifies nor provides a reasonable basis to identify the individual. There are two ways to de-identifying information:

- A formal determination by a qualified statistician.
- The removal of specified identifiers of the individual and of the individual’s relatives, household members and employers is required, and is adequate only if the
covered entity has no actual knowledge that the remaining information could be used to identify the individual.

The following identifiers of the individual or of relatives, employers or household members of the individual must be removed to achieve the “safe harbor” de-identification:

- Names.
- All geographic subdivisions smaller than the state, including street address, city, county, precinct and zip code, except for the initial three digits of the zip code unless the ZIP code is for a geographic unit containing 20,000 or fewer people. In that case, the initial three digits are changed to 000.
- All elements of dates, except a year, directly related to the individual, including birth date, admission date, discharge date and date of death.
- Telephone numbers.
- Fax numbers.
- Electronic mail addresses.
- Social Security numbers.

Principles for uses and disclosures

Basic principles
A major purpose of the Privacy Rule is to define and limit circumstances in which an individual’s protected information may be used or disclosed to covered entities. A covered entity may not use or disclose protected health information, except:

- As the privacy rule permits or requires.
- As the individual who is the subject of the information or the individual’s personal representative authorizes in writing.

Required disclosures
- To individuals, or their personal representatives, specifically when they request access to, or an accounting of, disclosures of their protected health information.
- To HHS when it is undertaking a compliance investigation or review of enforcement action. In these cases, refer to the OCR Government Access Guidance.

Permitted uses and disclosures
A covered entity is permitted, but not required, to use and disclose protected health information without an individual’s authorization for the following purposes or situations:

1. To the individual, unless required for access or accounting of disclosures.
2. Treatment, payment, and health care operations.
   - Treatment is the provision, coordination, or management of health care-related services by one or more health care providers, including consultation between providers regarding a patient, and referral of a patient by one provider to another.
   - Payment encompasses activities of the health plan to obtain premiums, determine or fulfill responsibilities for coverage, provisions of benefits, and furnish or obtain reimbursement for health care to an individual.
   - Health care operations may include any of the following activities:
     - Quality assessment and improvement activities, including case management and care coordination.
     - Competency assurance activities, including provider or health plan performance evaluation competency assurance activities, credentialing and accreditation.

- Medical record numbers.
- Health plan beneficiary numbers.
- Account numbers.
- Certificate and license numbers.
- Vehicle identifiers and serial numbers, including license plate numbers.
- Device identifiers and serial numbers.
- Web universal resource locators (URLs).
- Internet protocol (IP) addresses.
- Biometric identifiers, including fingerprints and voice prints.
- Photographic images and any comparable image.
- Any other unique identifying numbers, characteristics or code.

In addition to the removal of these identifiers, the covered entity may not have actual knowledge that the remaining information could be used alone or in combination with any other information to identify an individual who is the subject of the information.

Covered entities may rely on professional ethics and best judgment in deciding which of these permissive uses and disclosures to make.

Most uses and disclosures of psychotherapy notes for treatment, payment and health care operations purposes require an authorization as described below:

- Obtaining consent, which is written permission from an individual to use and disclose information for treatment, payment and health care operations, is optional under the privacy rule for all covered entities.
- The content of a consent form and the process for obtaining consent are at the discretion of the covered entity electing to seek consent.
- The counselor should refer to the ethics sections or their organization to determine how to proceed in disclosures of psychotherapy notes.

Informal permission may be obtained by asking the individual outright, or by circumstances that clearly give the individual the opportunity to agree, acquiesce or object.

Where the individual is incapacitated, in an emergency situation or not available, covered entities generally may make such uses
and disclosures, if in the exercise of their professional judgment the use of disclosure is determined to be in the best interest of the individual.

Refer to the code of ethics for the counseling or social work organization to address issues in the decision-making process related to these disclosures.

Facility directories

It is common practice in many health care facilities, such as hospitals, to maintain a directory of patient contact information. A covered health care provider may rely on the individual’s informal permission to list in its facility directory the individual’s name, general condition, religious affiliation and location in the provider’s facility. The provider may then disclose the individual’s condition and location in the facility to anyone asking for the individual by name, and also may disclose religious affiliation to clergy. Members of the clergy are not required to ask for the individual by name when requiring about patient religious affiliation.

Notification and other purposes.

A covered entity also may rely on the individual’s informal permission to disclose to the individual’s family, relatives, friends or other persons whom the individual identifies, protected health information directly relevant to that person’s involvement in the individual’s care or payment for care. This provision, for example, allows a pharmacist to dispense filled prescriptions to a person acting on the behalf of the patient. A covered entity may rely on the individual’s informal permission to use or disclose protected health information for the purpose of notifying family members, personal representatives or others responsible for the individual’s care, the individual’s location, general condition or death.

In addition, protected health information may be disclosed for notification purposes to the public or private entities authorized by law or charter to assist in disaster relief efforts.

Public interest and benefit activities

The Privacy Rule permits use and disclosure of protected health information without an individual’s authorization or permission for national priority purposes. These disclosures are permitted, although not required, by the rule in recognition of the important use made of health information outside the health care context. Specific conditions or limitations applied to each public interest purpose, striking the balance between the individual privacy interest and the public interest for this information, are as follows:

- **Required by law** – Covered entities may use and disclose protected health information without individual authorization as required by law, including statute, regulatory, or court orders.
- **Public health activities** – Covered entities may disclose protected health information to public health authorities authorized by law to collect or receive such information for preventing or controlling disease, injury or disability and to public health or other governmental agencies authorized to receive reports of child abuse and neglect.
- **Entities subject to FDA regulations** – Entities involved with FDA regulated products or activities may disclose information for purposes such as adverse event reporting, tracking of products, product recalls and surveillance.
- **Individuals** – When notification is authorized by law, information may be released on people who may have contracted or been exposed to a communicable disease.
- **Employers** – Information on employees about a work-related illness, injury or related medical surveillance may be sought and disclosed because such information is needed to comply with the Occupational Safety And Health Administration (OSHA) and Mine Safety and Health Administration (MSHA) regulations or similar state law.

Victims of abuse, neglect or domestic violence

In certain circumstances, covered entities may disclose protected health information to appropriate government authorities about victims of abuse, neglect or domestic violence.

Health oversight activities

Covered entities may disclose protected health information to help oversight agencies for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

Judicial and administrative proceedings

Covered entities may disclose protected health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Information may be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.
Law enforcement purposes

Covered entities may disclose protected health information to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specific conditions:

1. As required by law, including court orders, court ordered warrants, subpoenas and administrative requests.
2. To identify or locate a suspect, fugitive, material witness or missing person.
3. In response to a law enforcement official’s request for information about a victim or suspected victim of a crime.
4. To alert law enforcement of a person’s death, if the covered entity suspects that criminal activity caused the death.
5. When a covered entity believes that protected health information is evidence of a crime that occurred on its premises.
6. By a covered health care provider in a medical emergency not occurring on its premises when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims and the perpetrator of the crime.

Covered entities may disclose protected health information to funeral directors as needed, and coroners or medical examiners to identify the deceased person, determine the cause of death and to perform other functions authorized by the law.

Research

“Research” is any systematic investigation designed to develop or contribute to general knowledge. The Privacy Rule permits a covered entity to use and disclose protected health information for research purposes, without an individual’s authorization, provided the covered entity documents:

- That an alteration or waiver of individuals’ authorization for the use or disclosure of protected health information
  about them for research purposes has been approved by an Institutional Review Board or Privacy Board.
- That the use or disclosure of the protected health information is solely to prepare a research protocol or for similar purpose preparatory to research, that the researcher will not remove any protected health information from the covered entity, and that information is necessary for the research.

Serious threats to health and safety

Covered entities may disclose protected health information that they believe is necessary to prevent or lessen a serious and imminent threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat, including the target of the threat. Covered entities may also disclosed to law enforcement if the information is needed to identify or apprehend an escapee or violent criminal.

Essential government functions

Authorization is not required to use or disclose protected health information for certain essential government functions. These functions include assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the president, making determinations of medical suitable for U.S. State Department employees, protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.

Workers’ Compensation

Covered entities may disclose protected health information to comply with workers’ compensation laws and other similar programs providing benefits for working-related injuries or illnesses.

Limited data set

A limited data set is protected health information from which certain specific direct identifiers of individuals and their relatives, household members and employers have been removed. A limited data set may be used and disclosed for research, health care operations, and public health purposes, provided the recipient enters into a data use agreement promising specific safeguards for the protected health information within the limited data set.

A limited data set excludes the following direct identifiers of an individual or of relatives, employers or household members of the individual:

- Names.
- Postal address information, other than town or city.
- State and zip codes.
- Telephone numbers.
- Fax numbers.
- Electronic mail addresses.
- Social Security numbers.
- Medical records numbers.
- Health plan beneficiary numbers.
- Account numbers.
- Certificate and license numbers.
- Vehicle identifiers and serial numbers, including license plate numbers.
- Device identifiers and serial numbers.
- Web universal resource locators (URLs).
- Internet protocol (IP) address numbers.
- Biometric identifiers, including fingerprint and voice identifiers.
- Full-face photographic images or any comparable images.
Authorized uses and disclosures

A covered entity must obtain an individual’s written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations, or otherwise permitted or required by the Privacy Rule. A covered entity may not condition treatment, payment, enrollment or benefits eligibility based on whether an individual grants an authorization, except in limited circumstances.

Any authorization must be written in specific terms. It may allow use and disclosure of protected health information by the covered entity seeking that authorization or by a third-party. Example of disclosures that would require an individual’s authorization are disclosures to a life insurer for coverage purposes, disclosures to an employer of the results of a pre-employment physical or lab tests, or disclosures to a pharmaceutical firm for its marketing purposes.

All authorizations must be in plain language and contain specific information about the information to be disclosed or used, the persons disclosing and receiving the information, expiration, right to revoke in writing, and other data. The Privacy Rule contains transition provisions applicable to authorizations and other express legal permissions obtained prior to April 14, 2003.

Psychotherapy notes

The covered entity must obtain an individual’s authorization to use or disclose psychotherapy notes with the following exceptions:

- The covered entity who originated the notes may use or disclose the psychotherapy notes for his or her own training with an individual’s authorization, and as part of a defense in legal proceedings brought by the individual.
- For HHS to investigate or determine the covered entity’s compliance with the Privacy Rules.
- To avert a serious and imminent threat to the public health or safety.
- To a health oversight agency for lawful oversight of the covered entity. These policies and procedures must identify the specific roles of the members working within the covered entity. These policies and procedures must establish and implement policies and procedures that restrict access and uses of protected health information based on the specific roles of the members working within the covered entity. These policies and procedures must identify the persons, or classes of persons, in the workforce who need access to protected health information to carry out their duties, the protected health information to which access is needed, and any conditions under which they need the information to do their jobs.

Limiting uses and disclosures to the minimum necessary

An essential aspect of the Privacy Rule is the principle of “minimum necessary” use and disclosure. A covered entity must make reasonable efforts to disclose and request only the minimum amount of protected health information needed to accomplish the intended purpose of the disclosure or requests. A covered entity must develop and implement policies and disclosures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose or request the entire medical record for a particular purpose unless it can specifically justify the whole record as the amount reasonably necessary for the purpose.

The minimum necessary requirement is not imposed in the following circumstances:

- Disclosure to order a request by a health care provider for treatment.
- Disclosure to an individual who is the subject of the information.
- The individual’s personal representative.
- Use or disclosure made pursuant to an authorization.
- Disclosure to HHS for complaint investigation.
- Compliance review or enforcement.
- Use of disclosure that is required by law.

- Use of disclosure required for compliance with the HIPAA Transaction Rule or other HIPAA administrative simplification rules.

Access and use: For internal uses, a covered entity must develop and implement policies and procedures that restrict access and uses of protected health information based on the specific roles of the members working within the covered entity. These policies and procedures must identify the persons, or classes of persons, in the workforce who need access to protected health information to carry out their duties, the protected health information to which access is needed, and any conditions under which they need the information to do their jobs.

Disclosures and requests for disclosures: Covered entities must establish and implement policies and procedures for routine, reoccurring disclosures or requests for disclosures that limit the protected health information disclosed to that which is the minimum amount reasonably necessary to achieve the purpose of disclosure. Individual review of each disclosure is not required. For nonroutine, nonrecurring disclosures or requests for disclosures that it makes, covered entities must develop criteria designed to limit disclosures to the information...
reasonably necessary to accomplish the purpose of the disclosure and review each of these requests individually in accordance with established criteria.

**Reasonable reliance:** If another covered entity makes a request for protected health information, a covered entity may rely, if reasonable under the circumstances, on the request as complying with the minimum necessary standard. Similarly, a covered entity may rely upon request as being the minimum necessary protected health information from:
- A public official.
- A professional, such as an attorney or accountant who is a covered entity’s business associates seeking information to provide services to or for the covered entity.
- A researcher who provides the documentation or representation required by the privacy rule for research.

**Privacy practices notice**

Each covered entity, with certain exceptions, must provide a notice of its privacy practices. The privacy rule requires that the notice contain certain elements:
- The notice must describe the ways in which the covered entity may use and disclose protected health information.
- It must state the covered entity’s duty to protect privacy, provide notice of privacy practices, and abide by the terms of the current notice.
- The notice must ascribe individual’s rights, including the right to complain to HHS and to the covered entity if the person believes his or her privacy rights have been violated.
- The notice must include a point of contact for further information and for making complaints to the covered entity.
- Covered entities must act in accordance with their notices.
- The Privacy Rule also contains specific distribution requirements for direct treatment providers and all other health care providers and health plans.

**Notice distribution:** Since April 14, 2003, a covered health care provider with the direct treatment relationship with individuals must deliver a privacy practices notice to patients, as follows:
- Not later than the first service encounter by personal delivery, by automatic and contemporaneous electronic response, and by prompt mailing.
- By posting the notice at each service delivery site in a clear and prominent place where people seeking service may reasonably be expected to be able to read the notice.
- In emergency treatment situations, the provider must furnish its notice as soon as the emergency is resolved.
- Covered entities, whether direct treatment providers or indirect treatment providers such as laboratories or health plans, must supply notice to anyone on request. A covered entity must also make its notice electronically available on any website it maintains for customer service or benefits information.
- The covered entity in an organized health care arrangement may use that joint practice privacy notice, as long as each agrees to abide by the notice content with respect to the protected health information created or received.
- The health plan must distribute its privacy notices to each of its enrollees by its compliance date.
- A covered health care provider with a direct treatment relationship with individuals must make a good-faith effort to obtain a written acknowledgment from patients of receipt of the privacy practices notice. The privacy rule does not prescribe any particular content for the acknowledgment.

The provider must document the reason for any failure to obtain the patient’s written acknowledgment. The provider is relieved of the need to request acknowledgment in an emergency treatment situation.

**Access:** Except in certain situations, individuals have the right to review and obtain a copy of their protected health information in covered entities’ “designated record set.” The designated record set is that group of records maintained by or for a covered entity that is used, in whole or part, to make decisions about individuals, or that is a provider’s medical and billing records about individuals or health plan’s enrollment, payment, claims adjudication and case of medical management records systems. The rule excepts from the right of access the following protected health information:
- Psychotherapy notes.
- Information compiled for legal proceedings.
- Laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access to information held by certain resource laboratories.
- For information included within the right of access, covered entities may deny an individual access in certain specific situations, such as when a health care professional believes that access could cause harm to the individual or another. In such situations, the individual must be given the right to have such denials reviewed by a licensed health care professional for a second opinion.
- Covered entities may impose reasonable, cost-based fees for the cost of copying and postage.

A covered entity may deny access to individuals, without providing the individual an opportunity to review, in the following protected situations:
- The protected health information falls under an exception to the right of access.
- An inmate request for protected health information under certain circumstances.
- Information that a provider creates or obtains in the course of research that includes treatment for which the individual has agreed not to have access as part of consenting to participate in the research, as long as access to the information is restored upon completion of research.
- For records subject to the Privacy Act, information to which access may be denied under the Privacy Act.
- Information obtained under a promise of confidentiality from a source other than a health care provider, if granting access would likely reveal the source.
Restriction and request

Individuals have the right to request that a covered entity restrict use of disclosure of protected health information, payment or health care operations, disclosure to persons involved in the individual’s health care or payment for health care, or disclosure to notify family members or others about the individuals general condition, location or death. The covered entity is under no obligation to agree to a request for restrictions. A covered entity that does agree must comply with the agreed restrictions, except for the purposes of treating the individual in a medical emergency period.

Confidential communications requirements

Health plans and covered health care providers must permit individuals to request an alternative means or location for receiving communications of protected health information. Health plans must accommodate reasonable requests, especially if the individual indicates the disclosure of all or part of the protected health information could endanger the individual. The health plan may not question the individual statement of endangerment.

Administrative requirements

HHS recognizes that covered entities range from the smallest provider to the largest multistate health plan. The rules are intended to allow covered entities to analyze their own needs and implement solutions appropriate for their environment. This may depend on the nature of the covered entity’s business, as well as its size and resources.

Privacy policies and procedures

A covered entity must develop and implement written privacy policies and procedures that are consistent with the HIPAA Privacy Rule.

Privacy personnel: A covered entity must designate a privacy official responsible for developing and implementing its privacy policy and procedures, and the contact person or office responsible for receiving complaints in providing information on the covered entity’s privacy practices.

Workforce training and management: Workforce members include employees, volunteers and trainees and may also include other persons whose conduct is under the direct control of the entity. A covered entity must train all workforce members on its privacy policies and procedures as necessary and appropriate for them to carry out their functions. A covered entity must have and apply appropriate sanctions against workforce members who violate its privacy policies and procedures or the privacy rule.

Mitigation: A covered entity must mitigate, to the extent practicable, any harmful effect it learns was caused by the use or disclosure of protected health information by its workforce or associates in violation of its policies and procedures or the Privacy Rule.

Data safeguard: A covered entity must maintain reasonable and appropriate administrative, technical and physical safeguards to prevent intentional or unintentional user disclosure of protected health information. For example, a safeguard might include shredding documents containing protected information before discarding them or securing medical records with a lock, key or pass code, and limiting access to key user pass codes.

Complaints: A covered entity must have procedures for individuals to make complaints regarding its privacy policies and procedures. The covered entity must explain those procedures in its privacy practices. The covered entity must identify to whom individuals can submit complaints to at the covered entity, and advise that complaints also can be submitted to the Secretary of the HHS.

Retaliation and waive: A covered entity may not retaliate against a person for exercising rights provided by the Privacy Rule for:

- Assisting in an investigation by HHS or another appropriate authority.
- Opposing an act or practice that the person believes in good faith violates the Privacy Rule.

A covered entity may not require an individual to waive any right under the privacy rule as a condition for obtaining payment, treatment, an enrollment or benefit eligibility.

Documentation and records retention: A covered entity must maintain until six years after the latter of the date of their creation or last effective date its privacy policies and procedures, privacy practices notices, disposition of complaints and other activities and designations that the Privacy Rule requires to be documented.

Personal representatives and minors

Personal representatives: The privacy rule requires a covered entity to treat a personal representative the same as the individual with respect to uses and disclosures of the individual’s protected health information, as well as the individual’s rights under the rule. A personal representative is defined as a person legally authorized to make health care decisions on an individual’s behalf or to act for a deceased individual or the estate.
The privacy rule permits an exception when a covered entity has a reasonable belief that the personal representative may be abusing or neglecting the individual, or that treating the person as the personal representative could otherwise endanger the individual.

**Special case – Minors:** In most cases, parents are the personal representatives for their minor children. In those cases, parents can exercise individual rights, such as access to the medical records, on behalf of their minor children. In certain exceptional cases, the parent is not considered the personal representative.

### State law preemption

In general, state laws that are contrary to the Privacy Rule are preempted by the federal requirements, which mean that the federal requirements will apply. “Contrary” means it would be impossible for a covered entity to comply with both the state and federal requirements, or that the provision of state law is an obstacle to accomplishing the full purposes and objectives of the administrative simplification provision of HIPAA. The Privacy Rule provides exceptions to the general rule of federal preemption for contrary state laws that:

- Relate to the privacy of individually identifiable health information and provide greater privacy protections or privacy rights with respect to such information.

### Enforcement and penalties for noncompliance

Consistent with the principles of achieving compliance provided in the rule, HHS will seek the cooperation of covered entities and may provide technical assistance to help them comply voluntarily with the rule. The rule provides processes for persons to file complaints with HHS, describes the responsibilities of covered entities to provide records, compliance reports, and to cooperate with and permit access to information for investigations and compliance reviews.

However, the American Recovery and Reinvestment Act of 2009 put new teeth into the laws and penalties for HIPAA violations when it implemented tiered penalties reflecting the circumstances surrounding the violation. These acknowledged whether the violator did not know about the violation, had reasonable cause, allowed the violation because of willful neglect but subsequently corrected it or allowed the violation because of willful neglect and did not correct it.

In these situations, the Privacy Rule defers to state and other law to determine the rights of the parents to access and control the protected health information of their minor children.

If state and other law is silent on parental access to the minors’ protected health information, a covered entity has discretion to provide or deny a parent access to the minor’s health information, provided the decision is made by a licensed health care professional in the exercise of professional judgment. For further information, review the OCR Personal Representatives Guidance.

- Provide for the reporting of disease or injury, child abuse, birth or death, or for public health surveillance, investigation or intervention.
- Requires certain health plan reporting, such as for management or financial audits.

**Exception determination:** In addition, preemption of a contrary state law will not occur if HHS determines, in response to a request from a state or other entity or person, that the state law:

- Is necessary to prevent fraud and abuse related to the provision of or payment for health care.
- Is necessary to ensure appropriate state regulation of insurance and health plans to the extent expressly authorized by statute or regulation.
- Is necessary for state reporting on health care delivery or costs.
- Is necessary for purposes of serving a compelling public health, safety or welfare need, and if the Privacy Rule provision is at issue, if the secretary determines that the intrusion into privacy is warranted when balanced against the need to be served.
- Has as its principal purpose the regulation of the manufacture, registration, distribution, dispensing or other control of any controlled substance as defined in 21 U.S.C.802, or that is deemed a controlled substance by state law.

- For violations that the entity did not know about, minimum fines are $100 per violation up to $50,000 may be imposed, with an annual maximum of $1.5 million.
- For violations that had reasonable cause and were not due to willful neglect, a minimum fine of $1,000 up to $50,000 may be imposed, with an annual maximum of $1.5 million.
- For violations due to willful neglect that were corrected within the required time period, a minimum fine of $10,000 up to $50,000 may be imposed, with an annual maximum of $1.5 million.
- For violations due to willful neglect that were not corrected, a minimum fine of $50,000 per violation may be imposed, with an annual maximum of $1.5 million.

However, courts have in some cases have treated multiple violations as separate cases, allowing the maximum fines to be much higher than $1.5 million.
In addition, criminal penalties may apply in some cases. A person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA faces a fine of $50,000 and up to one year imprisonment. The criminal penalties increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and up to $250,000 and up to 10 years imprisonment if the wrongful conduct involves the sale, transfer or use of individually identifiable health information for commercial advantage, personal gain or malicious harm. Criminal sanctions are enforced by the Department of Justice.

**Compliance dates**

All covered entities, except “small health plans,” were required to be compliant with the privacy rule by April 14, 2003. Small health plans had until April 14, 2004, to comply.

**Small health plans:** A health plan with annual receipts of not more than $5 million is a small health plan. Health plans that file certain federal tax returns and report receipts on those returns should use the guidance provided by the small business administration at Number 13 Code of Federal Regulations (CFR) 121.104 to calculate annual receipts. Health plans that do not report receipts to the Internal Revenue Service (IRS), for example, group health plans regulated by the Employee Retirement Income Security Act 1974 (ERISA) that are exempt from filing income tax returns should use proxy measures to determine their annual receipts.

The entire HIPAA Privacy Rule as well as guidelines and additional materials may be found on the government website www.hhs.gov/ocr/hipaa.

**Client Education: Confidentiality and privacy rights**

Clients may feel betrayed when therapy records become part of their general medical or health records in an HMO or other managed-care facility and may be disclosed to third-party resources and eligibility compliance. Not all clients understand that submitting a claim for mental health services leads to the provider of services sharing information such as diagnosis, types of services offered, dates of service, duration of treatment and so on.

Sometimes, insurers or companies assigned to manage mental health benefits may be authorized to seek detailed information from case files, such as client current symptoms status, treatment plan specifics or other personal information. Insurance companies may not protect such information as diligently as a provider of services, so confidentiality lies beyond the control of the therapist in this circumstance.

The Council of the National Academies of Practice, which includes medicine, dentistry, nursing, optometry, osteopathic and podiatric medicine, psychology, social work and veterinary medicine, adopted the “Ethical Guidelines for Professional Care in a Managed Care Environment,” and confidentiality is one of the five guidelines indicated as a primary concern.

The council recognized that utilization and quality assurance reviews are functional in a health care system, but it also promotes safeguards to protect confidentiality of patient/client data and practitioner clinical materials, and to obtain client consent.

It concludes, “The rationale for this position is founded on the patient’s autonomous right to control sensitive personal information. It is further based upon historical recognition of the Oath of Hippocrates, and corroborated throughout the centuries, on the enduring value of preserving confidentiality in order to enhance mutual trust and respect in the patient provider relationship” (1997).

All mental health practitioners, their employees and students must have a thorough and working knowledge of their organization’s ethics code and the HIPAA Privacy Rule as it applies to their practice.

In addition, they should inform clients about issues of confidentiality governing their practice and help them gain understanding of the HIPAA Privacy Rule as it may apply to disclosure of their health care information. They should be prepared to answer questions on these issues in a manner best suited for their individual client’s needs.

**Resources for information**

- American Counseling Association: [www.counseling.org](http://www.counseling.org).
References

- American College of Physicians, Ad Hoc Committee on Medical Ethics. (1984). Part 1: History of Medical Ethics, the physician and the patient, the physician’s relationship to other physicians, the physician and society. Annals of Internal Medicine, 101,129-141.
1. The HIPAA Privacy Rule and codes of ethics for mental health practitioners share all of the following EXCEPT:
   a. Both compliment each other.
   b. Both were developed to ensure privacy, confidentiality, and the well-being of the individual and society.
   c. Both have enforcement agencies and structured monetary penalties sanctioned by the Federal level of government.
   d. None of the above.

2. The guiding moral principals described by Kitchener include all of the following EXCEPT:
   a. Autonomy.
   b. Non-malfeasance.
   c. Justice.
   d. Confidentiality.

3. The following statements about confidentiality are true EXCEPT:
   a. Confidentiality is based on society’s belief that individuals have a right to privacy and the right to decide what information they will share and with whom.
   b. Confidentiality is an ethical principle.
   c. Both codes of ethics and the HIPAA Privacy Rule provide explicit, detailed provisions the cover client consent for disclosure of information.
   d. Privileged communication from a therapy session, however, is not a legal concept that protects clients from having confidential information disclosed without their consent.

4. A review of the codes reveals similarities in values, principles and standards. The codes included for each organization include information from the following areas EXCEPT:
   a. Communication, privacy and confidentiality.
   b. Client relationships.
   d. HIPAA privacy rules.

5. Multicultural diversity competency includes:
   a. A capacity where by practitioners possess cultural and diversity awareness.
   b. Knowledge about self and others.
   c. How this awareness and knowledge is applied effects the practice with clients and the client group.
   d. All of the above.

6. Which of the following definitions is not correct?
   a. Assent - To demonstrate agreement when a person is otherwise not capable or competent to give formal consent.
   b. Competency - Demonstrating excellent skills in many areas of counseling.
   c. Psychosocial - Involves aspects of social and psychological behavior and development.
   d. All of the above.

7. Codes of ethics serve to:
   a. Help mental health professionals construct a professional course of action.
   b. Clarify the nature of ethical responsibilities held by all counselors for current and future practitioners.
   c. Establish principles that define ethical behavior and best practices for counselors.
   d. All of the above.

8. Corey, Corey and Callahan describe an eight-step ethical decision model, which includes all of the following statements EXCEPT:
   a. Identify the problem or dilemma.
   b. Try all interventions even if they are innovations in the research phase.
   c. Look at relevant codes of ethics for general guidance.
   d. Consider applicable laws and regulations.

9. Van Hoose and Paradise suggest that practitioners are probably acting in an ethically responsible way with a client if their behavior includes all of the following EXCEPT:
   a. They have the client’s best interest as a priority.
   b. They act without malice or personal gain.
   c. They maintain personal and professional honesty.
   d. They have a Master’s level or higher degree.

10. Koocher and Keith-Spiegel suggest all of the following safeguards to protect electronic records EXCEPT:
    a. Apply encryption software.
    b. Apply Internet firewalls.
    c. Both you and our client should use pseudonyms.
    d. Consult a technology specialist when disposing of information electronically.

11. Codes of ethics address behaviors among practitioners that may result in ethical violations. Which of the situations below represent Jorgenson’s list of causes of action that clients may allege in civil lawsuits:
    a. Negligent infliction of emotional distress.
    b. Setting rates higher than the local average.
    c. Breach of contract.
    d. Intentional infliction of emotional distress.

12. Which of the following was not a result of rulings in cases subsequent to Tarasoff?
    a. All 50 states have mandatory reporting for child abuse.
    b. Parents do not have to be notified.
    c. Counselors MUST legally report information as outlined by law if a counselor believes a client under 16 is a victim of incest, rape, or some other crime.
    d. Counselors MUST legally report information if they believe the client needs hospitalization.
13. APA guidelines for disclosure of confidential information without the individual’s consent is allowed in the following cases EXCEPT:
   a. To protect clients or others from harm.
   b. To obtain professional counsel.
   c. To obtain payment for service.
   d. For clinical research.

14. Which of the following is TRUE about confidentiality in group counseling?
   a. Confidentiality cannot be guaranteed.
   b. Counselors cannot control the behavior of the group members.
   c. Counselors must inform all members of the group of the rules of confidentiality.
   d. All of the above.

15. The Privacy Rule applies to “covered entities,” which include the following EXCEPT:
   a. Health plans - individual and group.
   b. Medicare and Medicaid.
   c. A group plan with less than five participants that is administered by an employer.
   d. Church-sponsored health plans.

16. “Individually identified health information” excludes which of the following?
   a. Name, address, birthday and Social Security number.
   b. Present physical and mental health information.
   c. Past, present, and future payment information for the provision of health care.
   d. Health information employment records that a covered entity keeps in its capacity as an employer.

17. To achieve “safe harbor” de-identification, all of the following should be removed except:
   a. All geographic subdivisions smaller than the state except for the initial three digits of a Zip Code or the numbers 000 in some cases.
   b. The year of death.
   c. Medical records numbers.
   d. License plate numbers.

18. Covered entities may disclose protected health information to law enforcement officials under which of the following circumstances?
   a. As required by court order, court ordered warrant and subpoenas.
   b. To identify or locate a suspect, fugitive, witness or missing person.
   c. In response to information about a victim or suspect in a crime.
   d. All of the above.

19. The Privacy Rule prohibits disclosure of psychotherapy notes without authorization UNLESS:
   a. The notes are handwritten.
   b. The notes are in electronic form.
   c. The notes are part of a defense in legal proceedings brought by the individual.
   d. The notes are part of a conversation during a counseling session.

20. The American Recovery and Reinvestment Act of 2009 put new teeth into the laws and penalties for HIPAA violations, including all of the following EXCEPT:
   a. The maximum penalty per violation was increased to $1.5 million.
   b. Fines disregard whether the violation was due to willful neglect or whether it was corrected.
   c. Criminal penalties apply in some cases.
   d. None of the above.