Professional Ethics, Boundaries and Law

6 CE Hours

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Learning objectives:

- Understand the importance of professional values and ethics in mental health practice.
- Identify the role and the impact of law in mental health practice.
- Recognize and distinguish between problematic and non-problematic boundary issues in mental health practice.
- Describe ways mental health practitioners can prevent unethical or illegal behaviors in daily practice.
- Identify issues of cultural competence and social diversity in mental health work.
- Identify elements and conditions of informed consent.
- Understand the basic requirement of HIPAA and the Privacy Rule as it relates to practice.
- Understand the impact of genetics and technology on mental health practice and the unique responsibilities that are included.
- Identify a protocol for ethical decision-making.
- Understand the role of consultant as it applies to mental health supervision and practice.

INTRODUCTION

Ethics and mental health practice

In an increasingly technical and complex world, it is essential for licensed mental health professionals to regularly review ethics in mental health practice. Providing ethical mental health counseling services has a fundamental impact on individuals and includes not only relying heavily on relationship building and knowledge, but also keeping current on regulations pertaining to best practice and technological innovations.

According to the National Board for Certified Counselors (NBCC), mental health “counseling” is the application of mental health, psychological or human development principles through cognitive, affective, behavioral or systemic intervention strategies that address wellness, personal growth or career development in addition to pathology. It can consist of a few brief interactions to several sessions over time. And it can be delivered in a variety of locations that can include face-to-face sessions or at a distance with technology assistance. The communication text can be read, heard or seen.

Unlike many other professions, the mental health field deals with extremely complicated issues and requires licensed mental health practitioners to understand laws, professional codes of conduct, and consultation and supervision guidelines. The primary obligation of mental health practitioners is to respect the integrity and promote the welfare of clients in a variety of settings that include family units, individuals or in group counseling. (Within group settings the mental health professional is also responsible for taking reasonable precautions to protect individuals from any psychological or physical abuse that results from group interaction.)

In addition to external ethics guidelines, mental health professionals must also rely on their internal cues through personal character. For example, consider these examples that illustrate how well-intentioned mental health professionals may find themselves confronted with ethical dilemmas:

- **Mary**, a licensed mental health counselor, provided counseling services at a community mental health center. Most of her clients did not have insurance, nor could they afford to pay privately anywhere else. After several years of post-graduate, full-time practice, Mary felt competent providing services for most issues. After three sessions, one of her clients confessed that he wanted a sex change operation and would need Mary’s support through his transition. Mary had taken a few graduate level courses in human sexuality but had no special training in this area. However, given her strong belief in client self-determination, the client’s belief in her ability to assist, and her willingness to read the literature and consult the Internet on procedural issues, Mary agreed to revise the plan of treatment and continue to work with her client.

- **Joaquin**, a licensed clinical social worker, and his client, a young man with bipolar disorder, have successfully worked together to achieve the man’s treatment goals. Joaquin and his client are close in age, have many interests in common and consequently have achieved a strong rapport and mutual trust. Now Joaquin is transferring to a supervisory position, which will effectively end his professional relationship with the client. His client wishes to continue their relationship as friends, and Joaquin is tempted to do so.
In these two illustrations, each mental health practitioner demonstrates both a compassion for and commitment to their respective clients. They are at a crossroads in their relationship with their clients. What they decide to do next must consider different issues that include what is in the best interest of the client and the client’s right to self-determination.

What is easiest, most comfortable, and/or desired by these mental health practitioners should never be the primary reason for action. If the needs of the client versus that of the mental health therapist were the only considerations, decision-making would be easy. However, a mental health professional must also consider the ethical guidelines established by various government agencies and national mental health professional associations, in addition to the law.

In the first scenario, Mary must balance both her and her client’s desire to continue what appears to be a comfortable and trusting therapeutic relationship, with the need to provide the most effective service for the client. Clearly Mary is not qualified to provide the service this client needs. Is her plan for a crash course in transgendered treatment adequate? Should she make a referral to a more competent therapist? Should she work with the client to overcome the financial barriers he is facing?

If Mary makes the wrong decision, she might either violate ethical guidelines or the law, or both. She may be committing a medical error and putting her client at risk of harm. Her actions may also result in Mary being sued or censured.

Joaquin, too, must ask himself the question, “Am I considering crossing the boundaries of our professional relationship for my own needs or for those of my client?” Clearly both Joaquin and his client value a friendship, but what potential harmful impact could this have on either one or both of them?

Ethical decision-making is a complex process requiring mental health practitioners to look not just the immediate impact, but also the long-term and future consequences of their actions.

Defining ethics

The word “ethics” is derived from both the Greek word “ethos”, which means character, and the Latin word “mores”, meaning customs. Ethics defines what is good for both society and the individual, and are the core values and beliefs that guide the behavior of a specific group, particularly in relation to interactions with clients, consumers or colleagues. (Torda, as cited in Dally, 2005)

Though closely related, law and ethics do not necessarily have a reciprocal relationship. While the origins of law can often be based upon ethical principles, law does not prohibit many unethical behaviors. Likewise, adherence to certain ethical principles may challenge a mental health practitioner’s ability to uphold the law.

For example, documenting that a service has occurred when it hasn’t may be unethical but not subject to prosecution. Unfortunately it may take high-profile adverse consequences of unethical behavior, such as the discovery that a child under protective custody has been missing for months, to create new laws that support ethical standards of behavior. For instance, in the wake of a highly publicized case years ago, the state of Florida made the falsification of documentation, e.g., visitations that never took place, illegal for people employed as child welfare workers.

Implications for practice

Ethical standards are, according to Reamer (Ethical Standards in Social Work, 1998) “created to help professionals identify ethical issues in practice and provide guidelines to determine what is ethically acceptable and unacceptable behavior.” What makes mental health work unique is its focus on the person, as well as its commitment to the well-being of society as a whole.

Being part of a professional association or board not only brings a wealth of knowledge and expertise to ethical issues, but also certain rights and privileges for its members. But those benefits must not overshadow a mental health professional’s commitment to promote ethical behavior on behalf of clients.

When an individual identifies with a mental health profession, he or she is pledging to practice in an ethical and responsible manner. In addition to allegiance to the professional ethics and standards of practice it promotes, the individual also has a duty to support the values, rules, laws and customs of the society of which he or she is a part.

The social work profession adopted its first code of ethics in 1947. In 1960, following the formation of the National Association of Social Work (NASW), another code of ethics was drafted, with multiple revisions made in the following years.

Ethics have been developed and written for other national mental health licensing associations and boards that include, among others, the American Association for Marriage and Family Therapy, the American Counseling Association, and the American Mental Health Association. The National Board for Certified Counselors (NBCC) includes members from different associations who are often licensed by jurisdictions that promulgate codes of ethics and has an underlying mission of responsibility to clients served and to the institutions within which the services are performed. NBCC requires that ethical behavior among professional associates must be expected at all times.

The American Association for Marriage and Family Therapy “strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as professional expectations” that are enforced by their own ethics committee. The American Counseling Association “promotes ethical counseling practice in service to the public.” And the primary mission of the National Association for Social Workers
is to: “Enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty.”

The therapeutic relationship

The intention and manner of the therapist and client relationship sets the course in providing people with ethical mental health treatment. While many issues under this topic area will be addressed throughout this course, the issue of initial contact by potential clients sets the tone for treatment. For example, if a potential client is already receiving similar services from another professional, it is not ethical to offer such services.

In addition, mental health professionals must carefully consider that when services begin, the professional relationship as well as the client’s welfare should proceed with sensitivity. And during the course of treatment, an effort must be made to follow through with all possible caution to legally (by obtaining informed consent) consult with other professionals involved with the client so as not to risk confusion and potential conflict.

The National Board for Certified Counselors, (NBCC) Code of Ethics states, “When counseling is initiated, and throughout the counseling process as necessary, counselors inform clients of the purposes, goals, techniques, procedures, limitations, potential risks and benefits of services to be performed, and clearly indicate limitations that may affect the relationship, as well as any other pertinent information. Counselors take reasonable steps to ensure that clients understand the implications of any diagnosis, the use of tests and reports, methods of treatment, and safety precautions that must be taken in their use, fees, and billing arrangements.”

The law and mental health

Law and mental health practice have long been affiliated with one another. Here is one scenario that illustrates how law can interface with mental health practice.

- A licensed mental health practitioner believed a foster teen’s allegations of abuse toward her foster father merely represented countercoercive behavior related to her adjustment within a more stable, rule-enforced environment and so chose not to report it. He rationalized that this family had successfully helped many children before without incident and that this was his young client’s way to draw attention to herself.

As pointed out earlier, criminal law and professional and ethical guidelines are not one and the same – they may complement each other or be in opposition to one another depending on the issue and on the state. For example, a minor legal offense may result in a small fine but could then lead to loss of a professional license. Licensed mental health practitioners have not just an ethical responsibility but also a legal responsibility to learn and follow any and all regulations in the jurisdiction within which they practice.

In the case described above, federal and state laws about mandatory reporting leave little choice for a professional but to report the allegations of abuse. Sometimes we can be too sure of our abilities or too fearful (in this case, potentially losing a foster parent), and in doing so ignore the very real consequences of violating the law. Or, in less obvious circumstances, we may just not know.

With the advent of technology-based practice, such as e-therapy, the mental health practitioner’s scope of responsibility is even larger; some jurisdictions identify the location of practice, and thus the applicable laws and rules as that of the client’s. We will explore more about technology-based and other practice implications later in this course.

Defining Law

According to Saltzman and Furman (1999), law can be defined as those standards, principles, processes and rules – usually written down in some manner – that are adopted, administered and enforced by governmental authority and that regulate behavior by setting forth what people may and may not do, and how they may and may not do it. Simply put, law is a “pronouncement of the rules which should guide one’s actions in society” (Gifis, 1996).

Reamer (2005) describes five distinct types of legal requirements and guidelines that may affect practice:

1. Constitutional law – Examples include protection from unreasonable searches and rights of privacy and free speech.
2. Statutory law – This includes laws enacted by federal, state, and local legislative bodies and cover such issues as confidentiality of records to obligations around suspected child or elder abuse.
3. Regulatory law – These are legally enforced guidelines disseminated by government agencies such as the Department of Health and Human Services and Department of Justice.
4. Court-made law and common law – These result from court rulings; for example, a recent court ruling in one state that prohibits child welfare workers from using office space for temporary sleeping accommodations for children removed from their homes.
5. Executive orders – Chief governmental executives, such as mayors or governors, may issue orders that resemble regulations. An example was the state of Florida’s governor prohibiting a husband from terminating life support measures.
Impact of law on practice

Currently the United States, including all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, and other countries regulate some form of mental health practice. Many typically regulate practice through statutes, i.e., practice acts, that stipulate who may practice and/or call themselves mental health practitioners (Saltzman and Furman, 1998). State oversight boards give authority to practice to qualified individuals, typically defined by three competencies:
1. Education.
2. Experience.
3. Passing score on an examination.

Failure to abide by these regulations can have serious and negative legal and financial consequences. For example, mental health professionals need to understand that they may not be covered by their insurance policy if they were not practicing legally at the time of a questionable ethical occurrence; i.e., were not licensed as required by law.

There are also laws that impose legal obligations to abide by practices that further serve to protect the consumer such as federal and state statutes requiring mandatory child abuse reporting, practices that ensure client confidentiality, or competence to perform certain services.

Unlike regulation under the law, adherence to regulations set forth by private credentialing bodies is voluntary. However, the regulations and codes of ethics are universally respected. Mental health professionals also practice in accordance to the professional standards of care established by private professional association organizations such as ACA, NASW, AAMFT or NBCC.

Establishing ethical codes of conduct

In addition to professional affiliation Code of Ethics, (such as established within national professional associations), state licensing laws and licensing board regulations identify basic competencies for mental health practice. Failure to follow the ethical codes of one’s profession may result in expulsion from the profession, sanctions, fines, and can result, if sued, in a judgment against the practitioner.

For example, Strom-Gottfried (2000) reviewed 894 ethics cases filed with NASW between July 1, 1986, and December 31, 1997. About 48 percent of the cases resulted in hearings and of those, 62 percent concluded that violations had occurred for a total of 781 different violations.

The study clustered those violations into ten categories:
1. Boundary violation, such as blurring the professional and client relationship through a sexual flirtation.
2. Poor practice, such as improperly terminating treatment with clients.
3. Competence, such as not being certified to provide a specific mental health technique such as eye movement desensitization reprocessing (EMDR).
4. Record keeping, such as failing to keep up-to-date client records.
5. Honesty, such as withholding important information about the therapist’s potential conflicts of interest.
6. Confidentiality, such as repeating a client’s confidential information to the client’s family.
7. Informed consent, such as failing to obtain the appropriate written consent from clients before sharing information with a referral source.
8. Collegial actions, such as failing to report the inappropriate or ethical violations by a colleague.
9. Reimbursement, such as charging clients for unnecessary or excessive treatment without informed and written consent.
10. Conflicts of interest, such as providing services for a client in exchange for personal services.

Of the 267 individuals found to have violated ethical standards, 26 percent were found to have violated only one ethics category, while 74 percent had violated more than one. Most of the cases (55 percent) involved boundary violations, such as those involving sexual relationships and dual relationships. Given the frequency that these violations occur (and remember, this study only examined reported violations), we will explore these two violation types in more depth. The findings reflected a variety of inappropriate behaviors that blurred the helping process and exploited clients including:
- The use of physical contact in treatment.
- The pursuit of sexual activity with clients, either during or immediately after treatment.
- Social relationships.
- Business relationships.
- Bartering.

Unintended actions

Because of the complexity of providing mental health services, it is not unusual to be challenged by ethical questions. Some mental health professionals may rationalize that an action is ethical as long as you are not intending harm and/or are not knowingly violating an ethical standard or law. Other questions include:
- What about those unique situations that don’t readily lend themselves to a reference in law or codes of conduct?
- What defines prudent practice?

Pope and Vasquez (1998) discuss the tendency to rationalize that an action is acceptable as it relates to the practice of psychotherapy and counseling. This rationalization encompasses two principles:
1. Specific ignorance.
2. Specific literalization.
Specific ignorance

The principle (or rationalization) of specific ignorance states that even if there is a law prohibiting an action, what you do is not illegal as long as you are unaware of the law. For example:

- **Allison** worked with a client who suddenly moved to another state. While in crisis, her client called a mental health practitioner in the other state to make an appointment. This mental health practitioner phoned Allison to gain insight into her new referral. Allison was unwilling to divulge any information without a written release from her client, but the new therapist was adamant about acquiring the information immediately and threatened to report Allison to their national association. Allison assumed that because her client was in crisis, she could share information. Allison was unaware of their association’s ethics rules as they pertained to disclosure during crisis. She grudgingly shared confidential information because she felt her client was at risk.

Literalization

The principle (or rationalization) of literalization states that if we cannot find a specific mention of a particular incident anywhere in legal, ethical or professional standards, it must be ethical. For example:

- **Harry** lived in a state that did not have an ethics board that specifically prohibited socializing with clients. Through Harry’s church, he often came into contact with his clients because their church pastor referred them. Due to his long-standing church affiliation, Harry felt comfortable socializing during church functions on a regular basis with his clients and their families, at and away from church.

Assisting mental health practitioners in resolving ethical dilemmas that may arise in practice is just one of several purposes for establishing ethical codes of conduct. Ethical standards of practice for mental health generally benefit both the practitioner and the public and include:

- Identifying core values.
- Establishing a set of specific ethical standards that should be used to guide mental health practice.
- Identifying relevant considerations when professional obligations conflict or ethical uncertainties arise.
- Providing ethical standards to which the general public can hold mental health professionals accountable.
- Mental health ethical practice and standards orientation to practitioners new to the mental health field.
- Articulating formal procedures to adjudicate ethics complaints filed against mental health practitioners.
- Promoting assurance in counseling practice.
- Promoting professionalism in counseling.

Internal or personal ethical guidelines that drive practice

Internal or personal ethical values and morals play a large role in the overall conduct of a mental health practitioner. Character underlies ethical practice and bears some discussion.

“Right” or ethical character demonstrates a mental health professional’s capacity to discriminate between a client’s need and his or her own. Exemplifying best practice in mental health means a professional must conduct a thorough inquiry to affectively understand and advocate for clients.

In addition, demonstrating good character in mental health practice also drives practitioners to live authentically in accordance with laws and regulations as well as demonstrate professional behavior within the field. Possessing good character pushes mental health professionals to continuously self-examine their motives and intentions, and when necessary seek consultation. It is the ethical responsibility for every mental health practitioner to continue to seek professional growth and to examine personal and professional attitudes and behaviors.

Conversely, lack of character in mental health practice reflects rigid and restricted professional growth. In his book, “The Force of Character,” James Hillman reflects that “bad character would refer to a person with little insight… (This) is simply one who does not imagine who he is. In short, an innocent. Innocence has no guiding governance but ignorance and denial.”

Kitchener (1984) has identified five moral principles that are essential ethics guidelines. They include:

1. **Autonomy** addresses the concept of independence and the responsibility of a counselor to encourage clients, when appropriate, to make their own decisions and to act on their own values. Two important considerations in encouraging autonomy are: 1) Helping clients understand how their decisions and their values may or may not be received within the context of the society in which they live and how they may impinge on the rights of others; and 2) the client’s ability to make sound and rational decisions.
2. **Nonmaleficence** is the concept of not causing harm to others; it is often explained as “above all, do no harm.”
3. **Beneficence** reflects the counselor’s responsibility to contribute to the welfare of the client by doing good, being proactive, and also to prevent harm when possible.
4. **Justice** is treating equals equally and unequals unequally, but in proportion to their relevant differences. If an individual is to be treated differently, the counselor needs to be able to offer an appropriate rational.
5. **Fidelity** involves the notions of loyalty, faithfulness and honoring commitments. The counselor must take care not to threaten the therapeutic relationship, nor to leave obligations unfulfilled. (Forester-Miller and Davis, 1996)

It has been said that the Greek philosopher Socrates considered ignorance as it relates to character to be like an arrow missing its target. For example, if mental health practitioners believe that they are “walking a perfect path” in their profession, they may begin to form habits that bypass thorough inquiry and perhaps miss the mark as it pertains to demonstrating best practice in mental health.
They should also be willing to assume responsibility for their mistakes and misjudgments, without blaming others, even when this may place them in vulnerable legal positions.

Chris was a licensed mental health professional who missed the mark:

- Chris was well trained and had received considerable supervision during his licensing process as a marriage and family therapist. He was prepared to enter the profession

Examining and reconciling personal and professional values

When licensed mental health practitioners are confronted with their personal values and those held by their clients, tension could surface. For example, mental health professionals may have strong reactions to the ways in which some clients violate the law, excessively use drugs or alcohol, mistreat others, practice their faith, parent their children or engage in self-destructive behaviors. It is extremely important, then, to examine their personal value structures and consider how to proceed to work with a client while understanding that clients are often struggling with their own moral compasses as well.

Core values and ethical principles

The core values espoused by mental health ethics codes incorporate a wide range of overlapping morals, values and ethical principles that lay the foundation for the profession’s unique duties. They generally include:

- Service.
- Autonomy – Allowing for freedom of choice and action.
- Responsibility to clients.
- Responsibility to the profession.
- Responsibility to social justice.
- Responsibility for doing no harm.
- Dignity and worth of the person.
- Confidentiality.
- Importance of human relationships.
- Being proactive.
- Professional competence.
- Integrity.
- Engagement with appropriate informational activities.
- Treating people in accordance with their relevant differences.
- Responsibility to students and supervisees.
- Fidelity.
- Responsibility to research participants.
- Financial arrangements that conform to accepted professional practices.

Depending on a particular mental health professional association’s code of ethics, ethical professional practice can include:

- Helping people in need, such as natural disaster victims.
- Challenging social injustice, such as advocating for the rights of individuals diagnosed with mental illness.
- Respecting the inherent dignity and worth of the person, such as treating all clients with the same level of compassion and care.
- Recognizing the central importance of human relationships, such as acknowledging the commonalities in all people.
- Behaving in a trustworthy manner by being consistently present and reliable in the professional setting.
- Practicing within areas of competence and developing and enhancing professional expertise through continuing to expand one’s professional knowledge and expertise.

The intent of some of the principles, such as responsibility to students and supervisees, are what mental health practitioners can aspire to, while others are much more prescriptive, clearly identifying enforceable standards of conduct (Reamer, 1998).

Most ethics codes describe specific ethical standards relevant to six areas of professional functioning. These standards provide accepted standards of behavior for all mental health clinicians concerning ethical responsibilities:

1. To clients.
2. To colleagues.
3. To practice settings.
4. As professionals.
5. To a particular mental health profession focus.
6. To the broader society.

Further, professionals should take responsible steps before practicing interventions or approaches that are new to them or that are an emerging area of practice, with little to no generally recognized standards. Bogle and Coleman (2000) recommend the following strategies for gaining and maintaining professional and ethical competence:

- Learning should never stop. Research, as well as using available education, training, consultation and supervision opportunities should be taken to increase competence.
- Stay informed about the state of the profession through membership in national and state organizations and the review of professional publications.
- Adhere to state licensing laws before providing service.

Overall, mental health practitioners can benefit from the following more specific, yet practical recommendations:

- Take proactive responsibility for errors in judgment.
- Manage time effectively.
- Acknowledge clients’ time constraints.
- Check record keeping.
- Return phone messages in a timely manner.
- Avoid being late for sessions or meetings.
- Be dependable.
- Make outside resource information available to clients.

This course will continue to look at issues around each of these areas.
Ethical responsibilities to clients

The issue of client rights has brought greater perspective to mental health work. For instance, clients have a right to be informed of their mental health provider’s qualifications, such as education, experience, professional counseling certification(s) and license(s). They have a right to receive an explanation of services as well. Client also have the right to:

1. Be informed of their provider’s limitations of practice to special areas of expertise.
2. Have all shared information treated confidentially and being informed of any laws that place limitations on confidentiality in the treatment relationship.
3. Ask questions about the counseling protocols, techniques and strategies and being informed of their progress.
4. Be participants in setting goals and evaluating their progress toward meeting them.
5. Be informed about provider contact in cases of emergency or in instances where there is less urgency.
6. Request second opinion referrals.
7. Request copies of records and reports to be used by other referral sources.
8. Receive a copy of any professional code of ethics.
9. Contact the appropriate professional organization if there are doubts or questions regarding ethical provider conduct, and also to file complaints.
10. Terminate the provider-client relationship at any time.

These additional illustrations highlight the complexity of ethical responsibility to clients and the situations mental health professionals may face.

- A depressed, 80-year-old client who is suffering from the painful, debilitating effects of arthritis, asks Rene, his licensed mental health therapist, for information on assisted suicide. He tells her that he only needs help downloading information from the Internet and then it is his right to weigh the options of proceeding. Rene believes the client’s depression is directly related to his pain, because the client is otherwise of sound mind, and therefore has a right to determine his future.

- A young woman with a borderline personality disorder diagnosis becomes angry with her therapist because he has set very clear and consistent limits with regard to not calling him in the middle of the night and leaving desperate messages. During one session, this client threatens to report him to the state department of professional regulations for not responding to her phone messages.

Commitment

Client interests are primary. The examples above epitomize the difficulties often faced by mental health practitioners when the principles of law, personal belief, professional codes of ethics, client need, professional training and cultural and societal norms intersect and at times contradict each other.

The professional is then faced with a conundrum that offers a multitude of potential decisions, actions and consequences. We will discuss more about how the worker can best weigh all these considerations to make the most ethical decision later in this course.

Self-determination

Another standard that strongly reflects the mental health practitioner’s commitment to a client is that of self-determination. Professionals have an obligation to support and assist clients in accomplishing their goals, deviating from this only when a client’s goal puts them or others imminently at risk.

Defining risk can be difficult – most mental health professionals cannot argue that suicide or homicide presents a clear risk to the client or to others. For example, when a client’s condition indicates that there is a clear and imminent danger to the client or others, the mental health practitioner must take action to inform responsible authorities and potential victims. Other client choices, such as staying in an abusive relationship or living in squalor or on the streets may challenge a professional’s personal values and sincere desire to protect, also known as “professional paternalism” (Reamer, 1998). These occurrences certainly challenge mental health therapists. However, in the absence of clear and present harm, the client has a right to choose his or her own path and make his or her own decisions, whether we agree or disagree. For example:

- Sam and Katie have been seeing a couple’s therapist to address their anger issues within the context of their live-in relationship. Their therapist has often emphasized that verbal abuse should not be part of how the couple communicates. Yet, both partners consistently revert to verbal abuse when one of the couple is triggered by the other. Sam and Katie’s therapist is struggling with her concerns regarding their ability to integrate and practice new communication skills and behaviors as a couple. Should she let them know she doesn’t see much hope for their relationship? Should she refer them to a domestic violence agency? Her interaction will need to proceed with sensitivity and perhaps further inquiry with the couple, along with reflection on their on-going behaviors.

A more precarious ethical decision occurs when suicide becomes a topic of concern.
Suicide: Right to choose versus duty to protect

Sometimes a mental health practitioner may be faced with a choice between a client’s right to choose suicide and the duty to protect his or her life. The request by the emotionally stable and rational terminally ill client is a good example of a situation that is not as “cut and dried” as involving a severely depressed young woman contemplating suicide. For instance, would one client deserve individual consideration and thus not be assessed for possible hospitalization over another client?

Most workers choose this profession because it supports respect for the strengths and abilities of clients, and thus their ability to learn, make good decisions, and be self-sufficient. But aside from laws prohibiting assisted suicides, workers also rely on intuition and judgment in determining whether to take action to protect a client from harm. This scenario blurs the line between respect for the client’s wishes and society’s obligation to protect. It also raises the issue of client autonomy versus the professional obligation to prevent discrimination. Therefore, it is essential that mental health practitioners establish clear procedures that ensure impartial assessment while valuing client autonomy and individual treatment. Some mental health licensing accreditation agencies, as well as national professional associations have established protocols and codes of ethics regarding this issue.

Yet, since laws and professional codes of ethics are not always clear and do not always spell out our specific duties and responsibilities, it is recommended that workers not only do everything to assist clients in taking advantage of any options to alleviate their distress, but also rely on practice guidelines that call for:

- Careful evaluation, such as clients’ ability to make rational choices based on their medical and mental state and social situation.
- A good therapeutic alliance.
- Consultation.

Informed consent

Informed consent services should not be provided until valid informed consent can be obtained. Therefore, clients must know the exceptions to self-determination before consenting to treatment or other services. Mental health professionals working in child welfare or forensic practice settings are faced with additional challenges. In their article about informed consent in court-ordered practice, Regehr and Antle (1997) state:

“Informed consent is a legal construct that is intended to ensure that individuals entering a process of investigation or treatment have adequate information to fully assess whether they wish to participate. This concept of informed consent is closely linked with the value of self-determination.”

In general, potential threats and factors to be considered in ensuring the validity of informed consent are:

- Language and comprehension.
- Capacity for decision making.
- Limits of service refusal by involuntary clients (including court-mandated clients).
- Limitations and risks associated with electronic media services.
- Audio and video taping

Competence (or professional and ethical competence)

Another issue that relates to informed consent, competence, is mental health professionals’ responsibility to represent themselves and to practice only within the boundaries of their education, experience, training, license or certification and level of supervisory or consultant support. For example, poor practice, or the failure of a worker to provide services within accepted standards, was the second-most common form of violation found in Strom-Gottfried’s study of code violation allegations resulting in social work practice (2000).

The study also revealed findings of incompetence, in conjunction with other forms of unethical behavior, in 21 percent of the cases. In these cases, reasons why a social worker was not competent to deliver services included:

- Personal impairments, such as physical or mental illness or addictions.
- Lack of adequate knowledge or preparation, such as proceeding with certain mental health treatment protocols without certification.
- Lack of needed supervision when there is a clear need for such.

Ethics in cultural competence and social diversity

Cultural competence and social diversity in mental health practice recognizes that mental health professionals provide services that are sensitive to each client’s various cultures. Demonstrating ethical cultural competence includes:

- Being knowledgeable about culture and its impact on human behavior.
- Recognizing and appreciating the strengths found in cultures.
- Considering the nature of social diversity and oppression

In general, cultural competence is defined as:

“The ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions in a manner that recognizes, affirms, and values the worth of individuals, families, tribes and communities, and protects and preserves the dignity of each.” (CWLA 1981)

Due to societal and cultural changes occurring now in the 21st century, understanding cultural competence is an ongoing
learning process and a vehicle to broaden knowledge and understanding about individuals and communities. For example:

- **Jackie**, a licensed mental health professional, had spent much of her career working with children within her Native American community. As her work expanded to helping children from another culture, she found that she struggled with her personal biases based on her past experience with that culture. Jackie felt that she needed to seek consultation and supervision, given her feelings and attitudes toward her newer, young clients.

- **Matt** was offered an administrative position at a mental health center in a southern state after working in the northeast part of the country for many years. When he arrived at his new job he was confused by and often misunderstood why staff members kissed their clients on the cheek when being greeted.

- **Carly** grew up in a conventional and traditional “western” environment with her two parents. When she arrived at her first job, she was surprised to learn that many of her clients had been reared, not by their birth parents, but by grandparents or other extended family members. Yet, Carly soon learned that their circumstances did not reflect a lesser value system than the one she’d grown accustomed to as a child.

The above examples illustrate that developing cultural competence is an ongoing process, requiring the clinician’s active involvement. Therefore, it is helpful for mental health practitioners to know five elements of cultural competence. These include:

1. Valuing diversity cross-culturally in behaviors, practices, policies, attitudes and structures. Valuing diversity can be demonstrated in a number of ways through professional affiliations and volunteerism, in addition to practice application.

2. Conducting cultural self-assessment to assess for personal and professional proficiency in cultural competence. Take time to ask yourself questions regarding your personal cultural competencies. A few questions may include:
   - I accept and respect that male-female roles in families may vary significantly among different cultures.
   - I accept that religion and other beliefs may influence how families respond to illness, disease, disability and death.
   - I accept that different cultures may present and resolve their issues in a variety of ways.

3. Managing the dynamics of difference within natural, formal or informal support and helping networks within clinical settings. For example, there is often a cultural shift from a hospital setting to an office setting, in addition to working with personnel from each of these settings.

4. Acquiring and integrating cultural knowledge by seeking out information and consultation and practice applications. Some states require continuing education courses in understanding cultural competence and its practice application.

5. Adapting to diversity and cultural contexts that include policies, structures, values and services. For example, working within the context of a large mental health group private practice is different from working within the context of a private nonprofit organization. Consequently, it is essential when working with clients who are affiliated with both to navigate effectively through those settings.

**Defining linguistic competence**

Linguistic competence is defined as:

“The capacity of a mental health professional to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who are not literate or have low literacy skills, and even individuals with disabilities.”

In positive culturally competent communication climates, trust is established and reaffirmed, allowing freedom to explore sensitive issues and express disagreements. Positive talk climates are:

- Descriptive.
- Oriented toward problems.

- Spontaneous.
- Empathic.
- Express equality.
- Provisional.

Richardson and Molinaro (1996) have suggested that self-awareness be a prerequisite for multicultural competence. Self-awareness often develops from personal and professional socializations to divergent cultural experiences. (Helms and Cook, 1999) When this self-awareness is integrated into clinical roles, mental health professionals are likely to develop complex perspectives on cultural influences in their role.

**Common errors in demonstrating cultural competence**

Demonstrating ethical behavior in cultural competency can be somewhat confusing for mental health practitioners, depending on their regional, cultural and linguistic orientation. Common errors demonstrated by often well-meaning professionals include:

- Unintentional racism, such as inserting inappropriate descriptions or statements within the context of sharing a joke.
- Miscommunication, such as using phrases that may mean one thing to the speaker but something very different to the listener.

- Lack of personal awareness, such as the inability to learn from culturally based mistakes in judgment or behavior with clients.
- Insensitivity to nonverbal cues, such as failing to pick up on a client’s body language when he or she is upset.
- Lapses in discussion of racial/ethnic issues, such as avoiding an awkward conversation about an apparent obstacle in the therapeutic relationship.
- Gender bias, such as making generalized statements about someone’s innate abilities based on gender.
● Overemphasis of cultural explanations for psychological difficulties, such as using cultural norms to explain inappropriate and problematic behavior.
● Lapses in including appropriate questions within the context of acquiring background information, such as failing to inquire about family rituals or celebrations.
● Inability to appropriately present questions that elicit valuable information or feedback, such as ignoring or bypassing important questions because of time constraints.
● Non-participation in multicultural activities that facilitate cultural awareness that would include interaction among people of similar and different racial identities, because of erroneous fears about participation with another culture.
● Little or no processing of cultural difference in supervision, thus avoiding what might be an uncomfortable discussion.
● Inability to identify multiple hypotheses and integrate this information in a culturally competent manner into a client’s presenting problem, such as failing to assimilate and reflect on any hypotheses with a client.

Recommendations to promote ethical cultural competence were developed by the Georgetown University Center for Child and Human Development University Center for Excellence in Developmental Disabilities, Education, Research and Service. Mental health practitioners can use these recommendations to promote ethical practice in cultural competence through the following:
● Display materials that reflect cultures and ethnic backgrounds of clients within your practice.
  ○ Printed materials in your reception area that are of interest to and reflect cultures of people served.
  ○ Treatment aids, such as play therapy and games that reflect cultures of people served.
● Attempt to learn and use key words in client’s language.

Conflicts of interest

One of the most difficult areas of responsibility to clients is conflict of interest. Workers need to avoid conflicts of interest that interfere with the exercise of:
● Professional discretion.
● Impartial judgment.

The issue of informed consent should include both proscribing the need to inform clients of potential or actual conflicts, and taking reasonable steps to resolve the conflict in a way that protects the client’s needs and interests. Mental health professional associations are excellent resources for providing guidelines around conflicts that may result from a therapeutic relationship.

Dual or multiple relationships

Dual or multiple relationships occur when mental health professionals relate to clients in more than one relationship, whether professional, social or business. Dual or multiple relationships can occur simultaneously or consecutively. For instance:
● Kevin, a licensed counselor, coaches a young men’s soccer team. During the process of completing an intake interview with a new client, he discovers that his client’s stepson, with whom she has relationship issues, is on his team. Kevin will make a decision whether or not to proceed with treatment.

Dual or multiple relationships with current or former clients should be avoided whenever possible, and the exploitation of clients for personal, religious, political or business interests should never occur.

Further, workers should not engage in dual or multiple relationships with clients or former clients when there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries.
Recognizing that there are many contexts within which mental health work is practiced, dual relationships are not always entirely banned by different professional associations’ ethical codes. The words “should” or “making reasonable efforts to” in sections where dual or multiple roles are outlined within various codes of ethics imply there is room for exceptions.

Boundary violations

Conflicts of interest relate closely to other types of unprofessional behavior such as boundary violations that more specifically identify harmful dual relationships. Most mental health professionals can easily recognize and identify common boundary issues presented by their clients.

Likewise, most can identify examples of boundary violations around professional behavior, for example, sexual misconduct. While not exclusive to the clinical role, there are certain situations that are more challenging than others, especially for workers vulnerable to committing boundary violations.

Boundary issues involve circumstances in which there are actual or potential conflicts between professional duties and social, sexual, religious or business relationships. These are some of the most challenging issues faced in the mental health profession, and typically involve conflicts of interest that occur when a worker assumes a second role with one or more clients.

Such conflicts of interest may involve relationships with:
- Current clients.
- Former clients.
- Colleagues.
- Supervisees and students.

With that in mind, the following would be examples of inappropriate boundary violations, and thus unethical, in that they are involved in a dual relationship that is exploitive, manipulative, deceptive or coercive in nature.
- Buying property from a disaster client at far below its market level.
- Falsely testifying to support fraudulent actions of clients.
- Imposing religious beliefs on a client.
- Suggesting that a client, entering hospice care, make you executor of his/her will.
- Referring a client to your brother-in-law, the stockbroker.
- Friendship with the spouse of a client you are treating for marital issues.
- Accepting stock market tips from a client.

Five conceptual categories with regard to boundary violations generally occur around five central themes:

1. Intimate relationships – These relationships include physical contact, sexual relations and gestures such as gift-giving, friendship and affectionate communication. For example:
   - It hadn’t occurred to Amanda that her client’s flower bouquet meant more than a thank you, until a week later at their session, he confessed his strong romantic feelings for her.
   - Phil received a call from a distraught former female client late one night wanting him to meet her at a restaurant for “a cup of coffee.”

2. Pursuit of personal benefit – The various forms this may take include monetary gain, receiving goods and services, useful information. For example:
   - Lawrence was surprised to learn that one of his colleagues was receiving stock tips from one of her clients, who ran a very successful stock brokerage firm.
   - Nell asked one of her clients, a retail store owner, for a customer discount in exchange for counseling sessions.
   - One of Mike’s clients was positioned to know more about an impending land sale than most people. Since Mike also invested in real estate, he was tempted to ask his client about the deal.

3. Emotional and dependency needs – The continuum of boundary violations ranges from subtle to glaring and arise from the social worker’s need to satisfy his or her emotional needs. For example:
   - Jeff thought of himself as a father figure to his clients and encouraged them to contact him at any hour of the day, including during his vacations.
   - Betsy became very attached to a foster child she’d been sporadically seeing for several months. Since she was single and had sorely wanted a family of her own, she seriously entertained the idea of adopting her young client.
   - Monica was very involved in her religious community and was devoted to a particular television evangelist. During one session, she felt compelled to encourage a distraught client, with no particular religious affiliation, to read one of the evangelist’s books and to attend her church.

4. Altruistically motivated gestures – These gestures arise out of a mental health practitioner’s desire to be helpful. For example:
   - Sandra felt compelled to give a newly sober client a small financial loan after the client cried that she didn’t have enough money to feed her children. After Sandra gave her the cash, the client proceeded to purchase alcohol and get drunk.
   - Jim felt badly for his client who took a bus to and from sessions. One night he offered to give his client a ride home.
   - Ed felt he had no option but to keep his young client’s drug habit from her parents because of his knowledge that both parents could become easily agitated and violent.

5. Responses to unanticipated circumstances – Unplanned situations over which the social worker has little to no control. For example:
   - Jake was uncomfortable when his mother was admitted to the same mental health facility where he was on staff.
practitioners are more familiar with examples of intentional and arising from their own emotional needs. Most mental health
Another tricky issue occurs when workers engage in behavior
certain cultures and contexts, but may confuse or intimidate a
psychological harm to the client. Kissing on the cheek for
determining whether an action presents the possibility of
Again, the professional is in the unenviable position of

● Entered into at the client’s initiative.

● Negotiated without coercion.

● An accepted practice among community professionals.

● Essential to service provision.

Another tricky area involves bartering arrangements, particularly involving the exchange of services. These should be considered carefully and according to Reamer (2003) be limited to the following circumstances when they are:

There are very respectful, sound and appropriate reasons for encouraging clients to share what they know and to pay attention to their skills and strengths. Benefiting from information the client has (i.e., stock tips and leads on jobs) is another matter. It is important to remember that this can apply both ways, e.g., the mental health professional needs to avoid offering assistance in areas outside his or her role. For example, it is grossly inappropriate to offer legal or medical counsel when one is not qualified to provide those services.

“Their usefulness to your patients lies in your clinical skills and separation of your professional role from other roles which would be better filled elsewhere in their lives. Do not suggest, recommend or even inform the patient about such things as investments, and be cautious about giving direct advice on such topics as employment and relationships. There is a difference between eliciting thoughts and feelings to encourage good decision-making and inappropriately influencing those decisions.” (Reid, W. 1999)

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- Essential to service provision.
- Negotiated without coercion.
- Entered into at the client’s initiative.
- Done with the client’s informed consent.

Again, the professional is in the unenviable position of determining whether an action presents the possibility of psychological harm to the client. Kissing on the cheek for example may be perfectly correct, and clearly non-sexual in certain cultures and contexts, but may confuse or intimidate a client in other contexts.

Another tricky issue occurs when workers engage in behavior arising from their own emotional needs. Most mental health practitioners are more familiar with examples of intentional and

Intimate relationships

Discussed earlier, boundary issues involving intimate relationships are the most common violations. Those involving sexual misconduct are clearly prohibited and will be further explored.

While most professionals might agree that having other nonsexual relationships, such as a friendship with a current clinical client, is inappropriate, the rules are not as clear regarding ex-clients and even less so for those clients in case management, community action or other nonclinical relationships.

When a dual relationship results in personal benefit to the practitioner, it also undermines the trusting relationship. Some of the scenarios mentioned earlier (getting property below market value, becoming the executor of the client’s will, and referring clients to a relative) are all examples.

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Another tricky issue occurs when workers engage in behavior arising from their own emotional needs. Most mental health practitioners are more familiar with examples of intentional and

even more egregious examples, such as the practitioner who uses undo influence to “convert” the client or takes sides in a custody case in order to foster a relationship with one of the spouses.

Many times boundaries are crossed unintentionally, as in a practitioner who becomes overly involved in a case in which she personally identifies. Or the worker may be experiencing life issues that make him or her more vulnerable to the attention of a client. For example, an on-going health concern, family member illness or a recent spousal argument can distract a mental health professional from doing his or her job.

- Keith, a licensed social worker, had been going through a rough patch in his marriage when a client with a similar issue came to him for counsel. Keith wondered if his answers to his client’s questions exemplified good clinical practice or were colored by his current marital situation, because both circumstances were so similar.

Mental health professionals have a responsibility to maintain competence in both the professional and emotional arenas.

While some types of situations may not be considered unethical or illegal, the worker needs to carefully review his or her motivation and the potential consequences of each decision. Some helpful questions to ask are:

- Would I do this for all my clients?
- Am I doing this because I feel uncomfortable (e.g., saying no)?
- Am I feeling at a loss to help the client any other way and thus feeling “I must do something” to feel competent?
- How might the client interpret my gesture?
- Am I doing this just for the client’s interest or also for my own interest?
- What are all the potential negative outcomes?

There are also times that the intent of the professional is truly out of a desire to be helpful, for example, buying merchandise from a client whose business is struggling or inviting a divorce recovery group client to a community function in order to help her broaden her social network.

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- Am I doing this because I feel uncomfortable (e.g., saying no)?
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- How might the client interpret my gesture?
- Am I doing this just for the client’s interest or also for my own interest?
- What are all the potential negative outcomes?

There will be occasions when you incidentally come into contact with a client, such as learning your client’s daughter is on the same soccer team as your child. Some practitioners go
out of their way to live in a different community so the chances are minimal that this could happen. Others see that as over-managing a potential situation that is unlikely to lead to harm for the client or colleague (as in the case of supervisees).

The appropriateness of relationships with clients is often debated across the profession. The unique service settings and roles assumed by workers often contrast with the traditional clinical approach to human service. Applying strict rules around relationships can appear excessive or contradictory with sound mental health practice. A worker, for example, may work in a small, isolated community that would expect its community members to share in social customs such as family meals and weddings.

Ethical guidelines recommend giving student supervisees guidelines to guarantee client protection instead of blanket advice to avoid dual relationships altogether. (Boland-Prom and Anderson, 2005).

Freud and Krug (2002) also feel that “overcorrecting a problem, as is a frequent tendency in our society, sometimes escalates the very transgressions against which the new rules are to protect us.” While necessary and healthy debate continues, practitioners need to, no matter what their scope of practice, seek guidance and input from a variety of sources to make good decisions around boundary issues.

There are some areas where clear rules about dual relationships are essential; they include:

- **Protection of the therapeutic process** – In the context of current clinical practice, “even minor boundary trespasses can create unwarranted expectations.” Transference and countertransference issues are present and cannot be underestimated. According to Freud and King (2002), “The mystique of the tightly boundaried, hierarchical therapeutic relationship heightens transference phenomena.” For example:
  - **Mark**, a mental health counselor, suspected his therapeutic alliance with a depressed young woman turned a corner when she reported feeling less hopeless and more energized. She gratefully acknowledged his assistance and stated that she was planning to return to college and become a therapist. Mark acknowledged her gratitude but was careful to point out that it was her own work that facilitated her recovery.

- **Client protection from exploitation** – A clinician may be tempted to meet personal sexual, financial or social needs with persons who may be particularly vulnerable to exploitation. Ethical guidelines serve to protect clients from exploitation. For example:
  - **Jeff**, a psychiatrist, was referred a patient who was severely depressed. Most of his patients were fairly wealthy, and Jeff was impressed that his new patient had a good deal of money as well. As time went by, Jeff insisted that his patient continue daily sessions, even though the man was clearly improving and was no longer in need of Jeff’s intense intervention.

- **Protection from potential legal liability** – Mental health workers are justifiably concerned about legal liability and the “careful adherence” to the boundary specifications that protect clinicians from malpractice suits. For example:
  - **Kim**, a newly licensed clinical social worker, was interested in practicing “progressive” forms of therapy. One practice she’d adopted emphasized focusing on empowerment issues for survivors of incest. Kim demonstrated a lapse in judgment when she encouraged a vulnerable young client to confront a relative regarding retrieved sexual assault memories, even though the client questioned the authenticity of her recovered memory.

Ultimately, it is the mental health professional’s responsibility to establish appropriate and clear boundaries for clients; doing so often prevents issues from surfacing in the first place. The worker cannot underestimate the importance of expectations – respecting the client means together creating a safe relationship where boundaries and expectations are unambiguous and openly discussed.

To further minimize possible harm to all parties: the client, the worker, the employer and others, the following risk management protocols to address boundary issues are suggested:

- Be alert to potential or actual conflicts of interest and trust your instincts.
- Inform clients and colleagues about the possibility of potential or actual conflicts of interest; explore reasonable remedies to repair any offenses.
- Consult colleagues, supervisors, relevant professional literature, regulations, policies and ethical standards to identify pertinent boundary issues and constructive options.
- Design a written plan of action that addresses the boundary issues and protects the parties involved to the greatest extent possible.
- Document all discussions, consultation, supervision and other steps taken to address boundary issues.
- Develop a strategy to monitor implementation of action plan (clients, colleagues, supervisors and lawyers).

### Sexual harassment

In 1980 the EEOC (Equal Employment Opportunity Commission), the agency that enforces Title VII of the Civil Rights Act of 1964, first defined sexual harassment as a form of sex-based discrimination and issued guidelines interpreting the law. These guidelines define unlawful sexual harassment as:

- Unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature, when:
  - Submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment.

**Sexual relationships, physical contact, sexual harassment, and derogatory language**

Ethical mental health practice limits sexual relationships with clients, former clients and others close to the client, physical contact where there is risk of harm to the client, sexual harassment and the use of derogatory language in written and verbal communication to or about clients.
offending professionals. They are described as affective or predatory. “Affective” offenders tend to have unresolved emotional problems and may engage in countertransference, be depressed, or have substance abuse issues. They may have underlying and unresolved abandonment issues.

“Predatory” offenders tend to have personality disorders that include narcissistic, borderline or psychopathic features. Predatory offenders have integrated their behaviors to use and exploit others in order to meet their needs.

Seven subtypes within the affective and predatory types have been identified. They include:

1. Sadistic – Offenders who enjoy using their power and authority to control and dominate the victim, receiving marked pleasure from being cruel and provoking suffering.
2. Exploitive – Offenders who purposely use their power and authority to fulfill their needs, including the need to dominate and control.
3. Incidental – Offenders who have impulsively behaved in a sexually inappropriate manner one time.
4. Narcissistic – Offenders who demonstrate a need for attachment, admiration, approval, validation, love and attention.
5. Angry – Offenders who persistently sexually harass and offend against women.
6. Compensatory – Offenders who offend to fulfill unmet needs for closeness, affection and sexual relations.
7. Interpersonal – Offenders who are motivated to establish a close, intimate and long lasting relationship. The relationship appears to be authentic without clear signs of exploitation or abuse.

Anyone working in mental health practice has experienced different relationships with clients. Sometimes it is nearly impossible not to form respect and even affection for clients. However, practitioners must work diligently to avoid problems by either crossing the boundaries of the professional relationship or even appearing to do so.

In addition to other previously discussed actions designed to prevent harm to the client, workers can proactively address this issue by doing the following:

- Limit practice to those populations that do not cause your own needs to surface.

Sexual misconduct

Some states also have laws making sexual misconduct subject to lawsuits and even arrest. Practitioners need to be sure about the rules that apply to them as well as be aware of how their behavior may be perceived by others. For example, Reid points out that in most situations, consent will not be an effective defense against sexual misconduct allegations. The reasons Reid (1999) gives for a client’s ability to consent being called into question are:

- The fiduciary trust between clinician and patient.
- Exploitation of transference feelings.
- The right of the patient to expect clinical needs to be the overriding priority in treatment.
- Exploitation of the patient’s purported inability to resist the therapists’ influence.
- The alleged “power differential” between any patient and his or her clinician.

Recorded history of sexual misconduct travels back to the 4th and 5th centuries B.C., and includes the Hippocratic Oath that states: “I will abstain from intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free.” In contrast, Sigmund Freud flagrantly sanctioned sexual misconduct when he excused such behavior by his male colleagues.

For example, Carl Jung, according to historians, became sexually involved with one of his patients by the name of Sabina Spielrein, a 19-year-old medical student. When corresponding with Freud, he stated, “The continued preservation of the relationship (with Sabina) could be rounded out only by sexual acts.” As Jung became more desperate when the affair became known, his colleague reassured him. Freud wrote to his friend not to blame himself and stated, “It was not your doing, but hers.”

Kenneth S. Pope has written extensively on sexual behavior between mental health professionals and their clients. He asserts that sexually abusive psychotherapists are well represented in the mental health profession. As a matter of fact, he feels there is nothing new about sexual contact between mental health practitioners and their clients.

Assailian and Ravart have identified two types of sexually offending professionals. They are described as affective or predatory.

In mental health practice, sexual harassment can take many forms including: offensive or derogatory comments, sexually oriented jokes, requests or demands for sexual favors, leering, visual displays depicting sexual imagery, innuendos, pinching, fondling, impeding someone’s egress and so on. Workers should not sexually harass supervisees, students, trainees or colleagues. Care should be taken not to send suggestive or implied sexual jokes via the Internet while at work. In Erica’s case her sexual harassment took the following form when:

- Erica had completed her internship with a mental health group in her college town. After becoming licensed, she continued to stay on as a group partner with the understanding that she might experience some tension at times because some of her colleagues had been her graduate school instructors and supervisors. Two of those people were men who sometimes shared lunch. While having lunch together, the men often shared lewd jokes and joked at Erica if she became embarrassed during their conversation. At one point they asked her questions about her sexual relationship with her partner.
• Seek clinical supervision to effectively deal with personal feelings.
• Document surroundings and who was present during sessions and visits.
• Avoid seeing the client at late hours or in locations that are atypical for routine practice.

Reporting sexual misconduct by a colleague is an ethical responsibility of mental health practitioners. Many states have laws that require licensed professionals to report such misconduct, as well as other ethical violations to their state boards. It is the responsibility of every professional to protect clients by reporting a reasonable knowledge or suspicion of misconduct between the client and colleague.

Professional boundaries self-assessment

Below are questions that raise red flags that professional boundaries may be compromised. Some relate to you and some to clients. As you honestly answer the following questions yes or no, reflect on the potential for harm to your client.

<table>
<thead>
<tr>
<th>Professional boundaries self-assessment</th>
<th>YES or NO</th>
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<tbody>
<tr>
<td>Have you ever spent time with a client “off duty”?</td>
<td>□ □</td>
</tr>
<tr>
<td>Have you ever kept a secret with a client?</td>
<td>□ □</td>
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<tr>
<td>Have you ever adjusted your dress for a client?</td>
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<tr>
<td>Has a client ever changed a style of dress for you?</td>
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<tr>
<td>Have you ever received a gift from a client?</td>
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<td>Have you shared personal information with a client?</td>
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<tr>
<td>Have you ever bent the rules for a client?</td>
<td>□ □</td>
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<tr>
<td>Have you ever given a client a gift?</td>
<td>□ □</td>
</tr>
<tr>
<td>Have you ever visited a client after case termination?</td>
<td>□ □</td>
</tr>
<tr>
<td>Have you ever called a client when “off duty”?</td>
<td>□ □</td>
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<tr>
<td>Have you ever felt sexually attracted to a client?</td>
<td>□ □</td>
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<tr>
<td>Have you ever reported only the positive or only the negative aspects of a client?</td>
<td>□ □</td>
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<tr>
<td>Do you think you could ever become over-involved with a client?</td>
<td>□ □</td>
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<tr>
<td>Have you ever felt possessive about a client?</td>
<td>□ □</td>
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<tr>
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<tr>
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Clients who lack decision-making capacity

The mental health practitioner’s responsibility is to safeguard the rights and interests of clients who lack decision-making capacity. Persons who lack this capacity include intellectually delayed or impaired individuals, the elderly, or children under the age of 18. It is especially important to utilize consent forms at all times and to inform and document contact with family and other service providers. In addition, mental health professionals should understand how these clients may become vulnerable to and potentially harmed by businesses, institutions, family or other caregivers.

As an example, mental health professionals are obligated to serve the best interests of children and guide decision-making. Therefore, to ethically work toward their well-being they must focus on the potential of abuse. The welfare of all children should be of utmost concern to society. Their best interest is at the heart of decision-making. Yet, caring, ethical conduct also stresses the importance of promoting positive relationships and working toward the prevention of family disintegration. In some instances, this can pose an ethical dilemma. For example:

• Parent rights are in the process of being terminated for two sibling clients. Ana, their mental health counselor, must consider how the two girls would adjust to their prospective adoptive placement when one of the children has severe attachment disorder. Should they be placed together, or will placing them together prolong a prospective adoption? Should each sibling’s placement be separately planned?

• Ana knows that empirical research on the question of preserving the sibling relationship among children in foster care and adoption is limited. And she also knows that sibling bonds may be stronger than parental attachments in families where the parental system is dysfunctional. So she must refer to sources outside of her immediate level of expertise as she considers her recommendations. One important source of information would be the Child Welfare of America’s (CWLA) standard for out-of-home care for neglected and abused children that states that siblings should remain together, but also acknowledges that in some cases separation is indicated. (Rothman 1998)
Payment of services

With regard to payment of services it is most helpful to refer to your particular professional association's financial arrangement standards. Professional association ethical guidelines, in general, call for fair and reasonable fees for services, prohibition or no prohibition of solicitation of fees for services entitled and rendered through the workers' employer, and avoidance of bartering arrangements. Other guidelines include no acceptance or offering of kickbacks, rebates, bonuses or other remuneration for referrals. Clear disclosure and explanation of financial arrangements, reasonable notice to clients for intention to seek payment collection, third-party payor fact disclosure, and no withholding of records because payment has not been received for past services, except as otherwise provided by law, are also examples of ethical financial guidelines.

Deception, fraud and other related ethical issues

In his book, “Social Work Values and Ethics,” Reamer refers to “fraud” as the “unintentional or negligent, implied or direct perversion of truth for the purpose of inducing another, who relies on such misrepresentations, to part with something valuable belonging to him or to surrender a legal right. If one misrepresents the risks or benefits of therapy for one’s own benefit and not the patient’s to try to induce him to undergo treatment and pay the fee, this is fraud. Telling a patient that sexual intercourse is therapy may be seen as a perversion of the truth so as to get the patient to part with something of value. Hence, this would be seen as fraud.”

In addition to deception and fraud, other issues related to personal and professional integrity are:

- Misrepresentation.
- Solicitations.
- Acknowledging credit.

Practitioners have an obligation to avoid actions that are dishonest, fraudulent or deceptive. Such actions, or in some cases, lack of action, put the continued integrity of both the individual mental health worker and the profession at risk. Some examples include:

- Falsifying records, forging signatures or documenting services not rendered.
- Embellishing one’s education and experience history or qualifications (refer also to “Misrepresentation”).
- Lying to a client or his or her family to “protect” them from unpleasant information.
- Not sharing legitimate options to a client because they violate the professional’s beliefs.
- Misleading potential donors or current funders with false outcome data.

Misrepresentation occurs when mental health professionals present opinions, claims and statements that are either false or lead the listener to believe facts that they are not accurate. Three actions must be taken to ensure that clients and the public receive accurate information:

1. Clearly distinguish between private statements and actions and those that are representative of an organization or employer.

According to the National Board for Certified Counselors, (NBCC), “In establishing fees for professional counseling services, certified counselors must consider the financial status of clients. In the event that the established fee status is inappropriate for a client, assistance must be provided in finding comparable services at an acceptable cost. Certified counselors must refuse remuneration for consultations or counseling with persons who are entitled to these services through the certified counselor’s employing institutions or agency. Certified counselors must not divert to their private practices, without the mutual consent of the institution and the client, legitimate clients in their primary agencies or the institutions with which they are affiliated.”

2. Accurately present the official and authorized positions of the organization they are representing and/or speaking on behalf of.

3. Ensure accurate information about and correct any inaccuracies regarding professional qualifications, credentials, services offered and outcomes or results.

Client solicitation stems from a concern for clients who, due to their situation, may be vulnerable to exploitation or undue influence. Because of their circumstances, there is also the potential for manipulation and coercion. As such, mental health practitioners should refrain from:

- Engaging in uninvited solicitation.
- Soliciting testimonial endorsements from current clients or other potentially vulnerable persons.

Mental health practitioners also have an ethical responsibility to the contributions of others by acknowledging credit. They should:

- Take responsibility and credit only for work they have actually performed and contributed to.
- Honestly acknowledge the work and contributions of others.

Kirk and Kutchins, (1988) states that clinical social workers who deliberately misdiagnose clients are participating in “such acts that are legal and ethical transgressions involving deceit, fraud or abuse. Charges made for services not provided, money collected for services to fictitious patients, or patients encouraged to remain in treatment longer than necessary are examples of intentional inaccuracy.”

Licensed mental health professionals who market or advertise their services should be careful to avoid fraud and deception. They must present fair and accurate descriptions of their expertise, services, credentials, letters of reference and to avoid any exaggeration of claims of “effectiveness” (Reamer, 2006). They must also take care when they are applying for employment, license, certifications and insurance. If, by chance, accurate details were inadvertently omitted from a document, any added information should clearly reflect the entry was signed and dated and that it showed that it was an amendment.
Ethical responsibilities to colleagues

Licensed mental health practitioners should not only take responsibility for their own actions but also take actions that ensure the safety and well-being of any clients served by others in the mental health profession. Thus, their responsibilities include:

● Duty to clients.
● Duty to colleagues.
● Indirectly, duty to the mental health profession.

In addition, they demonstrate further ethical responsibility by:

● Respecting and fairly representing the qualifications, views and obligations of colleagues.
● Respecting shared confidential information.
● Promoting interdisciplinary collaboration.
● Not taking advantage of disputes between colleague and employer or exploiting clients in disputes with colleagues.

Ethical responsibilities to the mental health profession

In general, national mental health professional associations discuss the responsibility to help maintain the integrity of their particular mental health focus as well as issues related to mental health work evaluation and research. Maintaining the integrity of the profession is a responsibility of every licensed mental health professional and requires the active participation of each person, whether it be collaborating on the creation of new standards, continuing to challenge mediocrity or complacency, or taking advantage of educational opportunities. Mental health professionals should demonstrate the following integrity safeguards:

● Maintain and promote high standards of practice.
● Uphold and advance the values, ethics, knowledge and mission of the profession through study, research, active discussion and reasonable criticism.
● Contribute time and professional expertise to activities that promote respect for the value, integrity and competence of the profession.
● Contribute to the knowledge base and share with colleagues their knowledge related to practice, ethics and research.
● Act to prevent unauthorized and unqualified practice of mental health work.

Interruption of services and termination

Mental health practitioners should demonstrate reasonable efforts for continuity of services when services must be interrupted or terminated. Interruptions may come from practitioners’ or clients’ vacation or illness. There may be a loss of funding for the service. The typical reason termination occurs is when the client and practitioner agree that the:

● Goals of treatment or service have been met.
● Client can no longer benefit from treatment/service.
● Client will be referred to another professional or service.

When mental health practitioners determine that they are unable to be of professional assistance to a potential or existing client, they should not initiate the therapeutic relationship or immediately terminate the relationship according to their professional association’s standards. Practitioners should also suggest appropriate alternatives. However, the mental health therapist should not be responsible for continuing the relationship if the client declines the suggested referral sources.

Mental health practitioners should consider the needs and best interests of clients being served by other professionals or agencies before agreeing to provide services and discuss with the client the appropriateness of consulting with the previous service provider.

In addition, it serves clients best to be available to re-refer a former client when a transfer to another mental health practitioner does not work out. Well-planned transfers should incorporate a timeline, termination session and informed consent in order to properly consult with the client’s new mental health professional.

Informed consent is an important aspect of this issue in that a practitioner must discuss all implications, including possible benefits and risks of entering into a relationship with a new provider.

When a referral is made, the referring clinician is obligated to determine the appropriateness of the referral, including the abilities of the receiving professional or agency, and should follow up on the client’s progress wherever possible and permitted. Finally, mental health practitioners should continue to refer to their professional association’s ethical code guidelines and state laws regarding a related issue: the disposition of client records upon termination, referral or practice closure.
**ETHICS IN PRACTICE SETTINGS**

**Administration**

Mental health administrators should advocate within and outside their agencies for adequate resources, open and fair allocation procedures and a work environment that is not only consistent with, but also encourages compliance with ethical standards of practice. Ethics in mental health practice should be included in individual, group or peer supervision as well. And regular training on ethics should be part of employee professional development.

Ethical standards of practice should be included with materials given to new workers and emphasized during staff hiring, and some form of ethics language should be included with a mission statement. For example, Children’s Home Society of Florida states that it “provides effective solutions to build and support healthy families for Florida’s children.”

In addition to supervision, organizations can use staff or board member “retreat” settings to further clarify ethical practice and mission.

**Billing**

Practitioners need to establish and maintain accurate billing practices that clearly identify the provider of services. Many agencies, associations and boards include these expectations in their own values and codes of ethics, commonly under the category of stewardship.

Intense, short-term therapy intervention should be available at normal cost throughout the process as well. Billing records must be kept confidential and stored in accordance with state, professional board or association standards. False billing practices, such as inflating fees in order to take advantage of any individual, is unlawful as well as unethical.

**Client records and client record keeping**

Maintaining records of service and storing them is not always easy. Aside from the potential negative legal fallout of not doing so, there are good reasons for keeping records including:

- Assisting both the practitioner and client in monitoring service progress and effectiveness.
- Ensuring continuity of care should the client transfer to another worker or service.
- Assisting clients in qualifying for benefits and other services.
- Ensuring continuity of care should the client return.

To facilitate the delivery and continuity of services, the practitioner, with respect to documentation and client records, must ensure that:

- Records are accurate and reflect the services provided.
- Documentation is sufficient and completed in a timely manner.
- Documentation reflects only information relevant to service delivery.
- Client privacy is maintained to the extent possible and appropriate.
- Records are stored for a sufficient period after termination.

Records, in general, must be inaccessible to the public and stored in a locked file cabinet that is located behind locked doors when session areas are not being used. (However, remember to follow state and professional association rules.) Records should be maintained for a designated period of time, usually mandated by state or professional regulations. State statutes, federal regulations, contracts, accreditation bodies and other relevant stakeholders prescribe the minimum number of years records should be kept. For example, HIPAA has a requirement of six years for electronic records. The National Board of Certified Counselors requires a minimum of five years. The Council on Accreditation requires records be kept a minimum of seven years. The NASW Insurance Trust actually strongly recommends retaining clinical records indefinitely. Again, professionals who are primary custodians of client records should refer to additional legal requirements, such as those established by state licensing boards, regarding care for client records in the event they retire or close their business or practice.

Records include accurate session notes, test scores, correspondence, audio or visual tape recordings, electronic data storage and any other documents applicable for use in the therapeutic environment. The physical records are the property of the mental health professional, and yet the information contained within the records belongs to the client and is confidential. Information may not be released to anyone without the consent of the client or when “the counselor has exhausted challenges to a court order.”

With the advent of computer record storage, mental health professionals must ensure that any electronic storage sites are secure as well. (The NBCC’s ethical code states “counselors must document permission to practice counseling by electronic means in all governmental jurisdictions where such counseling takes place.”) Any electronically stored data must be destroyed when information is no longer of value in providing services or required as part of client records.
The Privacy Rule (HIPAA)

In 1996, the 104th Congress amended the Internal Revenue Code of 1986 and created Public Law 104-191, the Health Insurance Portability and Accountability Act. This established the first-ever national standards for the protection of certain health information. These standards, developed by the Department of Health and Human Services, took effect April 14, 2003. The Privacy Rule standards address who can use, look at and receive individuals’ health information (protected health information or PHI) by organizations (covered entities) subject to the rule. These organizations include:

- Most doctors, nurses, pharmacies, hospitals, clinics, nursing homes and other health care providers.
- Health insurance companies, HMOs and most employer group health plans.
- Certain government programs that pay for health care, such as Medicare and Medicaid.

Key provisions of the standards include:

- **Access to medical records** – Patients may ask to see and get a copy of their health records and have corrections added to their health information.

- **Notice of privacy practices** – Patients must be given a notice that tells them how a covered entity may use and share their health information and how they can exercise their rights.

- **Limits on use of personal medical information** – The privacy rule sets limits on how health plans and covered providers may use individually identifiable health information. Generally, health information cannot be given to the patient’s employer or shared for any other purpose unless the patient signs an authorization form.

- **Prohibition of marketing** – Pharmacies, health plans and other covered entities must first obtain an individual’s specific authorization before disclosing their patient information for marketing.

- **Stronger state laws** – Confidentiality protections are cumulative; any state law providing additional protections would continue to apply. However, should state law require a certain disclosure – such as reporting an infectious disease outbreak – the federal privacy regulations would not preempt the state law.

- **Confidential communications** – Patients have the right to expect covered entities to take reasonable steps to ensure communications with them are confidential. For example, a patient may want to be called on a work phone rather than home telephone.

- **Complaints** – Patients may file a formal complaint regarding privacy practices directly to the provider, health plan or to HHS Office for Civil Rights. Consumers can find out more information about filing a complaint at [http://www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa) or by calling 866-627-7748.

Practicing mental health professionals are responsible for following and enforcing the HIPAA Privacy Rule. Severe civil and criminal penalties can follow if proper procedures are not followed, and depending on the circumstances, an individual employee may be held responsible for not protecting a client’s privacy.

In October 2009, the Department of Health and Human Services created much larger civil penalties for violations of the Privacy Rule, although it also created a tiered structure that takes into account whether the violation was unintentional or was quickly corrected even if it was willful. The higher penalties and a more stringent enforcement approach to the Privacy Act were mandated by the HITECH Act (Public Law 111-5, 123 Stat. 115), Title XIII of the American Recovery and Reinvestment Act of 2009.

Penalties for violations can range from $100 to $50,000 for each violation with an annual cap of $1.5 million for multiple violations.

This rule ensures protections for clients by limiting the way covered entities can use personal medical information. The regulations protect medical records and other individually identifiable health information (identifiers), whether they are transmitted in electronic, written or verbal format. This then would include faxes, e-mail, online databases, voice mail and video recordings, as well as conversations among practitioners. Examples of identifiable health information include:

- Name or address, including city, state or zip code.
- Social Security numbers.
- Dates related to birth, death, admission, discharge.
- Telephone and fax numbers.
- E-mail or URL addresses.
- Medical record numbers, account numbers, health plan beneficiary numbers.
- Vehicle identifiers such as drivers license numbers and license plate numbers.
- Full face photographs distributed by the agency.
- Any other unique identifier, code or characteristic used to identify clients is protected under HIPAA.

In addition to reasonable safeguards, covered entities are required to develop and implement policies and procedures that limit the sharing of protected health information and to implement them as appropriate for their practices. The policies must limit who has access to protected health information and specify the conditions under which it can be accessed and designate someone to be responsible for ensuring that procedures are followed (a privacy officer).

It may seem that the law only places limits on the sharing of information. However it does allow the sharing of protected health information as long the mental health worker takes reasonable safeguards with the information. Some steps professionals can follow include:

- Ensure that protected health information is kept out of sight. This could mean keeping it in separate locked files, covering or turning over any material on your desk or setting your computer to display a password-protected screen saver after a minute or two in case you walk away.

- If you must discuss protected health information in a public area, such as a waiting room, hospital hallway or courtroom, make sure you speak quietly and others cannot overhear your conversation. If this cannot be assured, move
to another area or schedule another time to discuss the information.

- Use e-mail carefully. Make sure you send the information only to the appropriate people. Watch the “cc” lines to make sure your e-mail is not copied to unauthorized parties. Use passwords and other security measures on computers.
- If you send a fax, don’t leave the material unattended. Make sure that all of the pages go through, and check the fax numbers carefully to make sure it is sent to the correct person. You should also add a disclaimer stating that the information in your fax is confidential. Only send a fax to a machine that you know to be in a secure location.
- Avoid using client names in hallways, elevators, restaurants and other public places unless absolutely necessary.
- Post signs and routinely review standards to remind employees to protect client privacy.
- Secure documents in locked offices and file cabinets.

Supervision and consultation

The purpose of mental health supervision is to help create skill sets and sensitivities in the supervisee. These skills and sensitivities vary greatly from basic to complex. It requires that the supervisor be a good listener as well as a good teacher.

Mental health supervision and management generally include three primary aspects of the supervisory role:

1. Administration.
2. Support.

While the supervisor of mental health work may be increasingly involved in the administrative and political realm to get the work done, supervision, coaching, mentoring and consultation remain key roles. Mental health practitioners need to be keenly aware of the role of supervisor, because they are responsible for both the actions and omissions by a supervisee, known as vicarious liability.

To provide competent supervision, supervisors, particularly those in clinical settings, should remember the following:

- They need to possess the necessary knowledge and skill to ethically practice in mental health, and do so only within their area of competence.
- They must set clear, appropriate and culturally sensitive boundaries that would include confidentiality, sexual appropriateness and other sensitive boundaries outlined earlier in this training.
- They should not engage in dual or multiple relationships with supervisees when there is risk of exploitation or potential harm.
- They should fairly and respectfully evaluate supervisee performance.

Supervisors should consult their particular professional association guidelines and certification requirements regarding supervision, human resource policy and other applicable sources. Effective and ethical supervisory practices not only benefit the supervisees and their clients, but also the supervisor. Supervisors can manage their vicarious liability in several ways through:

- Clearly defined policies and expectations.
- Awareness of high-risk areas.
- Provision of appropriate training and supervision.
- Understanding supervisee strengths and weaknesses as practitioners.
- Developing an adequate feedback system.
- Knowing their own responsibilities.

At least three, and possibly four, models of supervision are used today within mental health services. (Schafer 2007) They include:

1. Administrative supervision.
2. Traditional mental health supervision.
   ○ Psychodynamic.
   ○ Behavioral health.
3. Relationship-based supervision.

Administrative supervision

Administrative supervision is most often used and involves “oversight,” in which one person reviews and assesses the performance of another. This form of supervision is concerned with appropriateness of services offered, the timeliness and accuracy of documentation and reporting for the purposes of reimbursement and the general flow of paperwork and information.

Traditional mental health supervision

Traditional mental health supervision grew from psychoanalytic practice in which there is a longer course of training under the supervision of a more experienced practitioner. As part of traditional mental health supervision, psychodynamic supervision focuses on two-way communication: the supervisee is asked to describe what has transpired in the treatment,
and the supervisor then helps the supervisee reach a deeper understanding of what might be going on. The psychodynamic supervision dynamic engages in intense interpersonal discussion. The behavioral health supervision dynamic focuses less on the role of conflict. It is more strength-based, favoring health and healing over pathology.

**Relationship-based supervision**

Relationship-based supervision grew within the field of infant mental health. This supervision, rather than utilizing interpretation and reframing, focuses more on “reflection” in the most active manner. It is a nonjudgmental mirroring with the supervisee that seeks to reproduce rather than to analyze the situation. It creates a parallel process between supervisor and supervisee.

**Consultation**

Licensed mental health professionals often need to obtain consultation from colleagues and other professional groups with special expertise. If a client’s presenting problem is outside the experience of the practitioner, the practitioner should seek consultation or make an appropriate referral. (Reamer, 2006) If they fail to seek consultation when it is warranted, mental health professionals open themselves to ethics complaints and malpractice allegations.

At the consultant level, ethical issues are related to professional competence, personal and professional values and cultural sensitivity. Acquiring adequate knowledge, skills, attitudes and values are key factors in mental health consultation. In addition, knowing one’s competence limits, participating in ongoing professional development and seeking supervision, support and resource referral is critical.

Mental health consultants, in general, work on two different planes at the same time. They must manage their consultative tasks while concentrating on maintaining the interpersonal relationship with the consultee. Other critical tasks include developing conceptual change models and delivering them in a strategic and ethical way.

In practice settings, consultants are often professionally isolated, with few opportunities to share their experiences and reflections with other consultants or supervisors. According to Wesley and Buysse, (2006) therefore, consultants must:

- Be aware of how their personal values, beliefs and culture impact their professional decisions and judgment.
- Understand the principles regarding how change occurs and plan strategies to build trust with the consultee.
- Have a clear understanding of the parameters of the consulting role and the purpose of consultation.
- Be certain about who the client is and to whom the consultant has reporting responsibility.
- Understand the importance of privacy within the relationship and be clear about the boundaries and limits of confidentiality.
- Develop clear professional and personal boundaries.
- Seek supervision and support when needed.

The mental health field should continuously ask itself these questions that impact ethical consultant practice:

- What qualifications should consultants who work in specialized mental health areas possess?
- What knowledge, skills and attitudes contribute to effective consultative practice?
- What are effective processes for providing training in consultation?
- What characterizes effective supervision and support for consultants?
- What evidence (research, professional and family wisdom, and professional and family values) exists – and what new evidence is needed – to address the last questions? How can an evidence base for consultation practice be established? (Wesley and Buysse, 2006)

**Education and training**

Mental health practitioners who function as educators, field instructors or trainers are obligated to provide instruction only within their areas of knowledge and competence, evaluate student performance fairly and respectfully, and take reasonable steps to ensure that clients are informed when services are provided by students. As noted above, professionals functioning as educators or field instructors must not engage in dual or multiple relationships and should set clear, appropriate and culturally sensitive boundaries.

Mental health administrators and supervisors should also take reasonable steps to provide for the continuing education and personal development of their staff.

**Commitment to employers**

Several standards that address issues around loyalty and ethical responsibilities in a person’s capacity as an employee are formally or informally discussed in professional association ethical guidelines. Generally, mental health practitioners should do the following:

- Adhere to commitments made to employers.
- Work to improve employing agencies’ policies, procedures and effectiveness of service delivery.
- Take reasonable steps to educate employers about mental health workers’ ethical obligations.
Ensure that the employing organization’s practices do not interfere with their ability to practice consistent with their mental health association professional ethical guidelines.

Act to prevent and eliminate discrimination.

Accept employment or refer others only to organizations that exercise fair personnel practices.

Be diligent stewards of agency resources

In general, mental health practitioners should support their agency’s mission, vision and values and also its policies and practices; in essence, maintain loyalty to the organization or agency they are committed to. That is not to say one should disregard the profession’s standards and ethical codes of conduct.

When an employer engages in unethical practices, whether knowingly or not, workers still have an obligation to voice those concerns through proper channels and advocate for needed change, while conducting themselves in a manner that minimizes disruption. But what does the worker do when faced with an ethical dilemma in the workplace that is not easily solved?

This issue has been discussed with regard to the practice of social work when Reamer (1998) in his review of the NASW Code of Ethics, discussed the challenge a social worker may have in deciding whether to continue honoring a commitment to the employer:

“This broaches the broader subject of civil disobedience, that is, determining when active violation of laws, policies and regulations is justifiable on ethical grounds. Most social workers acknowledge that certain extraordinary circumstances require social disobedience.”

He believes that it is possible to provide clear guidelines about when it is acceptable to break one’s commitment to an employer. He poses several questions that must be explored before taking action:

- Is the cause a just one? Is the issue so unjust that civil disobedience is necessary?
- Is the civil disobedience the last resort?
- Does the act of civil disobedience have a reasonable expectation of success?
- Do the benefits likely to result clearly outweigh negative outcomes, such as intra-organizational discord and erosion of staff respect for authority?
- If warranted, does civil disobedience entail the least required to rectify the targeted injustice?

**Labor-management disputes**

Mental health practitioners are generally allowed to engage in organized action, including the formation and participation in labor unions, to improve services to clients and working conditions. When involved in a dispute, job action or strike, workers should carefully weigh the possible impact on clients and be guided by their profession’s ethical values and principles prior to taking action.

**Professional competence**

The following guidelines discuss professional competence in mental health practice:

- Accept responsibilities or employment only if competent or there is a plan to acquire necessary skills.
- Routinely review emerging changes, trends and best practices in the mental health field and seek ongoing training and educational opportunities.
- Use empirically validated knowledge to guide practice/interventions.
- Disclose potential conflicts of interest.
- Do not provide services that create a conflict of interest or that may impair work performance or clinical judgment.

In addition to education and experience, mental health practitioners need to be cognizant of their personal behavior and functioning and its effects on practice:

- Refrain from private conduct that interferes with one’s ability to practice professionally.
- Do not allow personal problems (i.e., emotional, legal, substance abuse) to impact one’s ability to practice professionally or jeopardize the best interests of clients.
- Seek appropriate professional assistance for personal problems or conflicts that may impair work performance or critical judgment.
- Take responsible actions when personal problems interfere with professional judgment and performance.

**Burnout and compassion fatigue**

Areas receiving increasing attention within the mental health profession are burnout and compassion fatigue (also known as vicarious trauma or secondary traumatic stress). The consequences of these conditions (or any other form of professional impairment) include the risk of malpractice action. Results from the effects of day-to-day annoyances, overburdened workloads, crisis and other workplace stressors, burnout and compassion fatigue can be serious if not addressed.

**Burnout**

Burnout is a “breakdown of psychological defenses that workers use to adapt and cope with intense job-related stressors, and a syndrome in which a worker feels emotionally exhausted or fatigued, withdrawn emotionally from clients, and where there is a perception of diminishment of achievements or accomplishments.” Burnout occurs when gradual exposure to job strain leads to an erosion of idealism with little hope
of resolving a situation. In other words, when mental health practitioners experience burnout:
- Their coping skills are weakened.
- They are emotionally and physically drained.
- They feel that what they do does not matter anymore.
- They feel a loss of control.
- They are overwhelmed.

For example:
- Monica had been working for several years with clients who shared the same diagnosis. Because she was specialized in this particular mental health diagnosis, most of her referrals came from other practitioners who did not feel skilled enough to cope with the many stressors associated with working with that population.

Monica felt that she had a talent for her work, and for many years felt fulfilled in her chosen profession. Yet, in past months it seemed to her that her clients were becoming more difficult and were referred to her with more complex issues. One particularly stressful case exploded when her client attempted suicide. As a result of this experience Monica began to doubt her abilities and contemplated taking an extended time off. She felt exhausted as well as ineffective as a mental health practitioner.

**Compassion fatigue**

A newer definition of worker fatigue was introduced late in the last century by social researchers who studied workers who helped trauma survivors. This type of worker fatigue became known as compassion fatigue or secondary traumatic stress (STS). Mental health practitioners acquire compassion fatigue or STS as a result of helping or wanting to help a suffering person in crisis. As a result, they can often feel worthless and their thinking can become irrational. For example, they may begin to irrationally believe that they could have prevented someone from dying from a drug overdose. For example:
- Jim had run a crisis hotline at a domestic violence shelter for about two years when one of his callers shared that her husband had recently beaten their small daughter. Jim, with small children of his own, talked with the mother for an hour, trying to convince her to share her personal information or leave her spouse and enter his shelter. As the woman continued to resist, Jim felt great angst and panic, fearing that her little girl would be harmed. Yet, the woman refused to consider leaving her husband. The next day, Jim learned that a woman and her child who appeared to fit the description of the previous day’s caller were murdered by their husband and father. Jim became anxious and distraught and blamed himself for not taking enough action to persuade his caller to be more proactive.

Burnout is gradually acquired over time and recovery can be somewhat gradual. Compassion fatigue surfaces rapidly and diminishes more quickly while the mental health practitioner has more of a tendency to identify with the client. Both conditions can share symptoms such as emotional exhaustion, sleep disturbance, or irritability.

**Dealing with burnout and compassion fatigue**

A professional mental health practitioner can take steps to increase her or his ability to cope and achieve balance in life. Maintaining a healthy lifestyle balance and recognizing the signs of burnout and compassion fatigue, or secondary traumatic stress, are important: The responsible mental health clinician will also take action, such as a vacation break or change in schedule or job duties. Practitioners also need to not only be aware of the signs and symptoms of burnout and compassion fatigue, but also and more importantly, identify the situations that may set the stage for their occurrence. Ongoing supervision is the mental health practitioners’ best defense.

In addition to ongoing supervision and regular supportive contact with other practitioners to prevent isolation, Houston-Vega Nuehring, and Daguio (1997), recommend the following measures to help prevent burnout or compassion fatigue:
- Listen to the concerns of colleagues, family, and friends.
- Conduct periodic self-assessments.
- Take needed “mental health days,” and use stress-reduction techniques.
- Arrange for reassignment at work, take leave and seek appropriate professional help as needed.

**Research, evaluation, evidence-based practice and ethics**

In recent years, greater interest in “evidence-based practice” (EBP) has become a prominent theme in the mental health profession, due in part, to the need for justification for payment of services as well as the need for methods of best treatment practice in mental health. The role of professional ethics and values is an important source of evidence in the process of making decisions about evidence-based practice.

Clinical expertise refers to “the ability to use our clinical skills and past experience to rapidly identify each client’s unique characteristics, their individual risks and benefits of potential interventions and their personal circumstances and expectations” (Sackett, 2000). When evidence is not used while making decisions, significant failures in making decisions occurs that can include:
- Being ineffective in the use of interventions.
- Using interventions that do more harm than they do good.
- Not using interventions that can do more good than those interventions already being used.
- Interventions that do more harm than good are not discontinued (Gambrill, 2007).
Definitions of evidence-based practice differ in breadth and attention to ethical issues, ranging from the broad, systemic philosophy and related evolving process and technology to narrow views and total distortions. (Gambrill, 2007)

An evidence-based approach to practice is defined as “one in which professionals reflect upon and make decisions about their work by systematically considering information from several sources, (Wesley and Buysse, 2006)”.

Evidence-based guidelines for best practice in the mental health profession should draw upon critical thinking, practice related research, accountability, service to clients, informed consent, promotion of lifelong learning, and integrity. The NASW code of ethics stresses beneficence (helping), avoidance of harm, informed consent, self-determination and social justice as essential components of evidence-based practice.

Ethics in mental health evidence-based practice draws largely from evidence-based medicine in which clinical knowledge and patient values are important considerations in decision-making, (Sackett, Straus, Richardson, Rosenberg, and Haynes, 2000)

For example, the back cover of the seventh edition of Clinical Evidence (BMJ Publishing Group, 2002), the continuously updated book that is distributed to physicians, states that evidence-based practice provides an account of the current state of knowledge, ignorance, and uncertainty about the prevention and treatment of a wide range of clinical conditions.

Uncertainty sources include limitations in current knowledge, lack of familiarity with the kinds of knowledge available, and difficulties in distinguishing among personal ignorance, lack of competence and actual limitations of knowledge (Fox and Swazy, 1974). EBP utilizes the best available research evidence with individual and family professional wisdom and values.

And it should answer the following questions:
- Which treatment approaches and specific interventions are most effective?
- In what contexts and for whom?
- What constitutes effective mental health practice and how good is it?
- How could results of treatment be measured?

These questions illustrate the close connection between critical thinking and evidence-informed practice. In recent years more attention has been given to client preferences and actions because what clients do often differs from their stated preferences, and estimates of preferences are often wrong (Haynes, Devereaux and Guyatt, 2002).

Currently, it has been suggested that some evidence-based practice is attributed to the following:
- Overenthusiastic adoption of interventions of unproven efficacy.
- Failure to adopt interventions that do more good than harm at a reasonable cost.
- Psychological and social characteristics of the treated individual, such as a severely disturbed clinic-referred youth.
- Characteristics of families that include parental psychopathology, family life-event stressors and possibly even child maltreatment.
- Reasons for seeking treatment, such as referred by caregivers instead of being recruited through ads or screenings.
- Settings in which treatment is carried out, where there may be more forms to fill out, and/or financial constraints.
- Therapists who provide treatment, such as interns or the treatment developer who have vested interests in the evidence-based project.
- Incentive systems that could include being paid by the treatment developer with close adherence to the manual, as opposed to being paid by the clinic to see many cases with no method prescribed.
- The conditions under which mental health practitioners deliver the treatment, such as time to complete the satisfied requirements (Weisz and Gray, 2007).
- A broad base of evidence is needed to review policies, including experience and expertise, judgment, resources, values, habits and traditions, lobbyists and pressure groups.

The mental health profession has become more organized about searching out and adopting research-based practices. As part of being aware of evidence-based practice, licensed mental health professionals should:
- Respect the dignity and protect the welfare of research participants.
- Be aware of applicable laws and regulations and professional standards governing the conduct of research.
- Monitor and evaluate policies, program implementation and practice interventions by converting information needs related to practice and policy decisions into well-structured questions.
- Promote and facilitate evaluation and research by critically appraising the evidence for its validity and applicability.
- Critically examine and keep current with emerging mental health practice research by tracking down, with maximum efficiency, the best evidence with which to answer evidence-based research questions.
- Obtain voluntary, written informed consent, which includes:
  - There cannot be any implied or actual deprivation or penalty for refusal, or undue inducement to participate.
  - Respect for participant’s dignity, well-being and privacy are primary elements in obtaining consent.
  - All information about the nature, extent and duration of the participation and disclosure about the risk and benefits should be shared.
  - When a participant is not capable, provide appropriate explanations, obtain permission to the degree they are able to give it, and obtain written consent from appropriate proxy sources.
- Never design or conduct evaluation or research that does not use informed consent procedures.
- Inform participants of their right to withdraw from evaluation and research.
- Ensure that participants have access to appropriate supportive services.
- Protect participants from unwarranted physical or mental distress, harm, danger or deprivation.
Discuss collected information only for professional purposes with only those who have a professional concern for information.

Ensure anonymity and confidentiality of all participants and their data:
- Inform participants of limits of confidentiality, measures taken and when records will be destroyed.
- Omit identifying information from reports unless disclosure is authorized.
- When the possibility exists that others, including family members, may obtain access to confidential information, this possibility and a plan for protecting confidentiality is explained as part of the procedure for obtaining informed consent.

Respect each participant’s freedom to decline participation in or to withdraw from a research study at any time.

Evaluate research findings for their effectiveness and efficiency, and report them accurately.

Be alert to, and avoid conflicts of interest and dual relationships with participants.

Educate self, students, and colleagues about responsible research practices.

More about informed consent

The issue of informed consent relates closely with one of the most important values of ethical mental health practice: Self-determination. In order for informed consent to be valid, the following must be met:

- A person of legal age must give consent voluntarily.
- The individual must be competent to refuse or to consent to treatment.
- The client must be given thorough, accurate information about the service so she or he may weigh the benefits and risks of treatment.

One of the newest challenges for mental health practitioners is the issue of informed consent in e-therapy. Kanani and Regehr (2003) point out the following reasons for this:

- Anonymity on the Internet makes it more difficult to determine the client’s mental capacity or legal age.
- Potential conditions such as suicidal behaviors and eating disorders may not be suitable for online therapy.
- There is limited empirical research available, thus limiting both the practitioner and clients’ understanding of the efficacy and the risks associated with e-therapy.
- Internet identity issues place more burdens on the practitioner to determine whether the client is legally and ethically able to consent.

Ethical responsibilities to the broader society

The majority of people are shaped and impacted by such influences as their family, community, environment and culture. Mental health practitioners must remain vigilant about these influences in their practices and even promote them externally for the benefit of society at large. For example, NASW points out that social workers should remain mindful of:

- Social welfare.
- Public participation.
- Public emergencies.
- Social and political action.

Ethical social mindfulness can be demonstrated when mental health practitioners work to promote involvement in social and political actions that:

- Ensure equal access to resources and opportunities.
- Advocate for improvements in social conditions.
- Promote equality for all people.
- Expand choice and opportunity to all people.
- Promote cultural and social diversity.
- Prevent and eliminate the domination, exploitation and discrimination of any person, group or class of people.

ETHICS FOR SPECIALIZED PRACTICE AREAS

Responsible mental health practice can be found in a variety of settings and address multiple issues. As the world changes, they are increasingly challenged to broaden their knowledge and adopt practices that meet the unique needs of their service populations and settings.

Currently, most mental health associations provide additional guides or standards of practice that address areas, including:

- Substance abuse, health care, marriage and family issues, couples’ work, clinical social work, child welfare, palliative/end of life care, work with adolescents and long-term care. They also publish standards that address issues such as technology, cultural competence and genetics.

It is helpful to review a couple relevant issues impacting mental health practice:

Genetics

Years ago, mental health practitioners could neither fathom the science of genetics, nor predict its impact on the profession. Today genetics, or the study of genes and their effects on human growth and development, is looking increasingly promising as a solution to many of the health problems faced by humans.

Genetics enables science to diagnose certain conditions and offers hope of deeper understanding of diseases and conditions so that they may be prevented or treated. And as history has demonstrated, any innovation brings with it new challenges to what we consider right, fair, ethical and legal.
All licensed mental health practitioners can take an active role in ensuring their clients are protected against genetic discrimination in areas such as health and life insurance, employment and adoption. And national mental health professional associations are beginning to address the need to integrate knowledge of genetics into mental health practice. Some of their objectives are to:

- Inform about genetics as an expanding field of mental health knowledge.
- Improve the quality of services provided to clients with genetic disorders.

Infant mental health

Infant mental health intervention and the early childhood field have created a unique niche with regard to ethics practice because early childhood education and infant mental health intervention practices are routinely paired with one another. They reflect values and practice related to indirect service delivery models that involve collaborative relationships with other adults.

Within this field there is a need to use an evidenced-based process to make decisions about indirect services, specifically consultation, that include not only best available scientific research, but also professional and family wisdom and values as sources of evidence (Wesley, Buysse 2006).

The Canadian code of ethics for psychologists proposes an early childhood model for ethical decision-making in an attempt to provide more explicit guidelines when ethical principles are in conflict and when issues are in question for which clear-cut standards do not exist (Sinclair, 1998). They include seven steps:

1. Identify the ethical issues and practices.
2. Develop alternative courses of action.
3. Analyze the risks and benefits of each course of action.

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1. Identify the ethical issues and practices.
2. Develop alternative courses of action.
3. Analyze the risks and benefits of each course of action.

4. Choose a course of action after conscientiously applying existing principles, values and standards.
5. Take action and assume responsibility for the consequences.
6. Evaluate the results of the action.
7. Assume responsibility for the consequences, correct any negative ones, or re-engage in the decision-making process.

In order to prevent, identify and resolve ethical conflicts, curricula, practice guidelines and other written products, along with evidence-based professional development efforts are needed to ensure that training is delivered in a consistent and effective manner to frontline early childhood professionals who experience any aspect of consultation from mental health professionals. It is necessary that frontline workers be able to recognize signs and symptoms of early childhood distress and know appropriate referral sources and how to make a referral in a timely manner.

As work continues to build evidence for early childhood mental health intervention, methods that should be examined include which knowledge and skills can be increased and how to support these skills in resolving ethical dilemmas that will inevitably arise. Therefore, ethical issues within a collegial relationship with other adults who work with young children and their families must continue to be addressed.

Technology

While there are many individuals who are hesitant to embrace new technology that can enhance best practice, one cannot ignore its many benefits. Currently mental health professionals can use technology, particularly the Internet, to conduct research, provide e-therapy, and to advertise their services and communicate on a global scale with both clients and other professionals, when permitted.

E-mail, though fraught with potential for security violations and miscommunication, has certainly increased the efficiency and speed to which people can communicate with each other. For example, a mental health researcher can conduct a search on the Internet to inquire about and then contact another professional in another region to investigate innovative approaches to service delivery.

Software applications (i.e., basic word processing, financial management systems and documentation templates) assist practitioners with service planning, delivery, evaluation and reporting. And wireless technology allows better utilization of their time away from the office. Cell phones have greatly increased accessibility as well. Mental health practice would be different without technology.

National mental health associations along with others are continuing to develop and publish guidelines to assist practitioners in the appropriate use of technology, including those who provide virtual therapy services. Technology and practice are generally defined as any electronically mediated activity used in the conduct of competent and ethical delivery of services.

For example, a copy of the standards as developed by NASW and ASWB (board) is available for both review and print at:

- http://www.socialworkers.org/practice/default.asp and is summarized below. Social workers shall:
  - Act ethically, ensure professional competence and uphold the values of the profession.
Counselors should observe the following standards of practice:

- Have access to and ensure their clients have access to technology and appropriate support systems.
- Select and develop culturally competent methods and ensure that they have the skills to work with persons considered vulnerable (i.e., persons with disabilities, or those for whom English is not their primary language).
- Increase their proficiency in using technology and tools that enhance practice.
- Abide by all regulations in all jurisdictions in which they practice.
- Represent themselves accurately and make attempts to confirm the identity of the client and their contact information.
- Protect client information in the electronic record.
- Provide services consistent with accepted standards of care, regardless of the medium used.
- Use available technology to both inform clients and mobilize individuals and communities so they may advocate for their interests.
- Advocate for technologies that are culturally sensitive, community specific and available for all who can benefit from it.
- For those in administrative practice, keep themselves informed about technology that can advance quality practice and operations, invest in systems and establish policies that ensure security and privacy.
- Conduct a thorough assessment, including evaluation of the appropriateness of potential clients for e-therapy. This includes the need for the social worker to fully understand the dynamics involved and the risks and benefits for the client.
- Evaluate the validity and reliability of research collected through electronic means and ensures the client is likewise informed.
- Continue to follow applicable standards and laws regarding supervision and consultation. Adhere to NASW Standards for Continuing Professional Education and applicable licensing laws regarding continuing education.

### Virtual or e-therapy

Depending on their mental health focus and where they practice, many mental health practitioners offer online therapy services through real-time chats, e-mail, videoconferencing, telephone conferencing and instant messaging. The benefits touted by supporters of online therapy, as described by Kanani and Regeh (2003), include the ability to:

- Serve millions of people who would otherwise not participate (i.e., people with certain conditions such as agoraphobia, persons living in remote locations, or those concerned about the stigma of counseling).
- Decrease inhibitions clients may have about fully disclosing relevant information.
- Increase the thoughtfulness and clarity of communication as an unintended by-product of written communication.
- Produce a permanent record that can be easily referred to, forwarded to clients or colleagues for review and consultation purposes.
- Substantially reduce overhead costs, thus reducing costs for the consumer. As discussed earlier in this training, one of the major areas still under debate as a result of this new technology is that of jurisdiction. These are some thought-provoking considerations.

The practice of technology-assisted distance counseling consists of computer-assisted assessment, computer-assisted information systems and telephone counseling. The National Board of Certified Counselors has established a Code of Ethics pertaining to ethical practice in Internet counseling. Internet counselors should observe the following standards of practice:

1. In situations where it is difficult to verify the identity of the Internet client, steps are taken to address impostor concerns, such as by using code words or numbers.
2. Internet counselors determine whether a client is a minor and therefore in need of parent/guardian consent. When parent/guardian consent is required to provide Internet counseling to minors, the identity of the consenting person is verified.
3. As part of the counseling orientation process, the Internet counselor explains to clients the procedures for contacting the Internet counselor when they are offline and, in the case of asynchronous counseling, how often e-mail messages will be checked by the Internet counselor.
4. As part of the orientation, the Internet counselor explains to clients the possibility of technology failure and discusses alternative modes of communication if that failure occurs.
5. As part of the orientation, the Internet counselor explains to clients how to cope with potential misunderstandings when visual cues do not exist.
6. As part of the orientation, the Internet counselor collaborates with the Internet client to identify an appropriately trained professional who can provide local assistance, including crisis intervention, if needed. The Internet counselor and Internet client should also collaborate to determine the local crisis hotline telephone number and the local emergency telephone number.
7. The Internet counselor has an obligation, when appropriate, to make clients aware of free public access points to the Internet within the community for accessing Internet counseling or web-based assessment, information and instructional resources.
8. Within the limits of readily available technology, Internet counselors have an obligation to make their website a barrier-free environment to clients with disabilities.
9. Internet counselors are aware that some clients may communicate in different languages, live in different time zones and have unique cultural perspectives. Internet counselors are also aware that local conditions and events may impact the client.
10. The Internet counselor informs Internet clients of encryption methods being used to help ensure the security of client/counselor/ supervisor communications. Encryption methods should be used whenever possible. If encryption is not made available to clients, they must be informed of the potential hazards of unsecured communication on the
Internet. Hazards may include unauthorized monitoring of transmissions or records of Internet counseling sessions.

11. The Internet counselor informs Internet clients whether, how, and how long session data are being preserved. Session data may include Internet counselor/supervisor’s e-mail, test results, audio/video session recordings, session notes and counselor/supervisor communications. The likelihood of electronic sessions being preserved is greater because of the ease and decreased costs involved in recording. Thus, its potential use in supervision, research and legal proceedings increases.

12. Internet counselors follow appropriate procedures regarding the release of information for sharing Internet client information with other electronic sources. Because of the relative ease with which e-mail can be forwarded to formal and casual referral sources, Internet counselors must work to ensure the confidentiality of the Internet counseling relationship.

13. Internet counselors review pertinent legal and ethical codes for guidance on the practice of Internet counseling and supervision. Local, state, provincial and national statutes, as well as codes of professional membership organizations, professional certifying bodies and state or provincial licensing boards need to be reviewed. Also, as varying state rules and opinions exist on questions pertaining to whether Internet counseling takes place in the Internet counselor’s location or the Internet client’s location, it is important to review codes in the counselor’s home jurisdiction as well as the client’s. Internet counselors also must consider carefully local customs regarding age of consent and child abuse reporting, and liability policies need to be reviewed to determine whether the practice of Internet counseling is a covered activity.

**Limiting risk in the practice of e-therapy**

In addition, Matthew Robb recommends for those practicing e-therapy as follows:

- **Full disclosure** – This relates to informed consent and the need to fully disclose the possible benefits and risks of distance counseling, including informing the client that this is a new area of practice that has not had the benefit of long-term study.
- **Comprehensive assessment** – Provide clients with detailed and complete assessment tools and encourage full disclosure by client.
- **Confidentiality and disclosure of safeguards** – Take all precautions to safeguard the confidentiality of information and avoid misdirected e-mails, eavesdropping, hacking, and so on. Alert the client to these potential risks as well.
- **Emergency contact** – Obtain information for an emergency contact and together develop a clear emergency plan.
- **Consult your association’s code of ethics** – Review standards regarding informed consent, confidentiality, conflict of interest, misrepresentation and so on.
- **Consult state licensing provisions** – Research both the statutory regulations of your board as well as those in the client’s home state.
- **Consult a malpractice/risk management attorney** – Consider asking a legal specialist to review website materials to determine compliance with standards of care and potential malpractice issues.
- **Provide communication tips** – If communicating solely by text-based messaging, provide client with clear tips regarding communication.

**Disciplinary procedures for processing possible violations of ethics standards**

Professional mental health associations and state regulatory boards have established set procedures with regard to processing possible violations of ethics standards. The person or persons initiating an ethics complaint against a licensed or certified and licensed mental health professional is known as the complainant(s). Complaints are usually completed through a form and are normally responded to within a certain period of time by a designated ethics committee through the association or other regulatory board.

Considerations and procedures for ethics violations complaints include whether the case will be litigated, additional referral to another governing body, improper disclosures or misleading information, time limitations concerning complaints, confidentiality, failure to cooperate, mediation, rejection or
acceptance of the ethics charges, methods of investigation, ethics complaint response, preliminary actions and orders, ethics hearing committee hearings, ethics hearing committee decisions and orders, and disciplinary actions. A board of directors Ethics Appeals Committee is usually incorporated or brought together when the action is appealed through an appeal action process.

According to the National Board of Certified Counselors (NBCC), an ethics case will normally be closed and all proceedings end when any of the following occur:

- Following the lapse of any appeal rights, the ethics case has not been accepted and the charges have been rejected as the basis for an ethics complaint.
- Following the lapse of any appeal rights, a final decision has been issued by the ethics officer, the ethics hearing committee, or the board of ethics committee.
- An ethics complaint has been terminated or withdrawn by the complainant(s).

In some cases, mental health professionals can apply for reinstatement after a set period of time following their revocation, suspension or probation.

### Decision-making model

As we have seen, it is not uncommon for mental health professionals to grapple with conflicts involving personal values and beliefs, ethical duties, employment practices and the law. Sometimes they may be faced with a choice between taking action that supports an ethical standard but violates the law, or vice versa.

While national mental health associations’ ethical standards usually provide excellent frameworks to guide practice and assist with the resolution of ethical dilemmas, it is naïve to assume they all hold the answers to all the questions faced by licensed mental health practitioners.

While both necessary and useful, some experts such as Freud and Krug (2002) argue that for ethical decision-making alone, they are insufficient. In effect, they state that codes of ethics are frequently used as a risk management tool, offering guidelines for practice that may not be compatible with other goals set forth by a particular mental health focus. In addition, unique and unexpected ways ethical issues may emerge in clinical practice work against attempts to apply codes of ethics.

For those reasons, Freud and Krug (2002) propose that “ethical judgments are best made in small groups where members bring different perspectives and intuitions to the process while agreeing on basic humanistic values.” Still, codes of ethics are invaluable tools for guiding mental health practitioners toward ethical practice. Thus they recommend that, in general, they be used to help guide professionals in decision-making and include:

- **Increased attention to our moral intuitions and emotions**
  - Rational, ethical decision-making should be supplemented by a person’s emotions and intuition, as shaped by culture and profession. In an effort to maintain a rational, detached and professional approach to service, mental health practitioners may ignore warning signals and gut instincts relevant to the reason for decision.

- **Institutionalized opportunities for dialogue and ethical concerns** – It is important to have safe, non-judgmental group forums for open and regular discussion of ethical issues.

- **Open acknowledgement and respect for moral diversity within a shared body of basic values** – The decision-making process works best when consulting with a diverse group of individuals who share basic values but differ in perspectives and intuitions.

Mental health practitioners also need to consider basic protocols and steps to take to increase their ability to make sound ethical decisions. While not all ethical dilemmas have a corresponding definitive solution, professionals can take reasonable steps to arrive at the best possible decision through an ethical decision-making model that would:

- Identify the problem or conflicts between the ethical and legal expectations and requirements, including the values and duties that may conflict.
- Understand and apply the state and national professional association code of ethics.
- Identify the individuals, groups and organizations that are likely to be affected by the decision.
- Tentatively identify all possible course of action and the participants involved in each, along with possible benefits and risks for each.
- Thoroughly examine the reasons in favor of, and opposed to, each possible course of action, considering relevant:
  - Ethical theories.
  - Codes of ethics.
  - Constitutional provisions, statutes, regulations, court decisions, and executive orders.
  - Personal values (including religious, cultural, and ethnic).
- Consult with colleagues and appropriate experts.
- Make and implement the decision and document the decision-making process.
- Monitor and evaluate the decision.

### Applying the model

We can use this model to critically examine the final scenario, that of David and his dilemma regarding placement of a child.

- **David**, a licensed marriage and family therapist, believes a child’s right to permanency would be better served by placement with an affluent, Caucasian, Christian family versus a middle class family of the same race as the child. He believes they are a very nice couple that has been waiting far too long for a child to adopt.

David’s obligation is to the best interests of the child, so it is clear where his commitment lies. Therefore, the length of time

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the one couple has spent waiting to adopt a child should not be a consideration. Finding the best family for the child is the primary consideration.

In addition, standards regarding competence and social diversity require David to be knowledgeable about the child’s culture and the importance it will play in the child’s life. He also needs to consider the overall strengths offered by both families as well as any potential barriers to placement. One family has unlimited resources, the other family has enough resources to afford a lifestyle typical of most families in the community.

**Conclusion**

Ethical dilemmas are varied, common and complex. Ethical decision-making can be difficult as well as time-consuming, while sometimes, mental health practitioners are still feeling ambivalent and uncertain. Typically, there will be more than one person involved with the ethical decision-making process; so it is always important to keep in mind that the power of supervision and consultation cannot be overstated in a mental health practice ethical dilemma.

In this continuing education course, a number of essential topics have been discussed that cover a wide range of ethical considerations. Law and ethics are distinct, but frequently woven together when ethical conflicts emerge. Self-determination plays an important role in how mental health professionals must guide or follow their clients’ lead. Informed consent covers a range of issues and is a necessary ethical consideration. Understanding HIPAA and the Privacy Rule prevents ethical missteps; incorporating cultural competence into mental health work is a less concise process but extremely valuable. Understanding intentional and unintentional boundary violations is another piece of integrating ethical practice as well as learning what is authentic evidence-based practice and incorporating it into mental health work.

Identifying and addressing burnout and compassion fatigue can help prevent ethics violations caused by feeling overwhelmed, hopeless and exhausted. And with the ever-increasing use of e-therapy, it is necessary, now more than ever, that mental health professionals understand codes of ethics around this issue. In addition, emerging practice in early childhood mental health intervention and genetics will continue to grow as methodology and science continue to enlighten these fields.

And finally, it is imperative that mental health professionals stay current with regard to national, state and association rules/regulations and routinely review evidence-based practice in the area of ethics and mental health practice.

**Bibliography**

- American Counseling Association Code of Ethics and Decision Making Model. (ACA), (2005), Alexandria, VA.
- Public Law 104-191 Health Insurance Portability and Accountability Act of 1996
**PROFESSIONAL ETHICS, BOUNDARIES AND LAW**

**Final Examination Questions**

Select the best answer for each question and then proceed to [SocialWork.EliteCME.com](http://www.socialelitecme.com) to complete your final examination.

1. Which of the following actions could be considered inappropriate ethical behavior on behalf of the mental health practitioner?
   a. Introducing two clients at a social event.
   b. Attending a social event as the date of a client.
   c. Attending the same event as a client.
   d. Leaving a social event when you notice a client is present.

2. Kitchener identified five moral principles that are essential ethics guidelines; the guideline that is often explained as “above all, do not harm” is called:
   a. Beneficence.
   b. Fidelity.
   c. Autonomy.
   d. Nonmaleficence.

3. The client has the right to be informed of all of the following EXCEPT:
   a. Their mental health provider’s qualifications.
   b. Their mental health provider’s home address.
   c. A right to receive an explanation of services.
   d. A right to terminate the provider-client relationship at any time.

4. Boundary issues involve circumstances in which there are actual or potential conflicts between professional duties and social, sexual, religious or business relationships. These conflicts may involve relationships with:
   a. Current clients.
   b. Colleagues.
   c. Supervisors and students.
   d. All of the above.

5. With regard to payment of services, ethical guidelines:
   a. Include the reasonable acceptance of kickbacks.
   b. Include offering rebates for referrals.
   c. Call for fair and reasonable fees for services.
   d. Encourage bartering arrangements.

6. A well-planned client transfer should incorporate a timeline, termination and informed consent in order to properly consult with the client’s new mental health professional.
   a. True.
   b. False.

7. Congress amended the Internal Revenue Code of 1986 and created Public Law 104-191, the Health Insurance Portability and Accountability Act in:
   b. 1994.
   c. 1995.
   d. 1996.

8. The approach to practice defined as “one in which professionals reflect upon and make decisions about their work by systematically considering information from several sources” is called:
   a. Research-based.
   b. Education-based.
   c. Experience-based.
   d. Evidence-based.

9. In order for informed consent to be valid, all of the following must be met EXCEPT:
   a. A person of legal age must give consent voluntarily.
   b. The individual must be competent to refuse or to consent to treatment.
   c. The client must be given the expected duration for treatment.
   d. The client must be given thorough, accurate information about the service so she or he may weigh the benefits and risks of treatment.

10. One of the newest challenges for mental health practitioners is the issue of informed consent in e-therapy.
    a. True.
    b. False.

This information is not intended to provide all of the details of the HIPAA Privacy Rule or of any other laws or guidelines. This presentation also does not constitute legal advice. If there is any discrepancy between the provisions of the HIPAA Privacy Rule, other laws, or regulations and the material in this presentation, the terms of the laws, rules, professional guidelines, and regulations will govern in all cases.

Any case examples used within this course do not reflect actual individuals.