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Ethical Decision Making for Counselors

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This distance learning coursework was developed for CEUMatrix by Charlotte Chapman, M.S., MAC, CCS, LPC.

This course is reviewed and updated on an annual basis to insure that the information is current, informative, and state-of-the-art. This package contains the complete set of course materials, along with the post test and evaluation that are required to obtain the certificate of completion for the course. You may submit your answers online to receive the fastest response and access to your online certificate of completion. To take advantage of this option, simply access the Student Center at http://www.ceumatrix.com/studentcenter; login as a Returning Customer by entering your email address, password, and click on 'View Lesson Quitz'.

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About the Instructor:

Charlotte Chapman has been in the addictions field for thirty years. She has practiced as a counselor, supervisor and program director. Charlotte has been teaching ethics for the past twenty years. She has published articles and courses on ethics for addiction professionals and has served on state and national certification boards and ethics committees. Charlotte is a licensed professional counselor, a licensed substance abuse treatment provider, a certified Masters Addictions Counselor (MAC) and a certified clinical supervisor in Virginia. She is currently the director of counseling services at the University of Virginia's Women's Center where she teaches and supervises graduate counseling students. More information is available at www.chapmantraining.com

Using the Homepage for CEU Matrix - The Institute for Addiction and Criminal Justice Studies

The CEU Matrix – The Institute for Addiction and Criminal Justice Studies homepage (www.ceumatrix.com) contains many pieces of information and valuable links to a variety of programs, news and research findings, and information about credentialing – both local and national. We update our site on a regular basis to keep you apprised of any changes or developments in the field of addiction counseling and credentialing. Be sure to visit our site regularly, and we do recommend that you bookmark the site for fast and easy return.

Introduction

"What the code says is the beginning, not the end of ethical consideration" (K.Pope)

Professionals who work in health care are often confronted with ethical dilemmas with little time to think about an ethical decision making process. The above-quote speaks to the issue of the need to do more in this process than just consult a code of ethics. Certainly codes are a vital part of ethical decision making, however, this course will examine many of the other elements that compose good ethical practice.

Several writers on this topic have suggested that an essential part of ethical decision-making involves self-reflection on the part of the therapist. To begin this process, please complete the following self-inventory. The purpose of this is to focus on some of the topics that will be discussed in this course and to provide an opportunity for reflection on personal values and beliefs regarding the helping relationship.

Self-Inventory

1. My primary professional identity is:
    a. psychologist
    b. counselor
    c. doctor/nurse
    d. social worker
    e. other

2. The ethical principle that is most emphasized in my professional training is:
    a. beneficence
    b. autonomy
    c. non-maleficence
    d. discretion

3. The most important part of the ethical decision making process is:
    a. following my code of ethics
    b. consulting with supervisor/colleagues
    c. following my own instincts
    d. prevention of harm to clients

4. The way I determine if client harm may occur is:
    a. based on my clinical training and experiences
    b. discuss the situation with the client
    c. consult with my supervisor/colleagues
    d. review my code of ethics

5. The most important quality for a helping professional to have is:

a. discretion
b. compassion
c. integrity
d. humility

6. Dual relationships are:
   a. always unethical
   b. can be therapeutic in some situations
   c. always illegal
   d. cause for consultation with a supervisor/colleague

7. Make a list of the reasons you entered the helping profession:

8. Now reflect on what personal values are evident in those reasons. How might those values impact your ethical decision-making?

Please discuss this self-inventory with a trusted colleague or the course instructor via email. Ethical decision making is a process that should not occur in isolation. The answers to this survey will hopefully give you some insight and awareness about one of the key factors of this process: you, the helping professional.

Clarifying Terms

Since the audience for this course is helping professionals in general, the clarification of terminology might be helpful. The terms counselor, therapist, practitioner, and helping professional will be used interchangeably as will counseling, therapy, and helping relationship. Some professionals use patient or consumer to refer to clients; but for the purposes of this course, the term client will be used.

Morals will be used to refer to the right and proper conduct that occurs in the context of a culture or community. **Ethics** are principles adopted by an individual or group, such as, a profession or organization, to provide rules/guidelines for right conduct. Those rules are called codes of ethics. Whereas morals apply to any member of the culture or community, a code of ethics applies only to those members of the specific group. In some cultures, what is moral is determined by religious values. Ethics are based on a standard of behavior that is nonreligious. **Virtues** are desirable personal characteristics. They are not related to skill or behaviors so much as character, desire and motivation. Virtues are about who a person is rather than how that person may act. Virtues cannot be regulated. Some codes of ethics do include mention of virtues expected of members, such as personal self-awareness, but in general, codes refer to behaviors.

Values are entities or ideas that have worth and are seen as promoting the good life or the good society. Some philosopher's use the term moral values to refer to humanly caused benefits that we provide to one another.

"Counselors and their clients center on issues of value and the meaning of life as they search out solutions for problems, goals and strategies related to this meaning. They use their own interpretation of what is good, bad, right, wrong and painful in their experiences and realities to guide them. These understandings are called values." (Cottone and Tarvydas, p. 121)

Laws are rules developed under the authority of a state, court or federal body. Statutes are the laws passed by a legislative body. An example of this is the law that requires the reporting of child abuse. Case law is laws that are prescribed by a court. An example of this is Tarasoff v. Regents of the University of California. Liability is a legal term and refers to a professional's responsibility to clients to perform competently. Four criteria must exist in order for the court to support the liability charge:

- The professional had a duty to the client
- The professional breached a duty to the client
- Evidence proves that the client was injured or damaged
- Proof that the injury was caused by the professional's breach of duty

Regulations are guidelines prescribed by a governing authority for a specific group. Regulations can be promulgated by private groups, like counselor certification boards or a professional association, and have no statutory authority. Regulations can also be promulgated by state and federal boards and agencies that do have statutory authority. The regulations only apply to the group for which they are promulgated. For example, the regulations for marriage and family counselors do not apply to someone who does not identify with this profession or hold this license. The most recent federal regulations that impact counseling are the Health Insurance Portability and Accountability Act (HIPPA).

Standards of practice are the minimal standard of behavior that is expected from a professional. In a liability suit, the standard of practice will be used to evaluate the counselor's professional judgment and conduct. The standards of practice are established through testimony of professionals who are considered experts in their field. Standards of practice are also influenced by ethical standards, state laws, cultural factors, and interpretations of case law.

Ethical Theories

Helping professionals would not attempt to practice their profession without a good grounding in psychological and/or counseling theories. However many professionals engage in ethical decision making without any knowledge of ethical theories. Theories give a foundation to why we may think or act in a particular way with clients. For example, if you believe the good of the many clients is more important than the good of one, that belief is based on a theory. How this theory

might look in practice is when a professional or agency sets limits on a set number of sessions for a client; resources are scarce and need to be distributed equally.

A brief discussion of ethical theories is covered in this section with some questions for professionals to consider that will increase awareness of how these theories may impact practice.

Utilitarianism

Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873) are two of the authors associated with this theory. The main principle of utilitarianism is that humans should act in ways that will produce the most benefit to humanity; however, the greatest good was defined differently by each philosopher. Bentham thought the greatest good for humans is pleasure, defined as when a state of deprivation is replaced by fulfillment. Bentham proposed that we tally the consequences of each action we perform and thereby determine on a case by case basis whether an action is morally right or wrong. This aspect of Bentham's theory is known as *act-utilitarianism*. In addition, he proposed that we tally the pleasure and pain which results from our actions. For Bentham, pleasure and pain are the only consequences that matter in determining whether our conduct is moral. This aspect of Bentham's theory is known as *hedonistic utilitarianism*. Mill believed that happiness is the greatest good and defined this as the realization of goals. His form of utilitarianism is known as rule-oriented. This focuses on the consequences or outcomes of behavior to determine whether or not it is ethical. Even if someone's intention is ethical, if the outcome does not promote the greatest good that would be considered unethical within this theory. Further, utilitarianism proposes that humans are responsible for all of the consequences of their choices. Therefore, ethical decision-making would involve an examination of the good vs. bad outcomes.

A clinical example of the use of this theory would be that a counselor decides it is in the greatest good of society to respond to a subpoena to testify in court about a client's treatment even though the client has not given the counselor permission to do so.

Questions to consider:

1. What are some examples in your practice where you have acted for the greater good of society in conflict with an individual client's good?
2. If you haven't, what are some situations where you think you might act this way?
3. Identify your own values in deciding which situations you would act this way or not.

Contract theory

Kant (1724-1804) is the philosopher most known for this theory. The main premise of contract theory is that moral life is about duty and that any moral

action is universal. Kant believed that there is a moral foundational principle of duty that encompasses our particular duties. It is a single, self-evident principle of reason that is called the "categorical imperative." A categorical imperative mandates an action; for example, “treat people as an end, and never as a means to an end.” Newton (1989) interpreted this theory to mean that the principles we use are the ones we would like applied to ourselves. To paraphrase, “do unto others as you would have them do unto you”.

A clinical example would be that a counselor who holds the value of justice would advocate for all clients for services regardless of the consequences.

Questions to consider:

1. What are some examples in your practice where contract theory has been applied?
2. If not, where would you like to see it applied? And how would you go about doing that?

Virtue Theory

Aristotle (384-322 B.C.) proposed that virtues are those strengths of character that promote human development. His definition of this has been interpreted by later writers to mean the results from actualizing human potential. This theory proposes that a virtuous person is not interested in outcomes but instead, chooses actions because they have value. Plato described four virtues, which were later called *cardinal virtues*: wisdom, courage, temperance and justice. In addition, these virtues are considered important in this theory: fortitude, generosity, self-respect, good temper, and sincerity. Virtue theory also includes the importance of moral education since it is believed that these traits are developed during childhood/adolescence. Adults are considered responsible for teaching and modeling these virtues for the young. After Aristotle, religious leaders developed a list of virtues which became part of Christianity; *theological virtues*: faith, hope, and charity.

A counselor practicing virtue theory would protect the privacy of a client because s/he believed in the intrinsic value of that privacy and would do so even if facing negative consequences, i.e. legal sanctions.

Question to consider:

1. What virtue ethics do you apply in your practice?

In reviewing these first three theories, the focus is on a relationship that is expert driven. In other words, one person or persons has the “right” answer. These theories have caused debate about certain issues: who defines the greatest good? who decides whether an action is moral?; who defines the virtues? However, these theories are often used as the basis for ethical codes and ethical decision-making models. Part of the debate is that these are seen as outdated and lacking contemporary relevance. Helping professionals today are dealing

with complex and diverse clients, fiscal accountability, legal mandates and shrinking resources. These theories were developed during a simpler time of healthcare services; however, it is clear to see that the values and belief systems from them still influence our ethical decision making. A few more theories will be briefly discussed which may be more helpful with current practice.

Care-based Ethics

In 1982, Carol Gilligan published a research project in which she had replicated Lawrence Kohlberg's research (1969) on moral development. Kohlberg had proposed a model of moral development based on his research that supported ethical decision-making based on general principles and "moral logic". However, this theory was based on a study of eighty-four boys. Gilligan used the same research design and focused on females instead. From her work, Gilligan concluded that females use a care-based ethic as opposed to a principle-based ethic.

Care-based ethics is based on connectedness in relationships. This theory proposes that ethical decision-making should be done within the context of the relationships central to the ethical dilemma. This theory moves away from the expert-based theory into a more collaborative model.

A counselor practicing care-based ethics might act in the following way. If served with a subpoena, the counselor would discuss the pros and cons of responding with the client. Even if the counselor and client disagreed, the client would understand the reasoning of the counselor's decision and efforts are made to preserve the helping relationship.

Question to consider:

1. Are there any ways in which you have practiced this ethical theory?

Ethical Relativism

Protagoras (480-411 BC) was a Greek philosopher who originated this theory based on the belief that moral standards originate from cultural norms.
This is in contrast to the theory that there are ideal moral standards and a "right" way to do things (ethical absolutism). Ethical relativism states that moral actions should be based on reality, i.e. how people/cultures really live as opposed to a philosophy or an abstract value. This theory states there is no "one truth" and that moral values differ from culture to culture.

Hinman (1997), a more current author on this theory, suggests that ethical relativism is based on:

- tolerance and understanding for each other
- recognition of moral diversity
- a non-judgmental approach to morality
- acceptance that reasonable people may differ on what is morally acceptable

However an important concern with this approach is that it doesn't offer specific guidelines for decision-making when different cultures interact and are in conflict with their morals. Hinman states that ethical pluralism (see next paragraph) may be a more reasonable theoretical approach considering the recent increase in cross-cultural clinical experiences.

Ethical Pluralism

Somewhere between ethical absolutism and ethical relativism is ethical pluralism. It proposes that there are some universal values that cultures do agree on; for example, having respect and caring for elders. In this theory, cultures agree on those actions that are morally prohibitive; e.g., abuse of elderly. They then agree to tolerate values and actions that have legitimate differences, e.g., elders living in nursing homes rather than with their family. This theory views disagreements as strengths and supports the view that no one culture has all the "right" answers.

For further reading on these theories go to www.ethics.acusd.edu .

Stages of Moral Judgment

In addition to ethical theories, stages of moral development need to be considered as part of the ethical-decision making process. As previously mentioned, Kohlberg (1984) proposes stages of moral development based on his longitudinal research study of eighty-six boys. This work helps to understand how values interact with levels of moral judgment.

Level One: Pre-conventional - Obedience and punishment: fear-based decisions. The focus is on individual needs

Level Two: Conventional - External factors in society are basis of decisions. The conceptions of fairness are based on societal agreement

Level Three: Post-conventional - Belief in universal principles: able to use moral logic as basis of decisions

In Gilligan's work (1982) she noted that if Kohlberg's stages were applied to the responses of females, they (females) appeared to be less morally developed than the males. Therefore different contexts for moral reasoning other than logic and principles exist for females, such as, relationships.

Kohlberg's theory is valuable in that it is based on child development models and provides a framework to think about how people make ethical decisions. It can perhaps be applied to counselor development as well. Beginning counselors are often afraid to do the "wrong" thing and make decisions based on what their

supervisor has told them vs. their own reasoning. (Level one) Hopefully, they move from this stage through the others to where ethical and clinical practice is integrated and decisions are based on client welfare needs. (Level three)

Van Hoose and Paradise (1979) have adapted Kohlberg's stages to counselor development.
Stage 1: Punishment Orientation: focus on consequences of any decision
Stage 2: Institutional Orientation: focus on what higher authorities want
Stage 3: Societal Orientation: focus on duty and welfare of society
Stage 4: Individual Orientation: needs of the individual are weighed against society
Stage 5: Principle or Conscience Orientation: concern for individual welfare is main focus

Gilligan's work is valuable in that it challenges some of the values inherent in Kohlberg's model and introduces collaboration in relationship as another value to consider in moral reasoning. This should be considered not only a gender issue but also a cultural one. Many cultures, such as American Indians, value preservation of community and relationship over individualistic values. For counselors working with clients in these types of communities, Gilligan's theory of moral reasoning may be more appropriate in addressing ethical dilemmas.
For more information on gender and ethical theories, go to the following website: www.ethics.acusd.edu.

Personal Values

"Values, assumptions, and practices are closely connected. The assumptions we make about people are influenced by our values. If we value self-determination very highly, we are likely to assume that in order to be psychologically healthy, most people should behave autonomously. These ideas, in turn, will influence practice." (Prilleltensky, 1997, p. 519)

There are many ways in which values influence ethical decision-making and clinical practice. Counseling approaches have inherent values. The counselor has personal values. Even a code of ethics is based on a value system. Add to all of this the values of a client, a community or a culture and it becomes clear why values clarification is such an important part of ethical practice.

There are training programs for counselors that caution against allowing personal values into the helping relationship. No matter how much experience or training a professional may have, personal values do exist and can influence practice, especially when addressing ethical concerns. However, a major focus in most training programs for helping professionals is to offer clients objectivity. This implies that the professional sets aside her/his own viewpoint and supports the client's autonomy and self-efficacy. The concern is that professionals will exert undue influence by imposing their own values and because of the imbalance in authority, this can cause harm to clients. However, some writers (Dougherty,

1995) believe that the lack of “moral courage” in therapists and the lack of discussion of moral issues with clients are some of the factors behind the current crisis in the counseling field. “I propose that therapists’ failure to attend to the broader moral and community dimension has left psychotherapy vulnerable to being managed as just one more commodity in the healthcare market”. (p. 8 To engage in a practice where moral and ethical discussions are the norm, the therapist would have to work hard on self-awareness of her own value system and moral reasoning process.

A suggested approach to discussing values in counseling that may be helpful is to view this issue on a continuum and discuss the pros and cons along this continuum. At one end is the professional who discloses his values to clients as a routine part of the counseling relationship and discusses values throughout the course of treatment. A positive of this approach is that it is good informed consent because he is advising clients about the value system of the person who will be helping them, and then the clients can decide if this is compatible with their beliefs. Clients may even request this information, such as asking a counselor about their faith or religious beliefs. The negatives about this approach would be how to insure client autonomy in a relationship with such imbalance of power. Would a client who disagrees with this counselor’s value system feel free to speak about that? And if so, how to work with clients who disagree with the professional’s value system?

At the other end of the continuum is the professional who never discloses personal information to clients and practices in a neutral way regarding values. The positive of this is that the client is free to explore their own values without undue influence. The danger with this position is that without adequate supervision, the counselor may lack awareness of personal values that do influence the counseling process. A counselor may believe she is practicing neutrality when stating to a client “it is your choice to come here or not” but the value the counselor is promoting is autonomy/self-efficacy.

So the middle of this continuum would be the professional who assesses the needs of each client and the clinical situation and chooses to discuss values when it is clearly in the best interest of the client to do so. Examples are an informed consent situation, or when the values conflict renders the professional unable to provide good care. The ethical practice with regard to values is **not** that all counselors be neutral. Rather, the suggestion is that counselors clarify their own values through self-reflection, training and supervision in order to:

- increase awareness of their values and the impact of these values on their practice
- identify when it is clinically appropriate to address the issue of values with clients
- acknowledge values conflicts and determine the best way to address them

Questions to consider:

1. Review your informed consent form and decide whether you need to include any values that are missing.
2. If you were working with a client who held a value that was in conflict with your value system how would you handle it?

There are numerous values conflicts that can occur in the helping relationship. Perhaps the most obvious examples are those with clients whose culture, gender, faith and lifestyle differ from the therapist's. Ethical practice requires that counselors be aware of these differences and how they impact clients' communication patterns and other behaviors.

However, values conflicts arise just as easily with clients from the same culture and background. A client may not value honesty in an intimate relationship to the extent that the counselor does or may have a parenting style that the counselor feels is harmful. Values also impact the counseling relationship through counseling theory and program design. Counseling theories typically emphasize verbal interactions. In fact, non-verbal clients can be labeled as "resistant". Some experiential approaches allow for other forms of interaction but typically, treatment is seen as a verbal process. The belief system inherent in these theories is that it is helpful to talk to someone about personal problems. However, there are families/cultures that would disagree with this value. Instead, they value indigenous healing rituals such as a sweat lodge. This is an example of where clinical skills and cultural awareness are an integral part of an ethical decision-making process. If an ethical issue surfaces with a client from a different culture, the professional needs to be able to discern what the cultural issues are in order to correctly resolve the dilemma. In addition, treatment program design is based on value systems. If family members are required to attend, if group therapy is required, or consultation with a psychiatrist, all of these reflect the value of what professionals believe will be helpful. The ethical concern is when the treatment design does not meet client needs or is in conflict with a cultural norm of the client. Professionals should hold beliefs about a counseling approach and the values inherent in their counseling style. The ethical concern is to ensure that the approach does not compromise client welfare. A potentially unethical practice would be to blame the client because he/she did not fit the treatment approach. A more ethical process is to acknowledge the values and biases inherent in the treatment approach and assess fully the needs of the client.

Prilleltensky (1997) summarizes the values inherent in four approaches used in psychology and how these values influence ethical practice. They are as follows:

Traditional Approaches

(Examples: psychoanalytic; object-relations)
Values: Promote caring and self-determination of individuals. Major value emphasis is helping the individual, not communities or society. Good life and good society are based on value-free liberalism and individualism. Ethics are

defined as rules of conduct to be followed in delivering services. Autonomy is valued over other principles such as moral responsibility to others.
Potential benefits: Preserves values of individuality and freedom.
Potential risks: Victim-blaming (individual is responsible for problems) and no confrontation of unjust social practices and structures. Solutions are personal not societal. It is an expert driven model; the therapist has the answers.

Empowering Approaches

(Examples: feminist therapy; community psychology)
Values: Promote human diversity and self-determination of individuals and marginalized groups. Good life is based on ideas of personal control. Good society is based on rights and entitlements. Ethics are based on individual and societal principles, such as, distributive justice. Ethical concerns are for the well-being of people and extend beyond individual clients.
Potential benefits: Addresses sources of personal and collective injustices. "Assert your rights and fight this".
Potential risks: Pursuit of own empowerment at expense of others. Can still be an expert driven model especially if the therapist is pushing this belief system. Client may not want to focus on injustice in society.

Postmodern Approaches

(Example: When a family-systems theory states that any family structure can be adaptive and therefore there is no "norm" for the definition of a family)
Values: Promotes human diversity and self-determination of individuals through collaboration and participation. Good life is associated with pursuit of identity. The legitimacy of professional ethics is questioned. Moral frameworks are subjective and constantly evolving.
Potential benefits: Values identity and the importance of context and diversity. "Others may see this as a problem but you should do whatever works well for you and your family".
Potential risks: Skepticism and lack of a consistent moral vision regarding society.

Emancipatory Communitarian Approaches

(Example: Prilleltensky offers this definition for communitarian psychology: "Community members, clients and psychologists would collaborate in setting the agenda for personal or social change, and interventions would be primarily proactive and directed at social systems" (p. 529). This is a combination of communitarian and emancipation theories.)

Values: Promote balance between self-determination and distributive justice. Concern for both the well-being of individual and communities. Good life and good society are based on mutuality, social obligations, and removal of oppression. Ethics based on societal principles, such as, concern for the health needs of the entire community not just an individual client (distributive justice).
Potential benefits: Promote sense of community and addresses societal inequities. "Do what is best for this community".

Potential risks: Sacrifice of personal uniqueness for good of the community.

Question to consider:
1. Based on these theories, which one do you identify as most prevalent in your approach or that of your treatment agency?

Codes of Ethics

The self-inventory asked which profession you identify with because values are also reflected in professional identity and in that professions' code of ethics. All helping professionals have a code of ethics: that is in fact one of the factors that defines a profession. These codes may look similar because they are all based on general ethical principles. These principles will be discussed fully in the next section. However, codes can differ in the professional values that are emphasized. Two codes, social work and the National Board for Certified Counselors, are discussed here as examples.

National Association of Social Workers

"The primary mission of the social work profession 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. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living."

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence

National Board of Certified Counselors

"The NBCC Ethical Code applies to all those certified by NBCC regardless of any other professional affiliation. Persons who receive professional services from certified counselors may elect to use other ethical codes which apply to their counselor. Although NBCC cooperates with professional associations and credentialing organizations, it can bring actions to discipline or sanction NBCC certificants only if the provisions of the NBCC Code are found to have been violated. NBCC promotes counseling through certification. In pursuit of this mission, the NBCC:

- Promotes quality assurance in counseling practice

- Promotes the value of counseling
- Promotes public awareness of quality counseling practice
- Promotes professionalism in counseling
- Promotes leadership in counseling

These are two very different codes. They both do a good job of explaining their mission and clarifying their values. This also illustrates the need for caution in judging another professional's behavior as "unethical" unless that professional's code has been reviewed. To summarize, differences in codes, theory of treatment, and value systems could make one professional's conduct appear unethical to another, but when examined within a context, the reverse may be true.

As stated in the opening quote for this course, codes of ethics are only one of the resources professionals have to assist in the ethical decision making process. A professional could be in trouble if relying only a code to resolve problems because of several issues:

- Codes are written by members of a professional association. In looking at just two examples above, the value system of the professionals who wrote these codes is obvious.
- Codes are written as general guidelines. It would be impossible to include all of the information all professionals would need to meet the demands of a complex clinical situation.
- Codes can be in conflict with laws, community standards and cultural practices.
- Codes are minimal, mandatory standards. Hopefully, professionals aspire to practice above these levels.

For example, a counselor practicing mandatory ethics is someone who has a client under the age of 18 sign a written consent form for the counselor to consult with the client's parents. Although the law may allow for the counselor of a minor client to talk with parents at any time, a counselor practicing aspirational ethics respects the integrity of the counseling relationship and asks for the client's permission.

Codes are also problematic because they tend to be reactive rather than proactive. It takes a considerable amount of time for a group of professionals to write and come to consensus about a code. Frequently, professionals are already working on solving problems that the code has yet to address. Because issues arise so rapidly, it is difficult for codes to always be current.

An additional concern with a code of ethics has to do with virtue ethics discussed in the definition section of this course. As mentioned, virtue ethics cannot be regulated. These are personal attributes of a counselor, such as, self-awareness, that are essential to an ethical decision-making process. All codes are based on the principle of non-maleficence, "do no harm". However, complaints are reported

to ethics committees and credentialing boards, indicating that there are professionals who act in ways that harm clients. This is an example of a professional lacking in virtue ethics.

In conclusion, professionals should always consult their code of ethics as it is a good resource in providing minimum guidelines for practice. Codes provide a sense of moral community in that all members are bound by these guidelines and have a responsibility to clients and each other to fulfill the expectations within the code. However, a code of ethics should not be the only resource used when trying to resolve an ethical dilemma for all of the reasons noted in this section.

Assignment:
Please go to www.nbcc.org and click on the link for ethics

Read the code and identify sections that illustrate the following:

1. Mandatory ethics
2. Aspirational ethics

Ethical Principles

The code that will be used for this course is the National Board for Certified Counselors located at www.nbcc.org.

Kitchener (1984) proposed that ethical decision making for psychologists should be based on ethical principles and not just personal value judgments. She identified the principles of autonomy, beneficence, non-maleficence, justice and fidelity. For the purpose of this course, six principles will be discussed: autonomy, beneficence, competence, discretion, justice and non-maleficence.

Autonomy

“”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 intended use of tests and reports, methods of treatment and safety precautions that must be taken in their use, fees, and billing arrangements.” (Section B: 8)

Autonomy is the principle that supports the self-efficacy of the client.

This means that the client has the choice to accept treatment or not and is given complete information to make a decision regarding treatment. When counselors provide informed consent to clients they are practicing this ethical principle. As is noted in the NBCC code, this process occurs throughout the counseling process,

not just in the first session. The following are some guidelines for good informed consent:

- Confidentiality of the relationship and records (these are two different legal entities)
- Situations which could lead to violation of client's confidentiality rights
- Qualifications of the helping professional, including code of ethics
- Benefits and possible harm of any treatment approach
- Expectations of client's behavior and if there are any conditions under which treatment will be refused
- Financial arrangements including how insurance/managed care is handled, cancellation guidelines, resolution of disputes
- What to do in an emergency: definition of an emergency can also be helpful
- Any other professional who may be involved in the treatment; for example, if you practice as a multi-disciplinary team

This is just a brief list of suggestions. In order to decide what else is needed in a particular setting, ask "What would I want and need to know if I were my client?"

Ethical Dilemmas with Autonomy

Professionals may find it challenging to practice this ethical principle with some client populations. It may seem dishonest to suggest to a client you are seeing in jail that he/she has freedom of choice. In fact, supporting some types of autonomy in some settings, such as criminal justice institutions or schools, could cause more problems for clients. This is where good ethical decision making is critical. Upholding the principle of autonomy within the counseling relationship is the ethical expectation with these clients with the additional responsibility of discussing with the client all of the possible consequences of making their own choices in this context. If a student has been sent to counseling by the principal but that student states they do not want counseling, the professional needs to respect this decision and at the same time discuss with the student the possible reactions of the principal to this decision.

In addition to the school setting or criminal justice setting, children and adolescents just by the nature of their developmental issues present ethical dilemmas with this principle. This is also where the helping professional's own value system and clinical approach could impact how he/she applies autonomy. A professional who believes in a family systems approach may resolve a dilemma differently than someone who treats adolescents as individual, independent clients. In addition, children and adolescents have different viewpoints and developmental issues than adults. Their decision-making skills can often put them at risk. Supporting the autonomy of a child or an adolescent could compromise other ethical principles such as client welfare.

There is also the issue of cultural values about autonomy. Self-efficacy and freedom of choice are ideals that are valued predominantly in Western European

cultures. A client from a culture that believes in the good of the community may not understand decisions made by a counselor who is supporting the client's autonomy. In addition, the clinical setting may be an influence in promoting autonomy.

The example of seeing a client in a jail setting has already been discussed. This is a very different setting from that of a private practice.

A counselor providing services in a private practice depends on clients to be functioning fairly autonomously as opposed to clients in correctional settings. And then, there is managed care. Typically these companies have a list of providers so the client is limited with regard to freedom to choose. The model most supported by managed care is that of brief therapy even if this approach does not meet the needs of the client. In addition, the case manager or reviewer for the managed care company has never met or talked with the client and offered the client any choices with regard to services. Licensed or certified counselors working in these positions need to carefully consider how they are upholding the principle of autonomy as do those professionals who contract with managed care and other third party providers. "When certified counselors are engaged in intensive, short-term counseling they must ensure that professional assistance is available at normal costs to clients during and following the short-term counseling" (Section B; 11)

The following case will provide an opportunity to practice ethical decision making with each of the following principles. We will start with autonomy.

Case:
You are a licensed counselor in a college counseling center. Donna, a sophomore, has been sent to you from the Dean's office for an evaluation regarding her mental health status and whether she can make it through the academic year. She is currently on academic probation. Your evaluation reveals that she has a diagnosis of major depression and post-traumatic stress because of a recent sexual assault and is in need of services. You recommend a psychiatric evaluation for medication in order for her to succeed with her classes. When you discuss the results of the evaluation with Donna, she becomes upset. She refuses to sign a release for you to give the Dean a copy of your evaluation because she says "the Dean will think I am crazy and call my parents. Then my parents will make me leave school". Donna says she will see you for counseling but refuses to see a psychiatrist.

1. What are your reactions to this client?
2. How would you respond to her?
3. Does your response support the principle of autonomy?

Beneficence

"The primary obligation of certified counselors is to respect the integrity and promote the welfare of the clients, whether they are assisted individually, in family units, or in group counseling…." (Section B: 1)

Beneficence is the principle of doing good. This is typically why most people enter the helping professions; they want to help others. Beneficence is also one of the principles cited when discussing client welfare issues. It may seem that this would be a simple principle to apply: doing good. It is complicated by two issues, the debate about what constitutes doing good as a therapist, and the definition of client.

Ethical dilemmas with beneficence

As discussed in the ethical theory section, "good" has been defined in different ways by philosophers. This is true also in the helping professions. Theories of counseling differ on what is helpful to clients vs. what is harmful. In the practice of an unethical practitioner, any theory or intervention can be harmful. Helping professionals hopefully are using a specific approach because they believe it will benefit the client. In our case example above, is doing "good" for Donna insisting that she seek the psychiatric evaluation? Or is it letting her schedule another appointment with you?

What are some questions to consider in deciding what is in the best welfare of a client? What is doing good?

1. Is doing good for the client defined by the decrease in symptoms? What about client populations whose symptoms may get worse as they begin counseling? For example, clients with trauma history or addictions.
2. Is doing good defined by the clients' feedback that they like the program or the counselor? What about the clients who report satisfaction but demonstrate no behavior changes?
3. Is doing good refusing to see clients who have relapsed a number of times? And how many times is the limit? Three, five, ten?

The second important issue in discussing beneficence is to clarify who is the client. Codes of ethics do not give guidance as to when a client becomes a client but this is an important guideline for practitioners to establish for themselves or their programs. This is important because once the person is identified as a client all ethical, clinical and legal obligations begin. First of all, there may be funding guidelines, which define the client population. Counselors working in public sector programs who serve everyone in a geographic area may consider all of the legal, tax-paying residents of that area as their clients. Another definition could be anyone who shows up at the clinic asking for services is the client. Some practitioners use the first phone contact as the guide for when someone becomes a client. Others use the point at which the client signs the informed

consent. Whichever guidelines are used, it is important that clients have this information, as well as, clarification by the provider of client loyalties.

If the family is considered the client, there needs to be discussion as to how ethical conflicts will be handled, especially confidentiality issues. One family member could disclose information about another that the counselor is ethically obligated to respond to in some manner. The same could happen in a school setting. Is the client the school? or individual students who meet with the counselor? In addition, it is important to define when a client is no longer considered a client because that is when ethical, clinical and legal obligations end. Some practitioners choose a length of time, such as two years after last contact. There are state legal guidelines regarding the statute of limitations in malpractice cases that some professionals use to determine how long client files are kept and professional obligations remain. If someone who was a client two years ago calls in a crisis, is there an ethical/clinical obligation to respond? This is where a good ethical decision making process would need to take place. Counselors should consult the regulations in their states as well as any state laws and know what the standard of practice is in their area. It is also recommended that practitioners include this information in their informed consent so that clients are aware of the limits of the professional relationship.

Some counseling theories hold that “once a client always a client”. This is based on the theory of unconscious process. This theory proposes that there are unconscious dynamics, which occur in the therapeutic relationship that continue after the client has completed services. If a professional is practicing from this theory, the length of time is irrelevant. This would mean that the professional still has ethical and clinical obligations to the client. All legal confidentiality mandates support this theory in that there is no time at which a licensed or certified practitioner has permission to divulge information that someone was their client. The only exception to this is in a legal matter in order to prepare a self-defense or to respond to a court order.

There are many other concerns with regard to client welfare. The emergence of evidence-based practices is one area. Practitioners need to carefully review the research to determine if their client population is included in the clinical trials. Professionals must also be adequately trained in these models, most of which require more than just a one day workshop to gain competence. Funding may be contingent on whether or not an agency is practicing this evidence-based practice so a dilemma could occur between continued funding for a program vs. whether this approach is beneficial to the clients. Another area of concern is the use of third party payment for mental health and substance abuse services. If a particular diagnosis is not covered by the funding source, does the professional change the diagnosis so that the client can have services paid for? Or tell the truth and risk the client not accessing services?

Question to consider:
What other areas of concern can you identify with regard to beneficence?

Returning to the scenario with Donna, review what you said you would do next. Does this action support the principle of beneficence? If yes, how?
If not, what would you do to change your next step?

Competence

"Certified counselors offer only professional services for which they are trained or have supervised experience. No diagnosis, assessment, or treatment should be performed without prior training or supervision. Certified counselors are responsible for correction of any misrepresentations of their qualifications by others"(Section A: 6)

This is the principle that requires professionals to have the knowledge, skills, and abilities to be of help to clients. When professionals practice within the areas that they are trained and credentialed, they are practicing ethically. Some examples of unethical practice are:

- Accepting a client that you know you do not have the training or expertise to treat
- Advertising that you have a credential you do not have
- Lack of referral of a client who presents additional issues in treatment that are outside your area of expertise

Some states have definitions of scope of practice for the state issued credentials so this can be used as a guideline as well.

<u>Ethical Dilemmas with competence</u>
One of the concerns with this principle is how to develop guidelines to determine when someone meets the ethical standards of competence. The process of obtaining a graduate degree is used by some as a measure of competence. There are some standards set by academic credentialing bodies so that psychology programs or counseling programs have some similarities but there are also enough differences in these programs that this is not the only measure that should be used for competence. Others believe that credentials such as certification or license are a good measure of competence. In addition, clinical experience can be used as a measure of competence. However, a professional could hold appropriate credentials and have years of experience but still not be competent in providing services for a specific population, such as eating disorders. "What the states license is the absence of deficiencies, rather than the presence of competencies" (Procidano, Busch-Rossnagel, Reznikoff and Geisinger, 1995).

Question to consider:
What are the guidelines you use to determine if you are competent to treat a client?

Haas and Malouf (1995) recommend these two questions: (1) “Am I emotionally able to help the client?” (2) “Could I justify my decision to a group of my peers?”

Typically codes and credential regulations require ongoing education as part of the ethical practice of competence. However, it is usually left up to the individual as to what type of ongoing education he/she pursues. “Certified counselors recognize the need for and seek continuing education to assure competent services” (Section A: 7)

Mandatory ethics, aspirational ethics and virtue ethics were discussed in the first section of this course. Continuing education is a good example of these three theories to discuss. A professional may obtain the required number of hours of training for a credential, thus practicing mandatory ethics for the principle of competence. However, this same counselor realizes she needs additional training with regard to a special area of practice that was not covered in the requirements. Her value is to be proficient at what she does so she seeks the additional training. This is practicing virtue ethics and aspirational ethics.

Another dilemma with competence is that of impairment. “Certified counselors have an obligation to withdraw from the practice of counseling if they violate the Code of Ethics, or if the mental or physical condition of the certified counselor renders it unlikely that a professional relationship will be maintained” (Section A: 15). A professional could be very well trained, knowledgeable and have abilities but be unable to perform. It is hard to self-monitor this principle. That’s why having ongoing consultations or working within a team of professionals is critical. Employee assistance programs and professional peer assistance programs are also possible resources for help with impairment. An impairment can be temporary and, once medical attention is received, the professional can practice ethically. Other impairments may require the professional to stop practicing in order to be in compliance with this principle.

“NCCs who offer and/or provide supervision must: Ensure that they have the proper training and supervised experience through contemporary continuing education and/or graduate training.” (Section C: a)

For those professionals who also serve as administrators or supervisors, personnel guidelines should be developed for addressing impairment to ensure that all staff is treated the same. Being in a supervisory role can present many ethical dilemmas but definitely around the issue of competence. “Word of mouth” accusation from other counselors can influence how a supervisor treats someone but legal guidelines typically indicate that there has to be documentation to show impact on work performance. For example, a supervisor may know that a staff

has problems with depression and then hears from others that this staff member has stopped taking anti-depressant medication. The supervisor may not be able to take action on this information until there is a demonstration of a decline in work performance.

It is also an ethical dilemma for counselors who are promoted to a supervisory position and do not yet have the knowledge and skills to be a supervisor. These are different from the competency areas of a counselor. When accepting a new position for which a professional is not yet fully qualified, it is recommended that a learning plan needs to be in place with time lines for achieving areas of competence.

Questions to consider:

1. If a client or another professional asked you about your competency to do what you do, how would you respond?
2. Are there areas you have overlooked in your practice that you need to further your education in? what is your learning plan?

(For further information on supervisor competency guidelines, go to www.siv.edu/~epse1/aces .This is the site for the Association of Counseling Educators and Supervisors)

Case:
In the case scenario with Donna, some of the competency issues are:

- Have you been trained in treating trauma? depression?
- Do you have training in working with this age group?
- What other areas do you identify?

Discretion

"The counseling relationship and information resulting from it remains confidential, consistent with legal and ethical obligations of certified counselors…"(Section B: 16)

The obvious value system inherent in this ethical principle is that clients have the right to privacy. Counselors do not discuss with anyone that someone is a client nor do they discuss information that is revealed in therapy sessions without following specific legal and ethical guidelines. This is practicing the principle of discretion.

Ethical dilemmas with discretion

This is the principle that can cause numerous ethical dilemmas because of conflict with laws as well as clinical practice or the professional's own value system. Many codes have incorporated sections that state exceptions to the principle of discretion as well as advising that professionals should follow local, state, and federal laws. One of the most common dilemmas is based on the

value conflict of the good of society vs. the good of the individual. In other words, situations when this principle is in conflict with the principle of beneficence. Inherent in these situations is the value that human life must be preserved and that this value is more important than the value of client privacy. That may not be the value the counselor or client holds as most important but it is what this code of ethics uses as criteria for ethical conduct, and it is also what the legal system values as evidenced by duty to warn case law and statutes.

Because of the numerous dilemmas associated with the principle of discretion and legal mandates, it is helpful for counselors to have some knowledge of legal terms. This course cannot provide all of the information needed by professionals so it is recommended that students consult their state laws and receive additional training in HIPPA regulations.

- Privileged communication: The legal right of the client to have information that is given to a counselor protected from disclosure in a court of law without their permission. The degree to which it is protected and which information is protected will differ from state to state by statute. Privilege only applies in individual counseling. It is also questionable whether it will apply to a clinical supervisor. Glosoff, Herlihy and Spence (2000) conducted a search in the United States and published the status of privileged communication laws. (See reference section.)

  Privileged communication was upheld by the United States Supreme Court in Jaffe v. Redmond (1996). This is case law and the ruling would apply only in federal cases or could be cited by professionals in states where there is no privileged communication law.
  (Refer to definition of terms section regarding statutes and case law.)

- Duty to warn: The legal responsibility of the professional to advise a third party if there is imminent danger. The case law that established this concept was Tarasoff v. Regents of the University of California (1976). The court ruled that the professional should have reasonable belief that the client poses a serious danger and that there needs to be an identifiable third party. In this case, the court ruled that it was not enough that the psychologist involved contacted local law enforcement. He was held liable for not contacting the party who was threatened. This ruling began the debate regarding standards of practice for where client privilege ends and public welfare begins. Since this ruling, some states have enacted duty to warn statutes that will vary in terms of what is required of the practitioner. For states that do not have duty to warn laws, practitioners typically follow the guidelines established in the Tarasoff case. However, legal consultation is always advisable in situations where a client's confidentiality will be violated without their permission.

- Duty to protect: Some state statutes may also include the duty to protect. This gives practitioners statutory authority to take action when a client is a danger to self. In other states, this duty may exist in regulations governing professional credentials and licensed programs.

- Duty to report: The legal responsibility of the professional to report mandated situations.

  The most familiar is the child abuse/neglect mandate. The law states that practitioners must report suspected situations. Again, states may vary on other mandated reporting, such as elder abuse, mentally impaired abuse, domestic violence, and impaired professionals.

In conclusion, some of the areas suggested for research in respective states/countries are: (enter key words on your state code website)

- Read the introduction to the legislation to determine if your profession or credential is covered by the law. Look for legislation on privileged communication.
- Look for a duty to warn statute and under what situations you have to report and what options you have
- If you receive federal funds for substance abuse treatment, you must follow federal regulations 42CFR (U.S. Department of Health and Human Services, 1987). www.gpo.gov/nara/cfr/indes.html
- If you work in a school setting you must follow the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) in addition to state statutes and school board policies. www.cpsr.org/cpsg/privacy/ssn/ferpa.buckley.html
- If you work with minors you need to know if they have the right to access treatment without parental consent. There may be two different statutes, one for mental health treatment and one for substance abuse.
- Some states are enacting statutes to require notification of parents if a child/college student threatens suicide/violence.
- Look for a scope of practice law that defines your area of practice and for the statute of limitations on malpractice suits.

These are some general areas of legal concern that can cause ethical dilemmas. As will be discussed in the ethical decision-making process section, whenever there is an ethical/legal conflict, practitioners are encouraged to seek legal advice.

Thompson (1990) discusses six different interactions between ethics and the law.

- Ethical and legal. This is following a just law that promotes ethical practice.
  Example: Providing access for services for all clients who are eligible. Responding to a subpoena to testify in court when your testimony benefits the client.

- Ethical and illegal. This is breaking a law but acting ethically.
  Example: Refusing to respond to a subpoena because you believe it will harm your client for you to testify in court.

- Ethical and alegal. This is practicing ethically where no law applies.
  Examples: Testifying at your state legislature to increase funding for under-served clients. No law requires that you do this but it is considered good ethical practice to advocate for services.

- Unethical and legal. This is practicing unethically but following a law.
  Example: Responding to a subpoena to testify and when on the stand, revealing more information than is necessary to complete the testimony.

- Unethical and illegal. This is disobeying the law and practicing unethically.
  Example: Failure to report child abuse.

- Unethical and alegal. This is practicing unethically and no law applies.
  Examples: Requiring clients to testify on behalf of a program's funding needs. There is no law that forbids this, but it is exploitation of clients. They have the right to violate their own privacy by admitting to being a client, but the program's request forces this issue.

In addition to legal issues, there are other ethical dilemmas regarding the principle of discretion. Even when legally authorized to release confidential information, helping professionals are expected to have discretion with regards to the content of the information. "Need to know" guidelines are expected, which means, only information is revealed that is relevant to the situation. For example, a client signs a release of information for her parents and one for her psychiatrist. What the professional discusses with the psychiatrist is different than what will be discussed with the parents. These same "need to know" guidelines apply to staff communications and interagency communications. Even when mandated to report, such as child abuse, the professional only discloses the information necessary to make the report. If additional clinical information is sought by the social services agency, the client would need to sign a release or the social services agency would need to obtain a court order. These guidelines are also important when sending information to third-party payers, such as Medicaid or disability reports. Clinicians should only send the minimum amount of information needed to assist the client in receiving reimbursement.

For practitioners working within the legal system or with a caseload of legally mandated clients, it is important to clarify these guidelines with all professionals involved. Employees of the court, regardless of their professional credential, may have different exceptions under a privileged communication statute.

Discretion concerns also arise with regard to confidentiality of records. All codes place the responsibility on the counselor to ensure the protection of client records.

“Records of the counseling relationship….and other documents are to be considered professional information for use in counseling. Records should contain accurate factual data. The physical records are property of the certified counselors or their employers. The information contained in the records belongs to the client and therefore may not be released to others without the consent of the client….” (Section B: 5) In addition here are some recommended guidelines for record keeping. Again, students should have HIPPA training for the most current record keeping guidelines if you are under HIPPA regulations.

- Accurate, written records should be maintained on all clients because it is the documentation of what has occurred in the helping relationship; in a court of law, written records take precedent over verbal reports.
- Records should provide documentation of the counselor’s professional judgment , not personal reactions, as well as treatment recommendations and the client’s response to treatment.
- There should be no demeaning comments about clients or their family members; any record could one day be read in a public court or be reviewed by a third party payer or professional ethics committee.
- Avoid statements that cannot be proven. For example, “client reports she has been abused” vs. “client has an abusive husband”. Unless the practitioner has made a clinical assessment or has other documentation, there is no verification for this statement about the husband.
- As stated in the NBCC Code above, the physical record belongs to the healthcare provider, but the information inside the record can be requested by the client. Some states and agencies limit access to records if it might endanger the client’s mental status. Carefully read any contracts with hospitals and third-party payers regarding their rights to access your records.

Technology offers some unique challenges to record-keeping responsibilities. Computerized records must be secure. Fax machines, answering machines, cell phones, laptop computers are all devices that professionals use to benefit clients. However, they must be sure these are secure enough to protect the client’s privacy. Here are some suggested guidelines that might be helpful with regard to technology issues and discretion:

- Treat computer files with client information, progress notes and evaluations the same way you would hard copy files.

- Use the informed consent process to discuss with clients any ways in which confidential information could be compromised via technology. For example, if you communicate with clients via email you need to be sure they understand the limits of privacy.
- Document the client's response. If they indicated concern, document what you did to respond to this concern; e.g., agree to communicate by phone only.
- Get client's permission regarding leaving messages on answering machines/voice mail systems at home and work, and discuss the best ways for these messages to be worded. Make a note so you don't forget.
- If you use a cell phone, advise clients of this and what procedure you have for safeguarding their privacy. For example, if you are called while in a public place, what do you do?
- Use caution if using computers in a public place where anyone could see client information.
- If you provide counseling via the internet, please see guidelines established by the American Counseling Association at www.counseling.org .

For further information about HIPPA, go to www.hhs.gov/ocr/privacy/index.html .

Case:
In continuing with the scenario with Donna what are the need to know guidelines for communicating with the Dean? Would you contact the Dean even without Donna's permission? If yes, why; if no, why not. Under what circumstances, if any, would you contact her parents without her permission?

Justice

The ethical principle of justice is about a commitment to fairness in all professional relationships. Equal treatment of clients and equal access to treatment are part of this principle. Non-discrimination is part of all codes of ethics.
"Through an awareness of the impact of stereotyping and unwarranted discrimination, certified counselors guard the individual rights and personal dignity of the client in the counseling relationship" (Section A; 12)
The principle of justice requires that professionals practice non-discrimination. Part of the ethical practice involved with this would be for counselors to increase their own self-awareness and obtain training regarding multi-cultural issues, gender issues, age and lifestyle issues. Lack of knowledge in these areas could lead to a counselor practicing discrimination, overtly or covertly.

Ethical Dilemmas with Justice

As discussed in the section of this course on values, there are traditional mental health approaches that may or may not be helpful for clients with different cultural worldviews. In addition, clients can also be victims of discrimination with regard

to referral source or diagnosis. Clients who are court-ordered are often treated in a different way than a client who self-refers as this client appears more "motivated". Clients who have a co-occurring illness may be seen as more "hopeless" than other clients. This is understandable due to the complicated problems a client with a co-occurring diagnosis often presents. However, therapists are obligated to provide the same standard of care for any client regardless of their diagnosis or referral source. The ethical practice of justice is not that counselors have no bias; that would be inhuman. Rather it requires that counselors be aware of their biases and take steps to address them so that clients are able to access services equally. If professionals are aware of discriminatory practices regarding clients within agencies or by other practitioners, it is their ethical obligation to address this also.

Another one of the ethical dilemmas with this principle is equal access to treatment. Client waiting lists may exist due to lack of staff and adequate funding. This is a reality that conflicts with this principle. Some programs are funded to provide services to a specific population, for example, co-occurring illness, or adolescent clients. These programs are created to address an underserved population and professionals must abide by the funding regulations. Ethical practice does not require every agency to treat every client; however it is important to have a good referral network so that if clients present who do not meet admission criteria, they can still access services elsewhere.

Another dilemma with justice could present when a counselor is following the principle of competency and believes he is not qualified to work with this client's diagnosis, culture or age. This could lead to denying service to some clients. The ethical response, again, is to maintain a good referral network to be able to help clients gain access to qualified providers. This referral network is also the key to ethical practice when trying to follow the Americans with Disability Act. This Act requires that anyone with a disability who is trying to access services must be accommodated.

For more information on the ADA go to
http://www.usdoj.gov/crt/ada/adahom1.htm

Case:
In the case of Donna, would you deny her services? And if so why? What are the other possible ethical concerns regarding justice?

Nonmaleficence

Non-maleficence is the principle of do no harm. The question then is what do we consider harm to a client?

Many professionals, including regulatory bodies and ethics committees, judge harm based on client self-report. If a client believes that she was harmed by the

professional's behavior, this is considered strong evidence to charge the practitioner with unethical behavior. The NBCC Code of Ethics gives some guidelines for what is considered harmful practice. These will be used as examples in this section.

"Certified counselors know and take into account the traditions and practices of other professional disciplines with whom they work and cooperate fully with such. If a person is receiving similar services from another professional, certified counselors do not offer their own services directly to such a person…" (Section B; 2) This is indicative of a belief that multiple counselors could be harmful to a client's treatment, especially if the counselors are not communicating about the client's care or have different approaches. Sometimes clients do not disclose the information that they are receiving services elsewhere. This presents a dilemma when a counselor discovers this information after already initiating treatment. This is another example of a dilemma that would best be resolved by using an ethical decision-making process.

"When certified counselors are engaged in intensive, short-term counseling, they must ensure that professional assistance is available at normal costs to clients during and following the short-term counseling" (Section B; 11) This is referring to harm as abandonment of clients due to your role or your treatment model when the client needs more services.

<u>Ethical dilemmas with nonmaleficence: Dual Relationships</u>

All professional codes of ethics have guidelines regarding dual relationships. A dual relationship is when a client and counselor engage in a second relationship either while the client is in treatment or after the client has ended treatment. This could be a friendship, a romantic relationship, a business relationship or a professional relationship. If a counselor provides treatment to someone they already have a relationship with, like a relative, friend or colleague, this is also considered a dual relationship.

"Certified counselors who have an administrative, supervisory and/or evaluation relationship with individuals seeking counseling services must not serve as the counselor and should refer the individuals to other professionals…Dual relationships that might impair the certified counselor's objectivity and professional judgment must be avoided and/or the counseling relationship terminated through referral to a competent professional." (Section B: 9)

Relationships are fluid and rigid boundaries are unrealistic as well as hard to maintain. The main issue with a dual relationship is for the counselor to avoid exploiting the client because of the fact that the person is a client.

Client/counselor relationships exist in many different forms. The nature of this relationship depends on who the client is, how the relationship starts and in what setting, and the ethical and legal responsibilities of the counselor. A licensed

professional counselor who provides in-home services has a different relationship with his clients than a licensed professional counselor in a private practice. However, the same standard of care should exist regarding the principle of do no harm.

Even in a private practice setting where a therapist can clearly define the parameters for the relationship, what was appropriate behavior with a client in the beginning phase of treatment may not be appropriate as the client progresses and ends therapy. For example, when a client is in a crisis state, just entering treatment, a counselor may extend herself by offering additional sessions or spending extra time on the phone to help stabilize the client. This behavior would not be in the best interest of the client when trying to terminate and could be interpreted as boundary violations of the client.

In clarifying ethical behavior within the client/counselor relationship, it is helpful to discuss several issues:

- the contrast of relationship vs. social contact
- the contrast between professional and personal relationships
- boundaries
- objectivity
- clients' needs
- exploitation
- confidentiality

A relationship is not the same as social contact. Social contact is something that happens accidentally; for example, going to a PTA conference and seeing the parent of a client or a client. Unethical behavior can still occur within this type of contact, such as the counselor saying something inappropriate, but it does not constitute a dual relationship. Relationships are typically defined as ongoing, planned and mutual. A counseling relationship may have some of the same characteristics as other relationships; planned meetings which occur frequently; personal information discussed; emotional attachments. This is one of the reasons that entering into a dual relationship can be harmful because of the confusion it causes for both client and helping professional. So in dealing with the ethical dilemmas of dual relationships it is helpful to clarify some things:
Why do clients seek out professional help rather than seeking help from a friend or family member? What are the differences between a client/counselor relationship and a personal relationship?

Here are some guidelines that might help:

Personal Relationships	**Therapeutic Relationships**
Mutual needs met, mutual sharing of personal information	Clients' needs are primary
Access to each other anytime	Access within prescribed limits (Office hours, appointments)
Visit in each others' homes	Visits occur in a prescribed place: professional visits at client's home only to provide services
No payment for listening to problems	Payment involved
No assessment process, treatment plan	Professional obligation to assess, diagnose, write goals, keep written records
No confidentiality obligations	Ethical and legal obligations for confidentiality
No obligation to report information disclosed	Ethical and legal obligations to report certain information
No competency expected in helping with problems	Expectation of knowledge and skills to assist with problems
Limited objectivity	Objectivity expected
Physical touching; sexual needs met	Touching for therapeutic reasons only; no sexual contact

Question to consider:
1. Are there other items you would add to this list?

Since the therapeutic relationship can become confusing, one of the ways to reduce confusion for clients and professionals is to maintain clear and consistent boundaries in the professional relationship. So what are boundaries? Everyone has a comfort level with physical space in terms of how close someone stands to another person, how often someone uses touch, etc. These are physical boundaries. There are also verbal boundaries, like saying the wrong thing at the wrong time. Boundaries in any relationship can be seen on a continuum. There are boundary crossings that occur which may or may not be harmful. A friend can cross a boundary by giving you feedback you did not ask for. The feedback may be helpful, but if said in a hurtful manner, that could be a verbal boundary crossing. If the friend is asked to stop, but continues this behavior, a boundary violation has occurred. These crossings and violations also occur in professional relationships.

For example, seeing a client in another setting like the PTA meeting mentioned previously. Within the professional relationship, the counselor and client may not eat together. But the PTA meeting is having a spaghetti dinner so eating together is expected. This is a boundary crossing that probably does not exploit the client or harm the integrity of the therapeutic relationship. Inviting the client to dinner on a regular basis would be seen as a boundary violation. This is not part of the normal treatment process and instead causes confusion by moving into a more social relationship.

Other areas of boundary crossings that can occur are touching, self-disclosure, giving and receiving gifts, amount of time spent together and special treatment of the client. Within each of these areas, there may be appropriate, therapeutic behaviors. Careful consideration must be given to these boundary crossings as the counselor could move down the continuum and become involved in a boundary violation. The following examples illustrate each of these areas.

- There are clinical assessments that involve asking clients a lot of personal information. This is a boundary crossing that is hopefully not harmful to the client when done with good informed consent and by a competent professional. However, asking clients for more details about something that is not relevant to the clinical assessment, like a sexual encounter, would be a boundary violation.

- Another counseling technique that needs to be monitored for boundary concern is the use of self-disclosure. Again, when used by a competent counselor this can be an effective counseling tool. However, the use of self-disclosure should meet the therapeutic goals of the client and not the personal needs of the professional. Excessive use of self-disclosure by the therapist changes the focus of the professional relationship moving it into a more social, mutual relationship. It can change the nature of the counseling relationship to the point that the client experiences it as a friendship, again, causing confusion.

- The same confusion can occur with gifts. In some cultures, accepting a gift from a client is the respectful, appropriate response and to refuse it could harm the therapeutic relationship. This would be a boundary crossing that is not harmful. Exchanging personal gift items on a regular basis with clients again invites a social aspect into the counseling relationship that can be harmful.

  As with many boundary concerns, professionals need to assess the age, culture, and clinical profile of the client in helping decide the most ethical response. Some counselors include information in their informed consent about their gift policy and request that clients make donations to a worthy cause instead. Some agencies have policies that state their employees may not receive gifts. The problem is that clients do not always follow our policies

and instead, follow cultural norms, such as bringing a gift when the counselor has a baby. Some counselors may be comfortable accepting gifts such as food or homemade items but not items that have a high monetary value.

What is important in managing this boundary issue is to have established guidelines that have been reviewed for ethical and clinical appropriateness and take into account the profile of the clients being served. An example of a client profile that might preclude accepting gifts is court-ordered clients. The gift could be seen as a bribe for a good report to the judge. Any counselors who feel this way should refrain from accepting all gifts from this client population.

- Clients can cross boundaries in the helping relationship. Some clients have histories of being violated or were raised in families where personal boundaries were not valued. They may act out some of this in the treatment process. Codes of ethics and the courts have clarified that even if a client initiates a dual relationship, it is the responsibility of the professional to assess the possible harm of this and to maintain the integrity of the counseling relationship. In other words, professionals cannot defend their actions of engaging in a dual relationship by stating that the client was the one who started the social relationship.

- One of the characteristics listed in the table that differentiates friendships from therapeutic relationships is that the counselor offers objectivity. If the helping professional becomes involved in another relationship with the client, her objectivity as a treatment provider can become compromised. For example, if a client becomes an employee, the counselor has a different kind of emotional investment now because the client is doing something for the counselor. It could be in the client's best interest to accept a job offer and re-locate; but the counselor, as employer, may have difficulty remaining objective or supporting the client's autonomy

- This leads to another important characteristic of a helping relationship; focus on the client's needs. "Certified counselors are aware of the intimacy in the counseling relationship and maintain respect for the client. Counselors must not engage in activities that seek to meet their personal or professional needs at the expense of the client." (Section A; 8)

  Once a professional enters into another type of relationship, as in the previous example of an employee, she is at risk of placing personal needs ahead of client's needs. The nature of a personal relationship is mutuality, so a shift would occur from focusing on the client to mutual needs. For example, the client has been hired to renovate the counselor's office but in counseling sessions it becomes clear that the client's depression is increasing and there is a need for inpatient services. The counselor's need to have the renovation project continue vs. the client's need for services would be in conflict.

- Conflict of needs can lead to exploitation of the client. As previously mentioned, this is the main concern with dual relationships. The client/counselor relationship is seen as a hierarchical relationship where there is an imbalance of power. Anytime there is this type of imbalance in a relationship, there is the potential for abuse and exploitation. In one of the previous examples, the counselor who has hired the client may delay sending this client for needed treatment in order to get the office renovation completed. This is exploitation. Other examples are counselors using client information for self-promotion and/or to increase income such as writing a book with a client; getting free legal advice from a client who is an attorney; asking a client to provide special favors, such as a client who works in a bakery bringing free baked goods.

- One of the other abuses that can occur is the violation of confidentiality. Privacy is another essential aspect of the helping relationship that contributes to treatment effectiveness. If a counselor enters into a social relationship with a client, it may be difficult to monitor which personal information was disclosed within the professional relationship and which was disclosed in the other relationship. As shown in the table comparing the two types of relationships, there are no ethical or legal obligations to keep information confidential that is discussed in social relationships. This would also be a concern in relationships with former clients as there is no time limit on how long a professional must maintain the principle of discretion.

Writers in the field of professional ethics disagree regarding guidelines for dual relationships. Kitchener (1988) believes that therapists cannot accurately predict or monitor all the factors inherent in a dual relationship and therefore should avoid them completely as a client welfare concern. Herlihy and Corey (1992) believe that dual relationships should be reviewed on a case- by- case basis and that to take a rigid position about these relationships is not realistic, especially when considering cultural issues such as those encountered when practicing in rural areas or small communities like a military base.

Questions to consider:

1. Have you engaged in a dual relationship? What were the reasons? What was the outcome?
2. If you have not engaged in a dual relationship do you see any positive reasons that you might do so with your current client population?

In conclusion, obviously practitioners need to monitor this area of ethical practice. If a pattern develops where a counselor is frequently involved in dual relationships, this would be of concern. A standard of practice should exist in the community and agency regarding guidelines for any type of dual relationship.

Ethical dilemmas with nonmaleficence: Sexual Relationships

To continue with the discussion of boundary violations, one of the most harmful is sexual conduct between a helping professional and a client.

"Sexual exploitation exists on a continuum that begins with poor judgment, proceeds to covert exploitation, and ends with overt sexual exploitation." (Benowitz, p. 73)

"Sexual intimacy with clients is unethical. Certified counselors will not be sexually, physically, or romantically intimate with clients; and they will not engage in sexual, physical, or romantic intimacy with clients within a minimum of two years after terminating the counseling relationship." (Section A; 10)

Pope (1990) did a review of the research regarding therapist/client sexual conduct and discovered the following issues that clients have difficulty with after the sexual contact:

(1) ambivalence
(2) guilt
(3) emptiness and isolation
(4) sexual confusion
(5) impaired ability to trust
(6) boundary disturbance and diffusion of identity
(7) emotional lability
(8) suppressed rage
(9) increased suicidal risk
(10) cognitive dysfunction in the areas of intrusive thoughts, flashbacks and nightmares

This list clearly indicates that sexual conduct with a client is in violation of the principle of non-maleficence. Some of the symptoms are those associated with a diagnosis of post-traumatic stress syndrome which would indicate that this sexual contact with a professional is experienced as trauma by some clients. So what type of professional would engage in what is clearly harmful behavior with a client?

Bates and Brodsky (1989) state: "The best single predictor of exploitation in therapy is a therapist who has exploited another patient in the past" (p. 141).

Schoener and Gonsiorek (1989) interviewed counselors who had admitted to being involved sexually with clients. They analyzed their responses and developed profiles which explain the counselors' actions:

- Uninformed/naïve. Someone who has not been trained.
- Healthy/situation breakdown. Someone who is reacting to a stressful situation and acts out one time.

- Neurotic/socially isolated. Someone with chronic problems and who is over-invested in role as counselor. Sexual behaviors become a part of the intense emotional involvement in the therapy.
- Impulsive/compulsive character disorder. Someone who is careless and has poor judgment. Could also sexually harass staff members as well as clients.
- Sociopathic/narcissistic. Someone who is self-centered and exploitive. Typically a repeat offender who avoids accountability and blames the client for what occurs.
- Psychotic/borderline. Someone whose orientation to reality is questionable. They may accumulate power and develop "therapy cults" before detected, or they may be easily detected because of bizarre thinking and behaviors

Pogrebin, Poole and Martinez (1992) reviewed cases adjudicated by the Colorado State Grievance Board involving psychotherapists who had sexual misconduct charges. In their article they quote responses of these psychotherapists. Some of these quotes are offered here to illustrate the profiles identified by Schoener and Gonsiorek.

- "I did not know that seeing clients socially outside of therapy violated hospital policy." p. 237. (Uninformed/naïve)
- "I was in the worst depression I had ever experienced in my entire life when we began our sexual involvement." p. 241 (Situation breakdown)
- "The following situations are not represented as an excuse for my actions…They are simply some of what I feel are circumstances that formed the context for what I believe is an incident that will never be repeated: 1. My mother-in-law who lived with us died. My oldest son and, the next fall, my daughter had left home for college. 2. I dealt with these losses and other concerns in my life by massive over-scheduling." P. 242 (Socially isolated)
- "I am firmly aware that my judgment at the time was both poor and impaired. I am also aware that my thinking was grandiose and immature…" p. 247 (Impulsive/poor judgment)
- "While my actions were reprehensible, both morally and professionally, I did not mislead or seduce her or intend to take advantage of her. My fault, instead, was failing to adequately safeguard myself from her seductiveness, covert and overt." P. 241 (Sociopathic or narcissistic)

This information is helpful in identifying some of the reasons sexual violations occur so that prevention strategies can be developed. Also for clinicians and supervisors who may be treating or supervising a counselor who participated in sexual misconduct, this can help with rehabilitation efforts. In conclusion, it is helpful to remember that every offender is not the same.

In addition to the information from Schoener and Gonsiorek another factor that should be considered in all dual relationship and boundary issues is transference and counter-transference.

Transference

Transference is the process in which clients project onto the therapeutic relationship feelings and attitudes that relate to other significant people in their lives, typically authority or intimacy/attachment figures. It can represent a repetition of past conflicts, or it could be a current pattern. One example of a current issue is a client whose father abandoned her family. Every time the counselor is late for an appointment, the client is in crisis, believing the counselor has abandoned her. Clients may experience many reactions to their counselors, such as, love, anger, fear, dependency, shame, hurt. Transference reactions are typically a projected image or experience and not something that has really occurred.

One possibility of what may occur in boundary violations in the client/counselor relationship is that professionals fail to treat these transference reactions as projections from the client's life experiences, and instead, take them personally, thereby acting on them. (Edelwich and Brodsky, 1991).

It should be noted that clients' reactions are not always based on transference. They may be responding to a professional's behavior. For example, a therapist who is always late for appointments may get anger reactions from a client. It would be important to distinguish this reaction from the transference pattern previously mentioned.

Watkins (1983) identified patterns of transference in counseling. The following is a discussion of these patterns and their ethical implications.

1. Counselor as ideal. The counselor is perfect and can do no wrong. The counselor is placed on a "pedestal" by the client.

   Ethical issues. The counselor accepts this idealized image and believes he can make no mistakes. This could prevent him from seeking consultation when needed. This could also lead to a cold distancing in the therapeutic relationship and escalate a client's shame issues. When the counselor does make a mistake or act human, the client could then have an extreme reaction, such as leaving treatment prematurely or rage.

2. Counselor as all-knowing. The counselor is the expert and has more knowledge than the client or any significant person in the client's life.

   Ethical issues. If the counselor accepts this role of "all-knowing", it undermines the client's self-efficacy and violates the ethical principle of autonomy. It also undermines the client's support system and could create a dependency on the therapist that could be harmful. As in the above example, when the therapist acts human; e.g., doesn't have the right answer; the client can have an extreme reaction.

3. Counselor as nurturer. The counselor is seen as the nurturing parent and the client acts as helpless/dependent child.

   Ethical issues. Counselors can offer nurturing to clients without doing anything unethical. The concern would be if nurturing is all that is offered and the counselor gets stuck in this transference pattern. Clients often need other types of interventions that may not feel so nurturing such as directive approaches. A counselor caught in this transference pattern would not be able to provide the full range of clinical interventions to meet the client's treatment needs. Again, if the counselor does try another approach, the client could have extreme reactions.

   The counselor is also in danger of creating dependency by being the sole source of nurturing for the client. Principles of autonomy and beneficence could be compromised.

4. Counselor as frustrator. The counselor does not respond in ways that the client demands, either covertly or overtly. The client becomes frustrated and tests the counselor's limits with behaviors such as defensiveness, confrontation, and/or complaints.

   Ethical issues. The counselor who has a need for approval may have a difficult time with this pattern and attempt to meet the client's demands, even if ill-advised. At the other extreme, the counselor may react to the client's defensive and become defensive as well, possibly escalating the problem. In either response, the client's treatment needs will not be adequately addressed. These responses could also compromise the counselor's competency.

5. Counselor as non-person. The counselor is perceived as non-human, without needs or problems.

   Ethical issues. The counselor who needs feedback and emotional connection with clients may have difficulty with this pattern. Reactions may be to move too close to the client in order to get more of an emotional reaction thus crossing a boundary. The other response might be to distance further from the client. Either of these reactions can damage the therapeutic relationship. Clients may act abusively towards the counselor, perceiving him as an object. A counselor could react in unethical ways to this abuse. Again, when the client does realize the counselor is human, an extreme reaction can occur which could disrupt treatment.

Case:
Please review this case scenario again.

You are a licensed counselor in a college counseling center. Donna, a sophomore, has been sent to you from the Dean's office for an evaluation regarding her mental health status and whether she can make it through the academic year. She is currently on academic probation. Your evaluation reveals that she has a diagnosis of major depression and post-traumatic stress because of a recent sexual assault and is in need of services. You recommend a psychiatric evaluation for medication in order for her to succeed with her classes. When you discuss the results of the evaluation with Donna, she becomes upset. She refuses to sign a release for you to give the Dean a copy of your evaluation because she says "the Dean will think I am crazy and call my parents. Then my parents will make me leave school". Donna says she will see you for counseling but refuses to see a psychiatrist.

Questions to consider:

1. Identify the possible transference patterns
2. The first time you read the case you were asked to list your personal reactions to this client. Please review those as an introduction to the concept of counter-transference.

Counter-transference

Since this is a relationship, clients are not the only ones with reactions. Counselors' reactions could range from just having a bad day to personal issues or to responding to a client's transference. Counter-transference is a process where the therapist projects onto the client emotional reactions either from the therapist's own issues or in reaction to a client's projection. Counter-transference is not necessarily unethical. Counselors will have many reactions to clients and many of these reactions are normal and appropriate. Counselors who are not aware of their counter-transference can engage in ethical misconduct.

Pope and Tabachnick (1993) surveyed three hundred females and three hundred males who were members of the American Psychological Association. The survey asked about emotional reactions to clients. Two hundred and eighty-five responses were received.

Some of the findings were:

- 97.2% reported feeling fear about clients
- 46% reported feeling so angry with a client that they had done something they regretted
- 87.5% reported feeling sexual attraction to a client
- 57.9% reported experiencing sexual arousal while with a client

The authors state: "In summary, the findings are a reminder of the intense, exciting, complex, stressful, and sometimes dangerous work that psychologists do and that the responsibilities of that work are not the sort that can be carried out in an unfeeling manner." (p. 151)

These findings suggest that professionals do have counter-transference reactions and these reactions raise ethical concerns. If counselors are feeling fear about a client, how effective would they be in their treatment approach?

Sexual attraction to a client is not unethical but the manner in which it is addressed can be. 65% of the psychologists in the study reported that their training did not prepare them for handling sexual attraction issues. This lack of training raises ethical concerns.

Reactions to clients can be a positive or a negative element of the therapeutic relationship. A counselor who is aware of counter-transference and uses supervision/consultation to assist with this process, may learn valuable information that improves their effectiveness with a client. For example, a client who provokes certain negative responses from a therapist may also be doing this in his other important relationships. Utilizing this counter-transference information could assist the client in making changes so that these other relationships become more positive.

Negative counter-transference can be seen as when a therapist's own needs or reactions interfere with the therapeutic process. This can cause loss of objectivity, compromise competence and weaken professional boundaries, all of which are ethical concerns previously discussed and relate to the issues regarding dual relationships. Therefore it is of clinical and ethical importance for helping professionals to be knowledgeable about and aware of possible counter-transference patterns.

- Overprotective with clients: Referring back to the survey, this pattern can develop in counselors who have fears regarding clients' abilities to make good decisions. It is sometimes appropriate to have fears about clients who are engaging in risky behaviors. The distinction here is that this would be a pattern in the counselor's relationships vs. an appropriate clinical response to a specific behavior.

  In this pattern, clients are treated as fragile, helpless, and unable to function.

- "Nice guy": These are counselors who need to be seen as a good person. In this pattern, difficult issues in therapy are avoided as the counselor does not want to upset the client. Therapeutic objectivity and professional boundaries eventually disappear and the sessions become friendly conversations.

- Over-identification: This pattern can develop in professionals who work with a client population that have many of the same characteristics or life issues as the counselor. For example, a social worker in recovery from addiction who specializes in working with clients who have been diagnosed with addiction. Some identification with clients is necessary for development of a positive therapeutic relationship in that it promotes empathy and positive regard. This

pattern is when a professional over-identifies to the point that objectivity is lost, such as, a client is told how to do something based on how the counselor did it without considering if this course of action meets the client's needs. Over-identification can also manifest when professionals see traits in clients that they dislike in themselves. This pattern could lead to distancing from clients or other acting-out such as being so angry the professional does "something regrettable. "(quote from the Pope survey)

- "True love": This is the pattern of believing that the feelings between the client and the helping professional are romantic feelings. This pattern can lead to sexual misconduct on the part of the professional. All codes of ethics forbid sexual relationships with current clients and vary regarding length of time post-treatment when it can occur with past clients. Even then, the research indicates that a percentage of helping professionals still engage in sexual relationships with clients suggesting that this pattern of counter-transference does occur. (Pope, 1990)

  Information has already been covered regarding possible profiles of counselors who engage in sexual misconduct with clients. In addition, this pattern of counter-transference along with some of the others discussed may help explain why this boundary violation occurs.

Questions to consider:

1. Do you identify any of these counter-transference patterns in your own work? If so which ones? Please discuss with a trusted colleague or supervisor

Simon (1995) reviewed cases of therapists who had been charged with sexual misconduct by clients and identified specific behaviors and a pattern that occurred in these cases:

- Counselor's neutrality gradually decreases
- Sessions become less clinical/more social
- Client is "special"
- Counselor touches client, leading to embraces
- Extra sessions occur
- Counselor manipulates transference
- Sessions are scheduled for the end of the day/sessions become longer
- Counselor stops billing client
- Counselor and client have dinner after sessions/dating begins

Again, the concern here is that this becomes a pattern. There may be times when extra sessions are needed for a client who is in crisis, etc.

One of the ethical dilemmas professionals can encounter is the situation where a current client accuses a former treatment provider of sexual misconduct. Part of the dilemma is whether or not to believe the client. It may be difficult to believe that colleagues would harm clients or engage in unethical behaviors. Some of the information in this course may be helpful in assessing the situation; for example, if the client describes some of the behaviors listed in the pattern identified by Simon. It is also important that clients' experiences not be discounted and under-reported.

As discussed in Schoener's (1989) research, there are offenders who will re-offend if not sanctioned. Another part of the dilemma is the implications for the current therapeutic relationship regarding boundary and transference concerns. Adding to this dilemma, professionals are ethically, and in some states may be legally, obligated to report this type of accusation. Often clients in these situations refuse to sign written consent forms to speak with the former therapist or to speak with the appropriate authorities. This is another example of where professionals will need to utilize an ethical decision making process because of all of the clinical and ethical issues involved.

As mentioned previously, clients can violate the boundaries of the professional relationship. Edelwich and Brodsky (1991) suggest that professionals should have guidelines for how to respond to clients who make sexual suggestions or advances. They caution against ignoring this behavior in the therapeutic relationship. Their suggestions are:

- Don't be rejecting of the client: express non-sexual caring
- This is an opportunity to re-set clear limits about the nature of the professional relationship and stick to them

- Don't be drawn into personal discussions that could lead to mixed messages. For example, " If you were not my client I would go on a date with you". This is confusing to the client and implies a future romantic involvement.
- Do confront the issue in a straight forward manner
- Do seek consultation/supervision and acknowledge your own feelings there: not with the client
- Do not refer out unless advised to do so by supervisor

Sexual Relationship with Former Clients

As seen previously in the NBCC code, there is permission for a sexual relationship after a two year period. However, the responsibility still rests with the helping professional to examine specific factors with regard to non-maleficence. It is considered unethical to terminate a counseling relationship for the purposes of beginning a sexual relationship even if the counselor waits for the two years. All ethical and legal obligations still exist even after a two year period.

The following guidelines were adapted from the work of Gonsiorek and Brown (1989). They stated that sexual contact with former clients should **never** be considered under the following conditions:

- After long-term therapy where there was a clear imbalance of power
- With severely disturbed clients
- With clients with a history of childhood abuse
- When post-termination contact is initiated by the therapist
- When the therapist has not obtained an independent consultation
- When there is any risk of harm to the client

The American Psychologist Association states: "Because sexual intimacies with a former therapy patient or client are so frequently harmful to the patient or client, and because such intimacies undermine public confidence in the psychology profession and thereby deter the public's use of needed services, psychologists do not engage in sexual intimacies with former therapy patients and clients even after a two-year interval except in the most unusual circumstances. The psychologist who engages in such activity after the two years following cessation or termination of treatment bears the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated, (2) the nature and duration of the therapy, (3) the circumstances of termination, (4) the patient's or client's personal history, (5) the patient's or client's current mental status, (6) the likelihood of adverse impact on the patient or client and others, and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a post-termination sexual or romantic relationship with the patient or client. (4.07)"

This section although applicable only to psychologists is a good guideline for all counselors in considering the many factors that should be considered with regard to sexual relationships with former clients. The psychologist's code refers to how this behavior not only has potential to harm an individual client, but how it can also undermine society's opinion of psychologists and thus impact access to services for future clients. This relates back to the concept that helping professionals are members of a moral community and one person's behavior can impact many people. One psychologist or counselor who engages in a harmful relationship with a client, potentially harms other professionals and clients.

In addition, these codes state that professionals cannot offer services to someone with whom they have had a sexual relationship in the past. Therefore, if a counselor engages in a sexual relationship after a two-year period with a client, that person will not be able to access treatment with their former counselor. The client- counselor relationship transforms into a personal, mutually beneficial relationship. This is an informed consent issue that would need to be discussed with the former client as it is denying access to future services. Again it is the professional's ethical obligation to ensure that the client understands the impact this new relationship will have on their former professional relationship.

In concluding this section on ethical principles, all of the issues that have been discussed apply to ethical conduct with a former client . Some professionals believe that there is no end to the counselor/client relationship "Neither transference nor the real inequality in the power relationship ends with the termination of therapy…Similarly, pragmatic efforts to define a post-termination waiting period, after which sexual relations might be permissible, disregard both the continued inequality of the roles of the therapist and former patient and the timelessness of unconscious process… (Herman, Gartrel, et al. 1987, p. 168)

Case Analysis
Throughout this section on ethical principles, a case scenario was offered for consideration in applying some of the concepts. Here is a brief overview of some of the issues to consider.

The principle of autonomy could be upheld by discussing with the client her options and the pros and cons of communication with the Dean. It could be that Donna is needing more informed consent with regard to what the Dean will or will not do with your evaluation. The counselor cannot release the information without the written consent; so if Donna continues to refuse, the counselor will need to decide whether to provide services or not. Denying access to services because of refusal to follow the evaluation or sign a release could be seen as denying access to services. It would need to be clearly stated as a policy of the counseling agency that staff reserve the right to refuse services in these situations. Clarification in the informed consent about client loyalties is also important. Is Donna the client ?

In the area of competency, it is possible that the counselor is not trained to assess or work with clients who have had a traumatic experience. A license does not guarantee competency in all areas. Donna has agreed to continue to see the counselor but not the psychiatrist, which adds more dilemmas regarding client welfare and whether the counselor is offering the best treatment. A counselor is not competent to provide a psychiatric evaluation and again that would need to be discussed with the client as part of the decision-making. Whether the counselor is receiving supervision in these issues would also be a competency concern.

Possible transference patterns are that Donna sees the counselor as “frustrator” and not meeting her needs/expectations. Possible harm could occur if the counselor reacts defensively or argumentatively and asserts his/her therapeutic power in an abusive manner or acts in a parental, authoritarian manner. The counselor could let this reaction influence decision making and decide it is in “Donna’s best interest” to get a report to the Dean in spite of no written consent.

Ethical Decision-Making

All of the sections of this course are components that comprise an ethical decision making process for helping professionals. Although this is a concept discussed throughout the literature on professional ethics, there has not been enough research on any one model to validate efficacy. Cottone and Claus (2000) offer a review of various models. Some of those will be discussed in this section.

The American Counseling Association offers a model developed by their ethics committee (Forester-Miller and Davis, 1996). This model is based on Kitchener's (1984) principle ethics discussed in the previous section. She named this the critical-evaluative process for justifying an ethical decision. Forester-Miller and Davis provide seven steps as guides in the process.

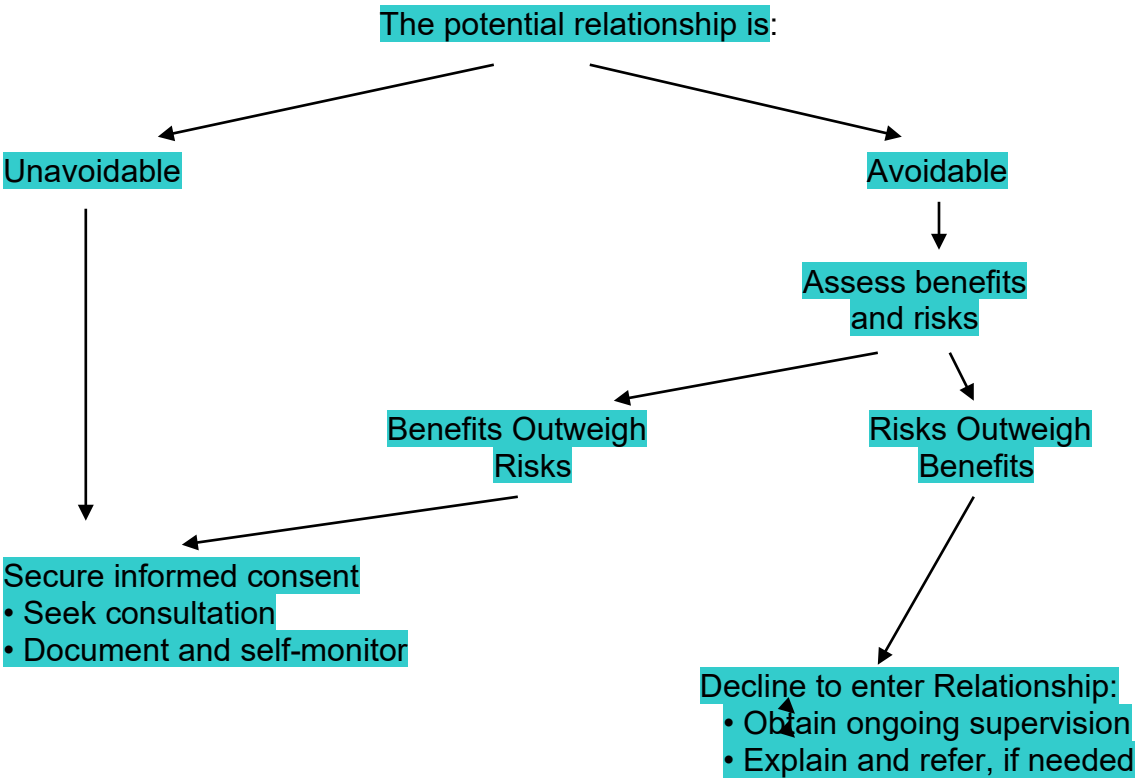
1. Identify the problem
2. Apply the ACA Code of Ethics
3. Determine the nature of dilemma
4. Generate potential courses of action
5. Consider potential consequences, determine course of action
6. Evaluate selected course of action
7. Implement

Other than Kitchener, no theory or research is available regarding the effectiveness of this model. Forester-Miller and Davis also cite Van Hoose and Paradise (1979) who offered these guidelines for ethical practice:

- Maintain personal and professional honesty
- Coupled with the best interests of clients
- Without malice or personal gain
- With justification that these actions are his/her best judgment.

In reviewing the section on ethical theory, Kitchener's model is principle based and adheres most closely to utilitarianism (consequences). Van Hoose and Paradise's model is based on virtue ethics. The ACA model is a combination of the two and is perhaps best interpreted as a standard of practice to utilize if a professional is a member of this association. (ACA)

Another model in the American Counseling Association literature has been developed by Herlihy and Corey (1992) specifically for the issue of dual relationships. They suggest that when a professional encounters a dual relationship, the following model could be helpful in responding:



(p. 231) This is another model that is based on utilitarianism theory.

Rest (1984) introduced a model based on the research of Kohlberg (1969, 1980), previously discussed in the section on moral judgment. This is a process for deciding on a moral course of action. This is not based on virtue ethics or principle ethics; rather a moral reasoning process.

1. Interpret the situation in terms of how one's actions affect the welfare of others
2. Formulate what a moral course of action would be and identify the moral ideal in the situation
3. Select among competing outcomes, the one to act on
4. Execute and implement

Rest summarized this model as: Moral Sensitivity, Moral Reasoning; Moral Motivation; Moral Character.

Moral sensitivity is the process of recognizing that a situation involves the welfare of others. For example, a helping professional discussing a client's case with another professional at a dinner party is someone lacking in moral sensitivity.

Moral reasoning is the process of deliberating the alternatives in the moral situation and making a decision about the best course of action. This part of

Rest's model relates to Kohlberg's and Gilligan's research discussed earlier on realizing that people have different developmental stages of moral reasoning. This would impact this part of Rest's theory. Following the example of the professional at the party, one therapist in this situation may reason that no harm was done since the client won't know it happened. Another therapist in the same situation may be upset about her behavior and seek advice from a supervisor.

Moral motivation is the process of deciding whether to carry out the moral alternative selected. This is where the values and reactions of the professional can impact Rest's theory. Continuing with the professional who has discussed a client at a party, this person has decided the best moral action is to advise her supervisor. However, she is afraid of the supervisor's response because it could lead to sanctions or loss of job. This could prevent the therapist from acting in the moral motivation stage of this theory.

Moral character is the process of implementing the moral action. This is where Rest's theory coincides with virtue ethics theory. He suggests that professionals need character to be able to follow through with the identified moral action. In the example discussed, this professional would need the virtue of courage to proceed. This model is described here because it is frequently cited in the ethical decision-making literature for psychologists.

Another model, which has been adopted by the Canadian Psychological Association, is offered by Tymchuk (1986). His process is based on utilitarianism and involves the following steps:

1. Determine stakeholders
2. Consider all possible alternatives
3. Consider consequences for each alternative
4. Balance risks and benefits to make the decision
5. Decide on level of review
6. Monitor the action and outcome

Challenging models based on principles or moral reasoning, Betan (1997) offers a hermeneutic perspective to ethical decision making. In this approach, the professional takes steps to gain awareness of ethical dilemmas within a personal and cultural context.

He emphasizes the need to take into account the subjective, shared experiences of the counselor, client and society. His model fits with the theories of ethical relativism and ethical pluralism.

Tarvydas (1998) integrated the work of Rest and Kitchener. Her recommended steps are:

1. Interpret situation
2. Review problem or dilemma

3. Determine standards that apply to dilemma
4. Generate courses of action
5. Consider consequences for each course of action
6. Consult with supervisors or peers
7. Select an action by weighing competing values within a context
8. Plan and execute the selected action
9. Evaluate course of action

Practitioners may have an ethical decision-making model recommended by their professional association or by an ethics committee in their work environment. This section is offered to help evaluate current models and understand the theories and values inherent in these models. For those helping professionals who don't have a model, it is suggested that this information be used to develop one that is appropriate for current practice.

Pulling it all together: Case Practice

Three scenarios are offered to practice applying an ethical decision-making model along with all of the information discussed in this course.

First identify the model and code of ethics that fits with your professional identity.

<u>Case One: Ann</u>

Ann is a licensed social worker working in a public mental health agency. She runs a group for women recovering from addiction who have histories of abuse, and the group has been going for three years with clients coming in and out. Ann has recently become pregnant and although she rarely self-discloses, she told the clients in the group so they could start preparing emotionally for her pregnancy leave. When Ann comes to the next group meeting, one of the women has brought her a knitted blanket for the baby. Another woman offers her a wrapped gift for the baby. The three women who did not bring gifts ask Ann what else she needs to get ready.

1. Consider your ethical decision making process.
2. If you were Ann, what would you do and why?
3. What is the primary ethical principle in your decision? Primary value?

<u>Case Two: Sonya and John</u>

Sonya is a counselor in a private agency who provides intake assessments on anyone trying to access treatment. She is a trainee under supervision for her license as a professional counselor. She is the only intake counselor at the agency today when John comes in asking for services. Sonya realizes John is a boyfriend from college three years ago. They dated off and on and were physically intimate a few times.

John recognizes her and says he is really desperate for services as he has been depressed for the past year, having trouble sleeping and not able to hold a job. He comments that he is relieved to see “a familiar face” so that he doesn’t feel so bad talking about all of this. Sonya tries to contact her supervisor for advice but he does not respond to the cell phone call.

1. Consider your ethical decision making process.
2. What would you do if you were Sonya?
3. What is the primary ethical principle in your decision? Primary value?

Case Three: George

George is a licensed psychologist who provides family therapy in his private practice. His son, a freshman in college, wants to go with his girlfriend’s family to the beach for spring break. George says he would like to meet the girlfriend and her parents first before making a decision. They arrange a dinner meeting in a restaurant. When George arrives, he recognizes the family as former clients. He remembers that Leah had been in trouble with the courts for smoking pot and that he had been concerned about possible violence in the home. The family does not acknowledge that they know George. Afterwards, George’s son asks if he can go with the family for spring break.

1. Consider your ethical decision making process.
2. What would you do if you were George?
3. What is the primary ethical principle in your decision? Primary value?

Conclusion

This course has offered an overview of ethical theories, principles and decision-making models that will hopefully provide helping professionals with resources to address many of the ethical concerns that occur in their practice. The goal is for practitioners to be able to integrate ethical and clinical practice in a way that fits with their treatment environment and client population. When ethical dilemmas occur, a model can be utilized to assist professionals in sorting through these more complex concerns. The final section of the course offers references and resources for those who want more detailed information in specific areas.

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Appendix A: Post Test and Evaluation for Ethical Decision Making for Counselors

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

> *Submit your test via the Internet.* All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:
>
> http://www.ceumatrix.com/studentcenter
>
> Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.
>
> To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.
>
> NOTE: THE QUESTIONS AND/OR ANSWERS MAY BE IN A DIFFERENT ORDER ON THE ONLINE EXAM.
>
> If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

If you have any difficulty with this process, or need assistance, please e-mail us at **ceumatrix@ceumatrix.com** and ask for help.

Answer the following questions by selecting the most appropriate response.

1. All of these are ethical theories except:
    a. Contract theory
    b. Ethical relativism
    c. Principle or conscience orientation
    d. Virtue ethics

2. One of the values that is part of the postmodern therapeutic approaches is:
    a. context and diversity.
    b. moral vision
    c. correcting societal inequities.
    d. self-determination of individuals.

3. The difference between mandatory ethics and aspirational ethics is:
    a. all practitioners follow mandatory ethics.
    b. mandatory ethics are reactive; aspirational ethics are proactive.
    c. mandatory ethics are minimal standards; aspirational ethics are ideal.
    d. All of the above.

4. A professional practicing the ethical principle of autonomy would:
a. discuss informed consent
b. refuse to treat a client if there was a values' conflict
c. provide only individual counseling.
d. practice a cognitive behavioral approach

5. Beneficence is the ethical principle:
a. that supports client welfare
b. that supports distributive justice.
c. that supports self-efficacy of the client.
d. do no harm

6. Duty to warn is:
a. the ethical principle of do no harm.
b. the legal responsibility of the professional to prevent a client from harming himself/herself.
c. the ethical principle of discretion.
d. the legal responsibility of the professional to contact a third party who has been threatened by a client.

7.An ethical dilemma with competence would be:
a. treating a client without doing informed consent
b. refusing to testify in court
c. treating a client you have not been trained to treat
d. All of the above.

8. The ethical principle of justice requires that:
    a. professionals do no harm.
    b. professionals practice non-discrimination.
    c. professionals maintain competence.
    d. professionals practice discretion.

9. The primary ethical concern with regard to dual relationships is:
    a. being charged with fraud by third party payer
    b. discrimination.
    c. exploitation of the client.
    d. loss of credentials

10. According to Bates and Brodsky's research, the best single predictor of exploitation in therapy is:
    a. a beginning, untrained therapist.
    b. a therapist who has exploited another patient in the past.
    c. a therapist without adequate supervision.
    d. a therapist who lacks self-awareness; needs own therapy.

11. Need to know guidelines are part of the principle of:
    a. discretion
    b. beneficence
    c. justice
    d. competence

12. Ethical guidelines for counselors in using technology include:
    a. do not use email to communicate with clients
    b. include information in the informed consent about how you communicate with clients
    c. fax only non-clinical information
    d. do not use provide counseling via the internet

13. Codes of ethics are based on principles.
    a. True.
    b. False.

14. Whereas morals apply to any member of the culture, a code of ethics applies only to those members of the specific group.
    a. True.
    b. False.

15. One of the differences between a counseling relationship and a personal relationship is:
    a. personal relationship is mutual
    b. counseling relationship has ethical guidelines
    c. objectivity is expected in a counseling relationship
    d. All of the above

16. An example of a boundary crossing is:
    a. an accidental meeting with a client in the community
    b. sexual contact with a client
    c. touching a client without permission
    d. All of the above.

17. Boundary crossings are always unethical:
    a. True.
    b. False.

18. A counselor ‘s primary obligation is to respect the integrity of the client is an example of which principle:
    a. autonomy.
    b. beneficence.
    c. competence.
    d. discretion.

19. Autonomy is something that is valued by all clients, regardless of the culture in which they were raised.
    a. True.
    b. False.

20. It is important to clarify when someone becomes a client and when someone is no longer your client in order to follow which principle:
    a. competence.
    b. autonomy.
    c. professionalism.
    d. beneficence.

21. Which of the following would be an example of an unethical practice?
    a. Refusing to accept a client that you are not qualified to treat.
    b. Referring a client who presents additional issues in treatment that are outside your area of expertise.
    c. Failing to seek ongoing training and supervision.
    d. Advertising services that you are trained or qualified to provide.

22. Which of the following would be an example of “duty to report?”
    a. Reporting a client’s threats against you
    b. Reporting a client’s HIV status to a state health authority.
    c. Reporting a client’s child abuse or neglect.
    d. Reporting a client’s illegal drug dealing activity

23. Equal treatment of clients and equal access to treatment are part of which ethical principle:
    a. justice
    b. non-discrimination
    c. competence
    d. beneficence.

24. If a counselor provides treatment to someone they already have a relationship with, like a relative, friend or colleague, this is considered a dual relationship.
    a. True.
    b. False.

25. Sexual activity with a client would be a boundary violation.
    a. True.
    b. False.

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ETHICS, BOUNDARIES AND DUEL RELATIONSHIPS. PROFESSIONAL ISSUES FOR ADDICTION PROFESSIONALS

Welcome to the growing family of coursework participants at CEU Matrix - The Institute for Addiction and Criminal Justice Studies.

This distance learning course was developed for CEU Matrix by Diane Sherman, Ph.D. It is based on information found in NAADAC manuals on counselor codes of ethics dating from 2011 to 2017.

This course contains the NAADAC course materials, along with the post test and evaluation that are required to obtain the certificate of completion for the course. You may submit your answers online to receive the fastest response and access to your online certificate of completion. To take advantage of this option, simply access the Student Center at http://www.ceumatrix.com/studentcenter; login as a Returning Customer by entering your email address, password, and click on 'Take Exam'. For your convenience, we have also enclosed an answer sheet that will allow you to submit your answers by mail or by fax.

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About the Instructor:

Diane Sherman, PhD, MAC, CCS, CES-2, EFT-II is an organizational consultant and national trainer. She has worked in the substance abuse profession since 1975. In her consulting services, she has three specific areas of focus: coaching, consultation and continuing education. Dr. Sherman provides Executive Coaching for those persons seeking to maximize their leadership potential. She is a CARF surveyor and consultant for agencies seeking or maintaining national accreditation. Presently, she is responsible for monitoring substance abuse services for the Georgia Department of Juvenile Justice. Dr. Sherman also conducts continuing education opportunities with Brown University through the Northeast Addiction Transfer and Technology Center. Over her professional tenure, Diane has trained nationally for NAADAC, National Association of Drug Court Professionals, CARF, Southeast School of Addiction Studies, South Carolina Behavioral Health Services Association, Tennessee Advanced School on Addiction, and locally for Georgia Department of Human Resources, Georgia Council on Substance Abuse, and Georgia Addiction Counselors Association.

Using the Homepage for CEU Matrix - The Institute for Addiction and Criminal Justice Studies

The CEUMatrix – The Institute for Addiction and Criminal Justice Studies homepage (www.ceumatrix.com) contains many pieces of information and valuable links to a variety of programs, news and research findings, and information about credentialing – both local and national. We update our site on a regular basis to keep you apprised of any changes or developments in the field of addiction counseling and credentialing. Be sure to visit our site regularly, and we do recommend that you bookmark the site for fast and easy return.

ETHICS, BOUNDARIES AND DUEL RELATIONSHIPS. PROFESSIONAL ISSUES FOR ADDICTION PROFESSIONALS

This course is derived from 4 separate articles released by NAADAC over the last few years. Topics covered include:

- The necessity of revising NAADAC Code of Ethics
- Why the code of ethics is important and how it can help professionals facing challenging situations
- How ethical decisions can vary from one person to another
- Ethics don't always come naturally
- Dual relationships between counselor and client
- Curbing inappropriate actions between addiction professionals and patients
- The role of non-clinical staff
- The NAADAC code of ethics approved October, 2016
- How and when it is appropriate to file an ethics complaint

Article published by NAADC's News magazine. Vol 21, #3, August/September 2011 - Page 4

I wanted to get some background on why the NAADAC Code of Ethics were being revised, as well as the importance of the code to the profession. The Chair of the NAADAC Ethics Committee, Anne Hatcher, EdD, CAC III, NCAC II, was just the person to talk to.

Donovan Kuehn: Why was the code of ethics revised?

ANNE HATCHER: The NAADAC Ethics Committee is instructed to review the code of ethics and make revisions as needed every two years. Two years ago the committee recommended standards related to evaluation, assessment and interpretation of client data. The recommendations were made as a result of a request from a member who needed guidelines. A review of other codes of ethics found standards on evaluation, assessment and interpretation of client data while the NAADAC Code of Ethics did not address the issue. To the best of my knowledge, the recommendations submitted were not reviewed by the executive board and so the suggested change was not made. In early 2010, we were asked to review of the code of ethics and to make suggestions for revisions. The committee worked diligently comparing the NAADAC Code of Ethics to the codes of ethics of other professional organizations working with similar populations. In addition, some of the committee members made suggested revisions based on the experience of being asked to respond to ethical dilemmas and grievances. We found that the current code of ethics did not describe ethical standards in a clear manner that would support us in addressing some of the grievances.

Some sections of the recommended code were rewritten to fit with the situations most likely to face us in 2011 as compared with the situations that arose in 2008.

DK: Why is it important for professionals to have a code of ethics?

AH: A code of ethics is a statement of an organization's standards for professional behavior. All of us are likely to make mistakes in judgment unintentionally or when we are in stressful situations. The stated code of ethical standards provides a guideline for evaluation of the situations in which we find ourselves and helps us evaluate the choices that face us. Rarely is an ethical dilemma a clear choice between right and wrong. Usually it is a choice between rights; the code of ethics guides us in making a choice that more clearly fits the values of the profession and our own professional standards for behavior.

DK: How can the code of ethics help professionals who are facing challenging situations?

AH: When faced with a situation that the addiction professional finds uncomfortable or questionable, the code of ethics provides a standards with which the possible actions can be compared. As I said to your first question, the code of ethics provides a guideline for members of the ethics committee when responding to a grievance filed against a member or an agency holding NAADAC provider status. The revised code of ethics provides more detail than the previous one because, ethics committee members found themselves essentially saying "this person's behavior does not meet our concept of professional standards and the code of ethics has no statement relating to the decision we need to make."

Donovan Kuehn is the Director of Operations and Outreach for NAADAC and serves as the NAADAC News editor. He can be reached at dkuehn@naadac.org or www.facebook.com/ donovan.kuehn

Anne Hatcher is Chair of the NAADAC Ethics Committee. She can be reached at hatchera@mscd.edu.

When Personal and Professional Values Dance

Our Core Values Lead us on Our Professional Journey

Frances Patterson, PhD, MAC, BCPC

Do you ever consider why one person makes an ethical decision one way and another person arrives at a different decision? Some questions may come into play when an ethical situation arises.

Is this situation an ethical violation?
Do I need to report this situation?
Will I hurt my colleague if I report this?
How is this going to affect me?
Are there clients involved?

Dilemma: Marc, a Licensed Clinical Social Worker who works with eating disorders, was presenting a workshop at a national addictions conference. During the workshop many participants noticed that Marc appeared to be under the influence of either alcohol or other drugs. His behaviors indicated there may be some impairment. Marc completed his workshop and afterwards many counselors who attended it were talking among themselves about Marc. They expressed disbelief that he would "show up high" to present. None of them approached him to express their concern. As a result, gossip ran rampant throughout the conference.

What is the core value or belief that would prevent these counselors from approaching Marc and to perpetuate the gossip? When questioned about this one may hear many different answers.

"It's not my place to stick my nose in his business."
Possible belief: I don't have a right to question another person's behavior.

"I am not the ethics police."
Possible belief: I have a responsibility to monitor my own behavior, not his.

"I don't know if he is really impaired. It could be something else wrong."
Possible belief: I don't judge other people. It may embarrass him if I say something.

"I don't want to ruin his career."
Possible belief: I have to protect my colleagues.

"I don't know him. And I don't know if he is a recovering person. If not, doesn't he have a right to drink if he wants?"
Possible belief: People have a right to do what they want.

"This is a conference. He's not seeing clients here."
Possible belief: Even as professionals, we have a right to our personal lives.

Our core values and beliefs lead us on our professional journey. They determine our philosophies and choices, why we chose a career in addictions counseling, the modality we use, even the population we choose as our focus. Our values not only influence how we interact with clients, but also how we interact with other professionals and how we make ethical decisions. The situations that are absolute e.g. sex with a client, financial dealings with a client, etc. are the easy ones. It is the grey areas that make it difficult and where, often times, there is a conflict between personal values and professional ethics.

In the example above, personal values have kept these counselors from addressing an ethical concern. Although the individuals may not be aware of the belief underlying their hesitancy to confront Marc, there may be a conflict between personal values and ethical obligations. This brings us to our ethical obligations around impaired colleagues. Is Marc impaired? If he is in fact under the influence or impaired while teaching a workshop at a professional conference, there is definitely some level of impairment. His judgment, at the very least, is impaired. Is this any different then being under the influence at work? Would these same counselors confront a colleague who came to work in the same condition as Marc?

An impaired professional is obligated to seek help. The professional has a responsibility to determine if the problem is affecting his/her professional competency. Often, an impaired person cannot make this determination because of that very impairment.

Therefore, we as professionals have an ethical obligation to help our impaired colleagues obtain help. If we don't help them, who will? Would we offer them any less help and respect than we would an impaired client?

We are the gatekeepers of our profession. If Marc is not willing to seek help and he continues to be impaired, we have an obligation to report that ethical violation. Lack of reporting is a major issue in our profession. We have ethical and legal obligations to report violations that continue to be unresolved. Failure to report major ethical violations is a violation in and of itself. If Marc is also a licensed or certified alcohol and drug counselor, he may also be in violation of his licensure or certification requirements.

Do not assume that someone else will make the report relieving you of the responsibility. Remember, we are not in this alone. Talk with a supervisor or colleague. Seek support from others and document all aspects of the incident. When possible, speak with the person who is in violation. Make sure you have your facts in order. Then, if needed, make the proper report. You are not the one ruining that person's career. You are protecting clients, the community and our profession. Examine your values, beliefs and ethical obligations. When a conflict arises, make sure your decisions are ethically sound. Be true to yourself, your colleagues and your profession.

Frances Patterson, PhD, LADAC, MAC, BCPC, CCJAS, QSAP, QCS, received her bachelor's and master's degrees at Virginia Commonwealth University in the Alcohol and Drug Education Rehabilitation Program and doctorate in Clinical Psychology at California Southern University. In addition to being a licensed alcohol and drug counselor in Tennessee, she is a NAADAC certified Masters Addictions Counselor and Qualified Substance Abuse Professional. She has worked as a counselor and program administrator in treatment programs in Virginia and Tennessee over the past 23 years, is the owner of Footprints Consulting Services, LLC in Nashville, Tenn., serves as the chair of the NAADAC clinical issues committee and is a member of the Ethics committee. She can be contacted at frances@footprints-cs.com.

Additional Reading William White and Renee Popovits, Critical Incidents: Ethical Issues in the Prevention and Treatment of Addiction. Lighthouse Institute, Bloomington, IN 2001 Barton Bernstein, J.D., LMSW, and Thomas Hartsell, Jr., JD. The Portable Ethicist for Mental Health Professionals. John Wiley & Sons, New York, 2000

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Natural Ethics

Ethics Don't Always Come Naturally

Kevin Quint, LADC (Nevada)

Counselor ethics consist of principles and standards that govern how we conduct ourselves in our clinical work. Some of these principles include non-malfeasance ("do no harm"), beneficence ("do good"), client autonomy (freedom of choice, informed consent, etc.), justice (fairness) and fidelity (keeping your word to the client). These are all high plane ideals that are found in most professional codes of ethics. Ethical principles help us stay the course, so to speak, in our inter actions with clients.

This all sounds so natural and so uncomplicated. Just do the right thing. That will take care of all ethical concerns. Right? Not really…

You see, a common myth is that alcohol and drug counselors bring an intact and appropriate set of ethics with them to the job. Embedded in this myth is the wrong-headed notion that we all have common sense. Unfortunately, ethics don't always come naturally and they don't always coincide with everyone's version of common sense. That's not because counselors are inherently immoral. It's because ethics are not as simple as they seem. And in certain situations we just don't know what to do.

I'm pretty sure that the vast majority of alcohol and drug counselors don't need to be told not to sleep with a client. But what about that slippery slope that starts with an innocent hug that may lead to emotional and physical arousal and weeks or months later ends up in a sexual relationship between counselor and client? I'm also pretty sure that the vast majority of counselors in our field know that breaking client confidentiality is not only illegal but it is unethical. But what happens when you see a client in the grocery store or at church or in the park? How do you know what to do?

The examples could go on, but the point is that while ethical principles are often natural and intuitive, the practical application of those principles can be elusive and difficult.

Hugs aren't necessarily wrong, but how do you know when to hug and when not to hug? Saying "Hello" to a client or former client in the grocery store isn't necessarily wrong, but how do you decide what to say or if you should say anything at all?

I believe that these issues, and the questions surrounding them, point to the fact that not all aspects of ethics are clear to everyone and we sometimes need help in navigating what can be murky waters. The clarity we need can and should be developed through several avenues but particularly through the supervisory process.

Clinical supervisors need to be practitioners of high ethical conduct. Clinical supervisors need to be able to impart those standards to those under their charge, as well. I would go so far as to maintain that one of the most important roles of a clinical supervisor is to provide support, structure and accountability to their supervisees in the area of professional ethics.

That's my opinion, of course. But if clinicians entering the field are mentored by their supervisors in developing and exercising a strong sense of ethics, I believe that many complaints that come to licensing and certification boards would decrease dramatically. So what's a supervisor to do? Here are a few thoughts:

- Supervisors need to deeply care about ethics. This is really an issue of passion and attitude. It's contagious.
- Supervisors need to demonstrate ethics to those they work with. This isn't about "Do as I say, not as I do." Supervisors need to lead by example. I once investigated a complaint against an intern related to alleged sexual misconduct with a client. By the end of the investigation, I discovered that the agency leadership had set a poor ethical example for their interns to follow. The intern was still held responsible for wrongful behavior, but I believe that situation could have been prevented through exercise of ethical principles in leadership.

- Supervisors need to teach their supervisees the basic principles of ethics. This can take the form of in-service trainings, case review, and general conversation. This becomes an everyday process, both formal and informal. This training should include development of an ethical decision making model and other guidance on how to work through ethical dilemmas
- Supervisors need to understand the gravity of NOT infusing the highest ethical standards in their supervisees. I once supervised an intern who engaged in inappropriate behavior on social media with a former client who was also a minor. As a result, the counselor was discharged from employment. But the question I was asked by my boss was, "Did you do everything you could BEFORE the incident to ensure that this person knew that this was inappropriate and unethical behavior?" After a great deal of introspection and soul searching, I believe I had performed my duty, but I also realized that I could have been dragged into any lawsuit or complaint against this intern. My license is connected to all those who I supervise. That reality is never far from my mind
- Finally, supervisors need to carefully choose who they super vise. I used to have the attitude of "Come One, Come All." I thought I was obligated to take on whoever asked. One day, a colleague asked me why I agreed to supervise a particularly difficult person. The only answer I could come up with was, "Because he asked." I felt a little foolish and realized that I hadn't even considered this person's capacity for ethical and skillful clinical work.

I should confess that I used to think that ethics all come naturally. But doing the right thing isn't always as apparent as it seems. I encourage all treatment programs, practices, and clinicians to engage in learning, living, and breathing counselor ethics.

I'll agree that some aspects of ethics come naturally but overall ethics need to be learned and they need to be practiced. This will help us stay the course as we encounter various complex and difficult issues and dilemmas in our practice and in our efforts to help the people we serve.

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Dual Relationship

Problem or Part of our Practice

Anne S. Hatcher, EdD, CAC III, NCAC II, Chair, NAADAC Ethics Committee

"Just don't have sex with your client; following the ethical code is easy if you remember that rule." However, the "No Intercourse Rule" applies to far more than having sexual encounters with a client or with another person who holds lower status than that of a professional. "

The addiction professional understands that the goal of treatment services is to nurture and support the development of a relationship of equals of individuals to insure protection and fairness of all parties" (NAADAC Code of Ethic, Principle I, Standard 3, 2011). The primary goal when working with addiction clients is to support responsibility and change in the client's life and to encourage independence (Swenson, 1997). A dual relationship is interacting with others in such a way that it interferes with one's objectivity, professional judgment and/or conduct. A legal definition of a dual relationship might be maintaining relationships with clients that are likely to impair professional judgment or increase risk of client exploitation.

With this information in mind, the reader is asked to consider the unique relationships that might develop in addiction counseling. Typically the counselor is a person who has life experience abusing psychoactive substances and who is now in recovery. Clients and counselors might find themselves in the same 12-step meeting or at social events attended by addiction professionals as well as persons in recovery. In some cultural groups, interactions between clients or potential clients and professional counselors are a part of everyday life and not easily avoided. Small towns and rural locations provide even more opportunities for interaction between client and counselor in settings other than the treatment facility. Other options for multiple interactions are found through social networks and other online sites where personal and professional information is posted. How much information can a counselor post online before a boundary is crossed?

Some clients use search engines to find out where a counselor lives and organizations in which she/he is active. With some diligence, clients searching online might even learn about debts the counselor owes. In such situations, whose boundary has been crossed and is an ethics complaint appropriate?

For many years, legal and ethical standards have advised mental health/addiction counselors to avoid interacting with clients in any situation other than the clinical treatment setting. A shift in this thinking began in the 1990s. Increased recognition that some boundary crossings such as self-disclosure and non-sexual touching might be clinical valuable in specific situations altered the rules to state that a dual relationship must be therapeutically helpful to the client or clearly defined to minimize harm to the client. One author cited by Corey, Corey & Callanan (2011) noted that the goal of ethical decision-making is to minimize the potential for exploitation. Zur (2011) described a number of situations in which a dual relationship might be a problem and contrasted those situations with dual relationships that might actually enhance the lives of both client and counselor. On the helpful side, he noted that dual relationships in which the counselor and client have established agreed upon boundaries are more likely to prevent sexual relationships than to encourage them. A problem is very likely to occur if the counselor also works as an expert witness and is called upon to be an expert witness in a client's court case. Unexpected dual relationships can occur when a counselor is assigned to work with a client and then learns that the new client is the ex-spouse of a current client. In some situations and where boundaries are discussed and agreed upon, a dual relationship might facilitate recovery. Exploring the ramifications of being in a dual relationship and making a clearly thought out decision is recommended for addiction counselors. The following scenarios are included to help the reader think about situations in which he/she might find him/herself.

Identify the slippery slope in these situations where one or more actions might be interpreted as a dual relationship:

Case #1 Ed, an addiction professional, counsels recovering persons at a DUI treatment center. On weekends, Ed teaches workshops required for persons seeking state certification in Idaho. The Idaho state certification board is taking appli cations for a position that requires the employee to evaluate course work completed in other states and that is included in applications for certification in Idaho. Ed has submitted his application.

Case #2 Gregory is a contract counselor who facilitates groups in several treatment agencies. In one of his groups, there is a very attractive woman that he would like to know better. Gregory suggested that she drop out of his group and enroll in a group facilitated by Sandra that meets at the same time. Since the groups end at the same time, they can meet for coffee afterwards.

Case #3 Georgina supervises entry-level addiction counselors at an addiction treatment agency with ten offices scattered across a metropolitan area. One of her supervisees, Larissa, who has ten years of recovery, reported that she used cocaine once last week. Larissa immediately began attending Cocaine Anonymous (CA) groups and entered individual counseling. She asked Georgina to be her sponsor in CA so she does not have to reveal her plans to be a counselor to a stranger.

Case #4 Felix is enrolled in an online course required for state certification as an addiction counselor. Online students taking state certification courses must take each of the three exams at a testing site where a proctor is present. Felix lives in a small town more than 60 miles from the nearest test site so he has asked permission to have his employer proctor the exams.

Case #5 Betsy, MSW, MAC, is an addiction counselor at San Juan Pueblo. She grew up in this community and understands the culture as well as the problems with alcohol and drug use. Tribal members consider each other to be relatives and refer to them as brothers, sisters, cousins, aunts, uncles, grandmother or grandfather. The state certification board/grievance committee has received a report that Betsy is counseling her brother who was arrested for driving under the influence of marijuana.

Case #6 Constance is a community college addiction studies educator who has a small private practice where she counsels persons in recovery. One of her students enrolled in a class taught by Constance after being a client for a year. Constance is required to serve on a community board to meet the service requirements of her teaching position. She has applied to the governor's office to be a member of the state board that reviews applications for addiction counselor certification, monitors agencies that provide state required workshops, evaluates reports of ethical violations and updates educational requirements for persons who are pursuing state certification.

Case #7 Susie Q is a state certified addiction counselor who became a counselor after 17 years of prescription drug abuse, becoming sober and completing a bachelor's degree in addiction studies. Two weeks ago, Susie attended her cousin's wedding and the reception. She had several glasses of wine before starting her drive back home. A police officer stopped her for not coming to a complete stop at a stop sign. The officer completed a roadside sobriety test after smelling alcohol on Susie's breath. A breathalyzer test indicated a BAL of 0.06. Susie was court ordered to complete five alcohol education classes and to work as a receptionist rather than as counselor for eight months. Susie enrolled in alcohol education classes taught in a town 30 miles from her home. Last night Carl, the group facilitator, seemed tired.

Continuation of **DUAL RELATIONSHIP**
PROBLEM OR PART OF OUR PRACTICE
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He reported that he had been working overtime filling in for group facilitators who were on vacation. Susie suggested that she might be able to help him by facilitating a group or two in an office owned by the same agency and located in her home-town.

Case #8 Tracy has completed all course work for a doctorate in counseling. While taking courses, she has also worked with clients through the college counseling center. Her research for the dissertation was on the correlation between sexual trauma and alcohol abuse. The first draft of the dissertation has been written and reviewed by Tracy's advisor. He suggested that the document be read and edited by someone who has specific training in editing and who is not familiar with the topic of the paper. Among Tracy's clients at the counseling center is a student who is a single mother and who is always struggling to make ends meet. The client was an editor for The NY Times Sunday Magazine for 10 years prior to being laid off when the magazine decided to change its format. Tracy wants to offer the extra counseling sessions requested by the client for free in return for the editing assistance.

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Addiction Professional Magazine

SPECIAL SERIES: Treatment centers have capacity to lessen chance of sexual misconduct

by Alison Knopf, Contributing Writer

Leaders in the credentialing of addiction professionals insist that treatment facilities can wield influence in stemming inappropriate sexual behavior by staff—incidents that are under-reported and damaging to organizations' reputation and bottom line.

"If [clinical] supervision was more centered around the ethics of those counselors, we would see a decrease in the number of ethics complaints," says Mary Jo Mather, executive director of the International Certification & Reciprocity Consortium (IC&RC), representing credentialing boards. "I can't tell you the number of times I get a call from a counselor who's asking me about an ethics question, and they never thought to ask their supervisor. There's something wrong with that."

Supervisors need to be aware of issues surrounding inappropriate actions toward patients, and not help treatment program administrators sweep them under the rug, says Patterson. One problem, she says, is that schools no longer are teaching about transference and countertransference, the phenomena in which a patient views the therapist as representing someone important in his/her life (such as a mother or husband) and the therapist in turn projects some feelings onto the patient.

Many addiction counselors come out of school thinking they're supposed to be a robot, says Frances Patterson, a member of the ethics committee for NAADAC, The Association for Addiction Professionals. "They think they're not supposed to feel, they're not supposed to like a client or dislike a client," Patterson says. "Then when they have these feelings, they think there's something wrong with them."

That's a key part of supervision, which must be ongoing, says Patterson, adding, "You never outgrow supervision—that's what keeps us out of trouble." It's also helpful to remember that if you're doing something you don't want to talk to someone about, there probably is something wrong, she says.

Kathryn Benson, chair of the National Certification Commission for Addiction Professionals, which is run by NAADAC, frequently talks on the phone to counselors who are confused. "It's not their fault if they're not getting good guidance from their agencies," Benson says. "They're afraid of retaliation. I'm not going to let them hang alone out there."

On the other hand, it also is hard to blame supervisors, because most of the time they are "doing the best they can with what they are working with," says Benson. "This isn't about pointing fingers—it's about coming up with a solution."

Sometimes the counselor is so afraid of the situation that he/she doesn't tell anyone, including the supervisor. But this fear proves destructive, says Benson. "I tell people they will get trapped in their own fear, because if you find yourself attracted to a client, you'll get trapped into thinking that there's

something wrong with you, and you're defective as a counselor," she says. "You're having a human feeling."

The counselor's job is to convey this to the supervisor, and the supervisor's job is to understand that this is human nature, and that the supervisor will help the counselor manage this.

"This is about real life," says Benson. "You cannot prevent everything." Even with the best policies and the best training, treatment programs still may not be able to prevent sexual misconduct. But where the true liability lies is in how the treatment program responds to a situation once aware of it.

Benson stresses that the absolutely wrong move to make when an incident of sexual misconduct occurs is to transfer the patient immediately to another counselor. "That's the mark of a poorly trained supervisor and clinician, who believes that the first response is to transfer," she says. "That's harmful to the counselor and to the client." Many people come to treatment with abandonment issues, and if the first time they show up they get rejected—which is how they will interpret a transfer to another counselor—they will feel that they must be worthless if even the therapist doesn't want to talk to them, Benson explains.

Patient blaming

Benson says patients don't seduce counselors. Rather, the patient comes into a program and is at the level of coping that he/she has in life at the time. "It's not at all uncommon, particularly for females, to use their bodies," she says. "They use sex as a way of controlling and minimizing further damage to themselves." It's a convoluted sense of survival, but by being in control of sex, these women believe they can reduce their chances of being harmed.

Counselors are trained in how human beings developed coping skills to help them survive, says Benson. "The burden is always on the clinician, on the staff person, to manage themselves," she says. "We're the professionals."

Patterson is outraged when she hears counselors claim to have been seduced by patients. "The patient is acting like a patient, using the coping skills she has," says Patterson. "The only way she knows how to interact is sexually."

Because of the disease patients arrive with, and the past trauma they may have experienced, it may take them months or more to report sexual misconduct, says IC&RC's Mather. "Maybe a year later they're back in treatment someplace else, and they realize this wasn't supposed to happen," she says.

Dual relationships

The concept of sexual misconduct has been broadened to include dual relationships, which are banned by ethics codes. A dual relationship is one that is outside of the clinical care the counselor is providing. On one end of the spectrum is running into a patient or former patient at a 12-Step meeting and interacting with them with a "social feel" to the relationship, including an activity such as going out

with a group for coffee. On the other end of the spectrum is full physical intimacy. The potential harm to the client varies, but it exists in all dual relationships.

Sean Conaboy, a risk management consultant with NSM Insurance Group in Philadelphia, recalls the slippery slope of relationships he witnessed in treatment programs. "When I was managing facilities and doing clinical supervision, I would see the relationships that would start to occur, and blossom into something that was inappropriate," Conaboy says. "We had to do a lot of training, a lot of policies and procedures. This is a danger sign, but these are human beings, and it happens. You have to deal with it."

IC&RC recently changed its code of ethics to ban not only exploitation of clients, but also dual relationships. "Sometimes it isn't physical, but it has crossed over from the professional relationship," says Mather. "Maybe they're texting at night, meeting for coffee, not doing anything sexual. It's still a dual relationship, and not allowed."

Role of non-clinical staff

While administrative staff are less likely to have dual relationship issues, they do get to make the big decisions. They're the people in power, and as Patterson said, "They look at lawsuits and the bottom line."

That's why consultants who work with treatment programs on ethics training frequently request to meet with non-clinical staff as well as clinicians. Treatment centers, says Benson, need to understand that the costs of letting the counselor simply go work at another program, with nothing ever reported, are too high.

When Benson works with a facility that is going through a sexual misconduct situation, she tells administrators that they need to terminate the employee, report the person to the appropriate authority, get the patient placed in another treatment program, and pay for that treatment. "They do not like hearing this," she says.

Importance of investigating

While investigating claims is onerous and expensive, it's something that treatment programs need to do, says Conaboy. "Firing the counselor and hoping they don't get sued won't make the problem go away," he says. Conaboy stressed that no attorney will sue only the counselor—the employing organization will get sued as well.

All cases end up b being settled out of court, because treatment programs don't want the publicity of a trial, says Conaboy. "Attorneys [for patients] make their money on the settlements, and on the billable hours," he says.

An organization must be acutely aware of the dangers of wrongful termination, says Conaboy. "We've all worked and dealt with transference," he says. "Patients lie, they fabricate, they're delusional, they're

trying to get back at you. So, don't rush to judgment." There must be due process, in which allegations are thoroughly investigated.

Sexual misconduct presents a "very challenging set of dynamics" for a treatment organization, says Conaboy. "And no matter how well managed you are, these things still happen, because this is human behavior." Some of the most prestigious programs have experienced these situations, he says.

All hospitals have general, professional, and sexual misconduct/abuse and molestation insurance coverage, and behavioral health providers should as well, says Conaboy. "Different carriers handle the premiums differently," he says. In many cases, the sexual misconduct coverage is bundled into general and professional liability coverage.

A preventive culture

"Ethical violations don't happen in a vacuum," says Sandy Wummer, corporate director of performance, standards and research at Pennsylvania-based Caron Treatment Centers. "We try from the beginning to create a culture of ongoing training and supervision around ethical issues."

Caron focuses on preventing ethical violations, says Wummer. A key component involves having a treatment team, not a single individual, treating each patient, she says. "When there are multiple staff members, this eliminates some of the boundary issues, the transference and countertransference," Wummer says.

She adds, "Ethical issues always arise, in any kind of medical treatment. It's how you respond that matters." Caron also educates patients and their families about ethical and appropriate behavior "on our part and on their part," she says.

What if the sexual relationship is between patients? "This is a clinical issue, a treatment team issue," says Wummer. "There are patients whose histories may lend themselves to that behavior—patients come here with a lot of issues."

If a patient reports sexual misconduct, Caron has processes in place to investigate. "It's a patient advocate process," says Wummer. "We take every allegation seriously. In the rare case that we have an allegation of an inappropriate relation between a staff member and a patient, we would explain to the counselor first that there is an allegation." In some cases, the counselor would have to stay home until the investigation is concluded.

"If we find an allegation to be accurate, we would take appropriate steps through the HR process and the licensing boards," says Wummer. "That is not a choice—that is a regulation."

It's important to use an allegation, whether it's true or not, as an opportunity for training, supervision and learning, she says. Doing nothing in response to an allegation sets up an organization for liability in many areas, says Wummer.

"It will cause repeat behavior," she says.

One patient's ordeal

Pamela Banker, who lives in Geneseo, N.Y., was arrested for drunk driving and had been sent to court-ordered treatment in 1999. The counselor who supervised her told her that if she didn't submit to his sexual advances, she would be sent to prison for 14 years.

When Banker did report the abuse (which she said went on for seven years) to her probation officer, the officer told the counselor. He retaliated by forcing her to plead guilty to drunk driving in the treatment court where he served as coordinator, so that she would stay under his jurisdiction.

Ultimately Banker was sent to prison for three years, for relapsing to alcohol use, which was triggered by the sexual abuse. The counselor eventually was allowed to resign, citing health reasons.

Banker's story was not reported until she filed a lawsuit in 2009, citing the abuse. The employer was the state because she had been in a state-run treatment program. The state refused to pay any award, saying that what the counselor did occurred outside of his purview as an employee.

The state Office of Alcoholism and Substance Abuse Services (OASAS) did confirm to *Addiction Professional* that its review of the situation concluded that the counselor had violated applicable ethical standards. OASAS adds that he is no longer credentialed by the state agency.

The patient's lawsuit was dropped, and Banker, who lives on $750 a month in disability, says she owes her lawyer more than $6,000. In August, a reporter with the Democrat & Chronicle newspaper met with her, and published her story on Aug. 29. *Addiction Professional* contacted Banker in early September, and she said she wants her story to be told.

NAADAC: The Association for Addiction Professionals
NCC AP: The National Certification Commission for Addiction Professionals
CODE OF ETHICS: Approved 10.09.2016

PRINCIPLES		
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INTRODUCTION TO NAADAC/NCC AP ETHICAL STANDARDS		
i-1		NAADAC recognizes that its members, certified counselors, and other Service Providers live and work in many diverse communities. NAADAC has the responsibility to create a Code of Ethics that are relevant for ethical deliberation. The terms "Addiction Professionals" and "Providers" shall include and refer to NAADAC Members, certified or licensed counselors offering addiction-specific services, and other Service Provider along the continuum of care from prevention through recovery. "Client" shall include and refer to individuals, couples, partners, families, or groups depending on the setting.
i-2		The NAADAC Code of Ethics was written to govern the conduct of its members and it is the accepted Standard of Conduct for Addiction Professionals certified by the National Certification Commission. The Code of Ethics reflects the ideals of NAADAC and its members. When an ethics complaint is filed with NAADAC, it is evaluated by consulting the NAADAC Code of Ethics. The NAADAC Code of Ethics is designed as a statement of the values of the profession and as a guide for making clinical decisions. This Code is also utilized by state certification boards and educational institutions to evaluate the behavior of Addiction Professionals and to guide the certification process.
i-3		In addition to identifying specific ethical standards, NAADAC recommends consideration of the following when making ethical decisions: 1. Autonomy: To allow others the freedom to choose their own destiny 2. Obedience: The responsibility to observe and obey legal and ethical directives 3. Conscientious Refusal: The responsibility to refuse to carry out directives that are illegal and/or unethical 4. Beneficence: To help others 5. Gratitude: To pass along the good that we receive to others 6. Competence: To possess the necessary skills and knowledge to treat the clientele in a chosen discipline and to remain current with treatment modalities, theories and techniques 7. Justice: Fair and equal treatment, to treat others in a just manner 8. Stewardship: To use available resources in a judicious and conscientious manner, to give back 9. Honesty and Candor: Tell the truth in all dealing with clients, colleagues, business associates and the community 10. Fidelity: To be true to your word, keeping promises and commitments 11. Loyalty: The responsibility to not abandon those with whom you work 12. Diligence: To work hard in the chosen profession, to be mindful, careful and thorough in the services delivered 13. Discretion: Use of good judgment, honoring confidentiality and the privacy of others 14. Self-improvement: To work on professional and personal growth to be the best you can be 15. Non-malfeasance: Do no harm to the interests of the client 16. Restitution: When necessary, make amends to those who have been harmed or injured 17. Self-interest: To protect yourself and your personal interests.

		Source: White (1993)	
PRINCIPLE I: THE COUNSELING RELATIONSHIP			
I-1 Client Welfare		Addiction Professionals understand and accept their responsibility to ensure the safety and welfare of their client, and to act for the good of each client while exercising respect, sensitivity, and compassion. Providers shall treat each client with dignity, honor, and respect, and act in the best interest of each client.	
I-2 Informed Consent		Addiction Professionals understand the right of each client to be fully informed about treatment, and shall provide clients with information in clear and understandable language regarding the purposes, risks, limitations, and costs of treatment services, reasonable alternatives, their right to refuse services, and their right to withdraw consent within time frames delineated in the consent. Providers have an obligation to review with their client - in writing and verbally - the rights and responsibilities of both Providers and clients. Providers shall have clients attest to their understanding of the parameters covered by the Informed Consent.	
I-3 Informed Consent		Informed Consent shall include: a. explicit explanation as to the nature of all services to be provided and methodologies and theories typically utilized, b. purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services, c. the addiction professional's qualifications, credentials, relevant experience, and approach to counseling, d. right to confidentiality and explanation of its limits including duty to warn, e. policies regarding continuation of services upon the incapacitation or death of the counselor, f. the role of technology, including boundaries around electronic transmissions with clients and social networking, g. implications of diagnosis and the intended use of tests and reports, h. fees and billing, nonpayment, policies for collecting nonpayment, i. specifics about clinical supervision and consultation, j. their right to refuse services, and k. their right to refuse to be treated by a person-in-training, without fear of retribution.	
I-4 Limits of Confidentiality		Addiction Professionals clarify the nature of relationships with each party and the limits of confidentiality at the outset of services when agreeing to provide services to a person at the request or direction of a third party.	
I-5 Diversity		Addiction Professionals shall respect the diversity of clients and seek training and supervision in areas in which they are at risk of imposing their values onto clients.	
I-6 Discrimination		Addiction Professionals shall not practice, condone, facilitate, or collaborate with any form of discrimination against any client on the basis of race, ethnicity, color, religious or spiritual beliefs, age, gender identification, national origin, sexual orientation or expression, marital status, political affiliations, physical or mental handicap, health condition, housing status, military status, or economic status.	
I-7 Legal Competency		Addiction Professionals who act on behalf of a client who has been judged legally incompetent or with a representative who has been legally authorized to act on behalf of a client, shall act with the client's best interests in mind, and shall inform the designated guardian or representative of any circumstances which may influence the relationship. Providers recognize the need to balance the ethical rights of clients to make choices about their treatment, their capacity to give consent to receive treatment-related services, and parental/familial/representative legal rights and responsibilities to protect the client and make decisions on their behalf.	
I-8 Mandated Clients		Addiction Professionals who work with clients who have been mandated to counseling and related services, shall discuss legal and ethical limitations to confidentiality. Providers shall explain confidentiality, limits to confidentiality, and the sharing of information for supervision and consultation purposes prior to the beginning of therapeutic or service relationship. If the client refuses services, the Provider shall discuss with the client the potential consequences of refusing the mandated services, while respecting client autonomy.	
I-9 Multiple Therapists		Addiction Professionals shall obtain a signed Release of Information from a potential or actual client if the client is working with another behavioral health professional. The Release shall allow the Provider to strive to establish a collaborative professional relationship.	
I-10 Boundaries		Addiction Professionals shall consider the inherent risks and benefits associated with moving the boundaries of a counseling relationship beyond the standard parameters. Consultation and supervision shall be sought and documented.	

I-11 Multiple/Dual Relationships		Addiction Professionals shall make every effort to avoid multiple relationships with a client. When a dual relationship is unavoidable, the professional shall take extra care so that professional judgment is not impaired and there is no risk of client exploitation. Such relationships include, but are not limited to, members of the Provider's immediate or extended family, business associates of the professional, or individuals who have a close personal relationship with the professional or the professional's family. When extending these boundaries, Providers take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that their judgment is not impaired and no harm occurs. Consultation and supervision shall be documented.	
I-12 Prior Relationship		Addiction Professionals recognize that there are inherent risks and benefits to accepting as a client someone with whom they have a prior relationship. This includes anyone with whom the Provider had a casual, distant, or past relationship. Prior to engaging in a counseling relationship with a person from a previous relationship, the Provider shall seek consultation or supervision. The burden is on the Provider to ensure that their judgment is not impaired and that exploitation is not occurring.	
I-13 Previous Client		Addiction Professionals considering initiating contact with or a relationship with a previous client shall seek documented consultation or supervision prior to its initiation.	
I-14 Group		Addiction Professionals shall clarify who "the client" is, when accepting and working with more than one person as "the client." Provider shall clarify the relationship the Provider shall have with each person. In group counseling, Providers shall take reasonable precautions to protect the members from harm.	
I-15 Financial Disclosure		Addiction Professionals shall truthfully represent facts to all clients and third-party payers regarding services rendered, and the costs of those services.	
I-16 Communication		Addiction Professionals shall communicate information in ways that are developmentally and culturally appropriate. Providers offer clear understandable language when discussing issues related to informed consent. Cultural implications of informed consent are considered and documented by Provider.	
I-17 Treatment Planning		Addiction Professionals shall create treatment plans in collaboration with their client. Treatment plans shall be reviewed and revised on an ongoing and intentional basis to ensure their viability and validity.	
I-18 Level of Care		Addiction Professionals shall provide their client with the highest quality of care. Providers shall use ASAM or other relevant criteria to ensure that clients are appropriately and effectively served.	
I-19 Documentation		Addiction Professionals and other Service Providers shall create, maintain, protect, and store documentation required per federal and state laws and rules, and organizational policies.	
I-20 Advocacy		Addiction Professionals are called to advocate on behalf of clients at the individual, group, institutional, and societal levels. Providers have an obligation to speak out regarding barriers and obstacles that impede access to and/or growth and development of clients. When advocating for a specific client, Providers obtain written consent prior to engaging in advocacy efforts.	
I-21 Referrals		Addiction Professionals shall recognize that each client is entitled to the full extent of physical, social, psychological, spiritual, and emotional care required to meet their needs. Providers shall refer to culturally- and linguistically-appropriate resources when a client presents with any impairment that is beyond the scope of the Provider's education, training, skills, supervised expertise, and licensure.	
I-22 Exploitation		Addiction Professionals are aware of their influential positions with respect to clients, trainees, and research participants and shall not exploit the trust and dependency of any client, trainee, or research participant. Providers shall not engage in any activity that violates or diminishes the civil or legal rights of any client. Providers shall not use coercive treatment methods with any client, including threats, negative labels, or attempts to provoke shame or humiliation. Providers shall not impose their personal religious or political values on any client. Providers do not endorse conversion therapy.	
I-23 Sexual Relationships		Addiction Professionals shall not engage in any form of sexual or romantic relationship with any current or former client, nor accept as a client anyone with whom they have engaged in a romantic, sexual, social, or familial relationship. This prohibition includes in-person and electronic interactions and/or relationships. Addiction Professionals are prohibited from engaging in counseling relationships with friends or family members with whom they have an inability to remain objective.	

I-24 Termination		Addiction Professionals shall terminate services with clients when services are no longer required, no longer serve the client's needs, or the Provider is unable to remain objective. Counselors provide pre-termination counseling and offer appropriate referrals as needed. Providers may refer a client, with supervision or consultation, when in danger of harm by the client or by another person with whom the client has a relationship	
I-25 Coverage		Addiction Professionals shall make necessary coverage arrangements to accommodate interruptions such as vacations, illness, or unexpected situation.	
I-26 Abandonment		Addiction Professionals shall not abandon any client in treatment. Providers who anticipate termination or interruption of services to clients shall notify each client promptly and seek transfer, referral, or continuation of services in relation to each client's needs and preferences.	
I-27 Fees		Addiction Professionals shall ensure that all fees charged for services are fair, reasonable, and commensurate with the services provided and with due regard for clients' ability to pay.	
I-28 Self-Referrals		Addiction Professionals shall not refer clients to their private practice unless the policies, at the organization at the source of the referral, allow for self-referrals. When self-referrals are not an option, clients shall be informed of other appropriate referral resources.	
I-29 Commissions		Addiction Professionals shall not offer or accept any commissions, rebates, kickbacks, bonuses, or any form of remuneration for referral of a client for professional services, nor engage in fee splitting.	
I-30 Enterprises		Addiction Professionals shall not use relationships with clients to promote personal gain or profit of any type of commercial enterprise.	
I-31 Withholding Records		Addiction Professionals shall not withhold records they possess that are needed for any client's treatment solely because payment has not been received for past services.	
I-32 Withholding Reports		Addiction Professionals shall not withhold reports to referral agencies regarding client treatment progress or completion solely because payment has not yet been received in full for services, particularly when those reports are to courts or probation officers who require such information for legal purposes. Reports may note that payment has not yet been made, or only partially made, for services rendered.	
I-33 Disclosures re: Payments		Addiction Professionals shall clearly disclose and explain to each client, prior to the onset of services, (1) all costs and fees related to the provision of professional services, including any charges for cancelled or missed appointments, (2) the use of collection agencies or legal measures for nonpayment, and (3) the procedure for obtaining payment from the client if payment is denied by a third party payer.	
I-34 Regardless of Compensation		Addiction Professionals shall provide the same level of professional skills and service to each client without regard to the compensation provided by a client or third party payer, and whether a client is paying full fee, a reduced fee, or has their fees waived.	
I-35 Billing for Actual Services		Addiction Professionals shall charge each client only for services actually provided to a client regardless of any oral or written contract a client has made with the addiction professional or agency.	
I-36 Financial Records		Addiction Professionals shall maintain accurate and timely clinical and financial records for each client.	
I-37 Suspension		Addiction Professionals shall give reasonable and written notice to clients of impending suspension of services for nonpayment.	
I-38 Unpaid Balances		Addiction Professionals shall give reasonable and written notice to clients with unpaid balances of their intent to seek collection by agency or legal recourse—when such action is taken, Addiction Professionals shall not reveal clinical information.	
I-39 Bartering		Addiction Professionals can engage in bartering for professional services if: (1) the client requests it, (2) the relationship is not exploitative, (3) the professional relationship is not distorted, (4) federal and state laws and rules allow for bartering, and (5) a clear written contract is established with agreement on value of item(s) bartered for and number of sessions, prior to the onset of services. Providers consider the cultural implications of bartering and discuss relevant concerns with clients. Agreements shall be delineated in a written contract. Providers shall seek supervision or consultation and document.	
I-40 Gifts		Addiction Professionals recognize that clients may wish to show appreciation for services by offering gifts. Providers shall take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift	

I-41 Uninvited Solicitation		Addiction Professionals shall not engage in uninvited solicitation of potential clients who are vulnerable to undue influence, manipulation, or coercion due to their circumstances.	
I-42 Virtual		Addiction Professionals are prohibited from engaging in a personal or romantic virtual e-relationship with current clients.	
PRINCIPLE II: CONFIDENTIALITY AND PRIVILEGED COMMUNICATION			
II-1 Confidentiality		Addiction Professionals understand that confidentiality and anonymity are foundational to addiction treatment and embrace the duty of protecting the identity and privacy of each client as a primary obligation. Counselors communicate the parameters of confidentiality in a culturally-sensitive manner.	
II-2 Documentation		Addiction Professionals shall create and maintain appropriate documentation. Providers shall ensure that records and documentation kept in any medium (i.e., cloud, laptop, flash drive, external hard drive, tablet, computer, paper, etc.) are secure and in compliance with HIPAA and 42 CFR Part 2, and that only authorized persons have access to them. Providers shall disclose to client within informed consent how records shall be stored, maintained, and disposed of, and shall include time frames for maintaining active file, storage, and disposal.	
II-3 Access		Addiction Professionals shall notify client, during informed consent, about procedures specific to client access of records. Addiction Professionals shall provide a client reasonable access to documentation regarding the client upon his/her written request. Providers shall protect the confidentiality of any others contained in the records. Providers shall limit the access of clients to their records – and provide a summary of the records – when there is evidence that full access could cause harm to the client. A treatment summary shall include dates of service, diagnoses, treatment plan, and progress in treatment. Providers seek supervision or consultation prior to providing a client with documentation, and shall document the rationale for releasing or limiting access to records. Providers shall provide assistance and consultation to the client regarding the interpretation of counseling records.	
II-4 Sharing		Addiction Professionals shall encourage ongoing discussions with clients regarding how, when, and with whom information is to be shared.	
II-5 Disclosure		Addiction Professionals shall not disclose confidential information regarding the identity of any client, nor information that could potentially reveal the identity of a client, without written consent and authorization by the client. In situations where the disclosure is mandated or permitted by state and federal law, verbal authorization shall not be sufficient except for emergencies.	
II-6 Privacy		Addiction Professionals and the organizations they work for ensure that confidentiality and privacy of clients is protected by Providers, employees, supervisees, students, office personnel, other staff and volunteers.	
II-7 Limits of Confidentiality		Addiction Professionals, during informed consent, shall disclose the legal and ethical boundaries of confidentiality and disclose the legal exceptions to confidentiality. Confidentiality and limitations to confidentiality shall be reviewed as needed during the counseling relationship. Providers review with each client all circumstances where confidential information may be requested, and where disclosure of confidential information may be legally required.	
II-8 Imminent Danger		Addiction Professionals may reveal client identity or confidential information without client consent when a client presents a clear and imminent danger to themselves or to other persons, and to emergency personnel who are directly involved in reducing the danger or threat. Counselors seek supervision or consultation when unsure about the validity of an exception.	
II-9 Courts		Addiction Professionals ordered to release confidential privileged information by a court shall obtain written, informed consent from the client, take steps to prohibit the disclosure, or have it limited as narrowly as possible because of potential harm to the client or counseling relationship	
II-10 Essential Only		Addiction Professionals shall release only essential information when circumstances require the disclosure of confidential information.	
II-11 Multidisciplinary Care		Addiction Professionals shall inform the client when the Provider is a participant in a multidisciplinary care team providing coordinated services to the client. The client shall be informed of the team's member credentials and duties, information being shared, and the purposes of sharing client information.	
II-12 Locations		Addiction Professionals shall discuss confidential client information in locations where they are reasonably certain they can protect client privacy.	

II-13 Payers		Addiction Professionals shall obtain client authorization prior to disclosing any information to third party payers (i.e., Medicaid, Medicare, insurance payers, private payors).	
II-14 Encryption		Addiction Professionals shall use encryption and precautions that ensure that information being transmitted electronically or other medium remains confidential.	
II-15 Deceased		Addiction Professionals shall protect the confidentiality of deceased clients by upholding legal mandates and documented preferences of the client.	
II-16 All Parties		Addiction Professionals, who provide group, family, or couples therapy, shall describe the roles and responsibilities of all parties, limits of confidentiality, and the inability to guarantee that confidentiality shall be maintained by all parties.	
II-17 Minors and Others		Addiction Professionals shall protect the confidentiality of any information received regarding counseling minor clients or adult clients who lack the capacity to provide voluntary informed consent, regardless of the medium, in accordance with federal and state laws, and organization policies and procedures. Parents, guardians, and appropriate third parties are informed regarding the role of the counselor, and the boundaries of confidentiality of the counseling relationship.	
II-18 Storage and Disposal		Addiction Professionals shall create and/or abide by organizational, and state and federal, policies and procedures regarding the storage, transfer, and disposal of confidential client records. Providers shall maintain client confidentiality in all mediums and forms of documentation.	
II-19 Video Recording		Addiction Professionals shall obtain informed consent and written permissions and releases before videotaping, audio recording, or permitting third party observation of any client interaction or group therapy session. Clients are to be fully informed regarding recording such as purpose, who will have access, storage, and disposal of recordings. Exceptions to restrictions on third party observations shall be limited to students in field placements, internships, practicums, or agency trainees.	
II-20 Recording e-therapy		Addiction Professionals shall obtain informed consent and written release of information prior to recording an electronic therapy session. Prior to obtaining informed consent for recording e-therapy, the Provider shall seek supervision or consultation, and document recommendations. Providers shall disclose to client in informed consent how e-records shall be stored, maintained, and disposed of and in what time frame.	
II-21 Federal Regulations Stamp		Addiction Professionals shall ensure that all written information released to others is accompanied by a stamp identifying the Federal Regulations governing such disclosure, and shall notify clients when a disclosure is made, to whom the disclosure was made, and for what purposes the disclosure was made.	
II-22 Transfer Records		Unless exceptions to confidentiality exist, Addiction Professionals shall obtain written permission from clients to disclose or transfer records to legitimate third parties. Steps are taken to ensure that receivers of counseling records are sensitive to their confidential nature. Addiction Professionals shall ensure that all information released meets requirements of 42 CFR Part 2 and HIPAA. All information released shall be appropriately marked as confidential.	
II-23 Written Permission		Addiction Professionals who receive confidential information about any client (past, present or potential) shall not disclose that information without obtaining written permission from the client (past, present or potential) allowing for such release.	
II-24 Multidisciplinary Care		Addiction Professionals, who are part of integrative care teams, shall not release confidential client information to external care team members without obtaining written permission from the client allowing such release.	
II-25 Diseases		Addiction Professionals adhere to relevant federal and state laws concerning the disclosure of a client's communicable and life-threatening disease status.	
II-26 Storage and Disposal		Addiction Professionals shall store, safeguard, and dispose of client records in accordance with state and federal laws, accepted professional standards, and in ways which protect the confidentiality of clients.	
II-27 Temporary Assistance		Addiction Professionals, when serving clients of another agency or colleague during a temporary absence or emergency, shall serve those clients with the same consideration and confidentiality as that afforded the professional's own clients.	
II-28 Termination		Addiction Professionals shall take reasonable precautions to protect client confidentiality in the event of the counselor's termination of practice, incapacity, or death. Providers shall appoint a records custodian when identified as appropriate, in their Will or other document.	
II-29 Consultation		Addiction Professionals shall share, with a consultant, information about a client for professional purposes. Only information pertaining to the reason for the consultation shall be released. Providers shall protect the client's identity and prevent breaches to the client's privacy. Addiction	

		Professionals, when consulting with colleagues or referral sources, shall not share confidential information obtained in clinical or consulting relationships that could lead to the identification of a client, unless the Provider has obtained prior written consent from the client. Information shall be shared only in appropriate clinical settings and only to the extent necessary to achieve the purposes of the consultation.	
PRINCIPLE III: PROFESSIONAL RESPONSIBILITIES AND WORKPLACE STANDARDS			
III-1 Responsibility		Addiction Professionals shall abide by the NAADAC Code of Ethics. Addiction Professionals have a responsibility to read, understand and follow the NAADAC Code of Ethics and adhere to applicable laws and regulations.	
III-2 Integrity		Addiction Professionals shall conduct themselves with integrity. Providers aspire to maintain integrity in their professional and personal relationships and activities. Regardless of medium, Providers shall communicate to clients, peers, and the public honestly, accurately, and appropriately.	
III-3 Discrimination		Addiction Professionals shall not engage in, endorse or condone discrimination against prospective or current clients and their families, students, employees, volunteers, supervisees, or research participants based on their race, ethnicity, age, disability, religion, spirituality, gender, gender identity, sexual orientation, marital or partnership status, language preference, socioeconomic status, immigration status, active duty or veteran status, or any other basis.	
III-4 Nondiscriminatory		Addiction Professionals shall provide services that are nondiscriminatory and nonjudgmental. Providers shall not exploit others in their professional relationships. Providers shall maintain appropriate professional and personal boundaries.	
III-5 Fraud		Addiction Professionals shall not participate in, condone, or be associated with any form of dishonesty, fraud, or deceit.	
III-6 Violation		Addiction Professionals shall not engage in any criminal activity. Addiction Professionals and Service Providers shall be in violation of this Code and subject to appropriate sanctions, up to and including permanent revocation of their NAADAC membership and NCC AP certification, if they: 1. Fail to disclose conviction of any felony. 2. Fail to disclose conviction of any misdemeanor related to their qualifications or functions as an Addiction Professional. 3. Engage in conduct which could lead to conviction of a felony or misdemeanor related to their qualifications or functions as an Addiction Professional. 4. Are expelled from or disciplined by other professional organizations. 5. Have their licenses or certificates suspended or revoked, or are otherwise disciplined by regulatory bodies. 6. Continue to practice addiction counseling while impaired to do so due to physical or mental causes 7. Continue to practice addiction counseling while impaired abuse of alcohol or other drugs. 8. Continue to identify themselves as a certified or licensed addiction professional after being denied certification or licensure, or allowing their certification or license to lapse 9. Fail to cooperate with the NAADAC or NCC AP Ethics Committees at any point from the inception of an ethics complaint through the completion of all procedures regarding that complaint.	
III-7 Harassment		Addiction Professionals shall not engage in or condone any form of harassment, including sexual harassment.	
III-8 Membership		Addiction Professionals intentionally differentiate between current, active memberships and former or inactive memberships with NAADAC and other professional associations.	
III-9 Credentials		Addiction Professionals shall claim and present only those educational degrees and specialized certifications that they have earned from the appropriate institutions or organizations. Providers shall not imply Master's level competence until their Master's degree is awarded. Providers shall not imply doctoral-level competence until their doctoral title or degree is awarded. The accreditations of a specific institution of higher learning or degree program shall be accurately represented.	
III-10 Credentials		Addiction Professionals shall claim and promote only those licenses and certifications that are current and in good standing.	
III-11 Accuracy of Representation		Addiction Professionals shall ensure that their credentials and affiliations are identified accurately. Providers shall correct all references to their credentials and affiliations that are false, deceptive,	

		or misleading. Addiction Professionals shall advocate for accuracy in statements made by self or others about the addiction profession.	
III-12 Misrepresentation		Addiction Professionals shall not misrepresent professional qualifications, education, experience, memberships or affiliations. Providers shall accept employment on the basis of existing competencies or explicit intent to acquire the necessary competence.	
III-13 Scope of Practice		Addiction Professionals shall provide services within their scope of practice and competency, and shall offer services that are science-based, evidence-based, and outcome-driven. Providers shall engage in counseling practices that are grounded in rigorous research methodologies. Providers shall maintain adequate knowledge of and adhere to applicable professional standards of practice.	
III-14 Boundaries of Competence		Addiction Professionals shall practice within the boundaries of their competence. Competence shall be established through education, training, skills, and super vised experience, state and national professional credentials and certifications, and relevant professional experience.	
III-15 Proficiency		Addiction Professionals shall seek and develop proficiency through relevant education, training, skills, and supervised experience prior to independently delivering specialty services. Providers engage in supervised experience and seek consultation to ensure the validity of their work and protect clients from harm when developing skills in new specialty areas.	
III-16 Educational Achievement		Addiction Professionals recognize that the highest levels of educational achievement are necessary to provide the level of service clients deserve. Providers embrace the need for formal and specialized education as a vital component of professional development, competency, and integrity. Providers pursue knowledge of new developments within the addiction and behavioral health professions and increase competency through formal education, training, and supervised experience.	
III-17 Continuing Education		Addiction Professionals shall pursue and engage in continuing education and professional development opportunities in order to maintain and enhance knowledge of research-based scientific developments within the profession. Providers shall learn and utilize new procedures relevant to the clients they are working with. Providers shall remain informed regarding best practices for working with diverse populations.	
III-18 Self-Monitoring		Addiction Professionals are continuously self-monitoring in order to meet their professional obligations. Providers shall engage in self-care activities that promote and maintain their physical, psychological, emotional, and spiritual well-being.	
III-19 Scientific		Addiction Professionals shall use techniques, procedures, and modalities that have a scientific and empirical foundation. Providers shall utilize counseling techniques and procedures that are grounded in theory, evidence-based, outcome-driven and/or a research-supported promising practice. Providers shall not use techniques, procedures, or modalities that have substantial evidence suggesting harm, even when these services are requested.	
III-20 Innovation		Addiction Professionals shall discuss and document potential risks, benefits and ethical concerns prior to using developing or innovative techniques, procedures, or modalities with a client. Providers shall minimize and document any potential risks or harm when using developing and/or innovative techniques, procedures, or modalities. Provider shall seek and document supervision and/or consultation prior to presenting treatment options and risks to a client.	
III-21 Multicultural Competency		Addiction Professionals shall develop multicultural counseling competency by gaining knowledge specific to multiculturalism, increasing awareness of cultural identifications of clients, evolving cultural humility, displaying a disposition favorable to difference, and increasing skills pertinent to being a culturally-sensitive Provider	
III-22 Multidisciplinary Care		Addiction Professionals shall work to educate medical professionals about substance use disorders, the need for primary treatment of these disorders, and the need to limit the use of mood altering chemicals for persons in recovery.	
III-23 Medical Professionals		Addiction Professionals shall recognize the need for the use of mood altering chemicals in limited medical situations, and will work to educate medical professionals to limit, monitor, and closely supervise the administration of such chemicals when their use is necessary.	
III-24 Collaborative Care		Addiction Professionals shall collaborate with other health care professionals in providing a supportive environment for any client who receives prescribed medication.	
III-25 Multidisciplinary Care		Collaborative multidisciplinary care teams are focused on increasing the client's functionality and wellness. Addiction Professionals who are members of multidisciplinary care teams shall work with team members to clarify professional and ethical obligations of the team as a whole and its individual members. If ethical concerns develop as a result of a team decision, Providers shall attempt to resolve the concern within the team first. If resolution cannot be reached within the	

		team, Providers shall pursue and document supervision and/or consultation to address their concerns consistent with client well-being.	
III-26 Collegial		Addiction Professionals are aware of the need for collegiality and cooperation in the helping professions. Providers shall act in good faith towards colleagues and other professionals, and shall treat colleagues and other professionals with respect, courtesy, honesty, and fairness.	
III-27 Collaborative Care		Addiction Professionals shall develop respectful and collaborative relationships with other professionals who are working with a specific client. Providers shall not offer professional services to a client who is in counseling with another professional, except with the knowledge and documented approval of the other professionals or following termination of services with the other professionals.	
III-28 Qualified		Addiction professionals shall work to prevent the practice of addictions counseling by unqualified and unauthorized persons, and shall not employ individuals who do not have appropriate and requisite education, training, licensure and/or certification in addictions.	
III-29 Advocacy		Providers shall be advocates for their clients in those settings where the client is unable to advocate for themselves.	
III-30 Advocacy		Addiction Professionals are aware of society's prejudice and stigma towards people with substance use disorders, and willingly engage in the legislative process, educational institutions, and public forums to educate people about addictive disorders and advocate for opportunities and choices for our clients.	
III-31 Advocacy		Addiction Professionals shall advocate for changes in public policy and legislation to improve opportunities and choices for all persons whose lives are impaired by substance use disorders.	
III-32 Advocacy		Addiction Professionals shall inform the public of the impact of substance use disorders through active participation in civic affairs and community organizations. Providers shall act to guarantee that all persons, especially the disadvantaged, have access to the opportunities, resources, and services required to treat and manage their disorders. Providers shall educate the public about substance use disorders, while working to dispel negative myths, stereotypes, and misconceptions about substance use disorders and the people who have them.	
III-33 Present Knowledge		Addiction Professionals shall respect the limits of present knowledge in public statements concerning addictions treatment, and shall report that knowledge accurately and without distortion or misrepresentation to the public and to other professionals and organizations.	
III-34 Organizational vs. Private		Addiction Professionals shall distinguish clearly between statements made and actions taken as a private individual and statements made and actions taken as a representative of an agency, group, organization, or the addiction profession.	
III-35 Public Comments NAADAC		Addiction Professionals shall make no public comments disparaging NAADAC or the addictions profession. The term "public comments" shall include, but is not limited to, any and all forms of oral, written, and electronic communication which may be accessible to anyone who is or is not a NAADAC member.	
III-36 Public Comments SUDs		Addiction Professionals shall make no public comments disparaging persons who have substance use disorders. The term "public comments" shall include, but is not limited to, all forms of oral, written, and electronic communication which may be accessible to anyone who is not a NAADAC member.	
III-37 Public Comments Legislative		Addiction Professionals shall make no public comments disparaging the legislative process, or any person involved in the legislative process. The term "public comments" shall include, but is not limited to, all forms of oral, written, and electronic communication which may be accessible to anyone who is not a NAADAC member.	
III-38 Development		Addiction Professionals actively participate in local, state and national associations that promote professional development.	
III-39 Policy		Addiction Professionals shall support the formulation, development, enactment, and implementation of public policy and legislation concerning the addiction profession and our clients.	
III-40 Parity		Addiction Professionals shall work for parity in insurance coverage for substance use disorders as primary medical disorders.	
III-41 Impairment		Addiction Professionals shall recognize the effect of impairment on professional performance and shall seek appropriate professional assistance for any personal problems or conflicts that may impair work performance or clinical judgment. Providers shall continuously monitor themselves for signs of impairment physically, psychologically, socially, and emotionally. Providers, with the guidance of supervision or consultation, shall seek appropriate assistance in the event they are	

		professionally impaired. Providers shall abide by statutory mandates specific to professional impairment when addressing one's own impairment.	
III-42 Impairment		Addiction Professionals shall offer and provide assistance and consultation as needed to peers, coworkers, and supervisors who are demonstrating professional impairment, and intervene to prevent harm to clients. Providers shall abide by statutory mandates specific to reporting the professional impairment of peers, coworkers, and supervisors.	
III-43 Referrals		Addiction Professionals shall not refer clients, or recruit colleagues or supervisors, from their places of employment or professional affiliation to their private practice without prior documented authorization. Providers shall offer multiple referral options to clients when referrals are necessary. Providers will seek supervision or consultation to address any potential or real conflicts of interest.	
III-44 Termination		Addiction Professionals shall create a written plan, policy or Professional Will for addressing situations involving the Provider's incapacitation, termination of practice, retirement, or death.	
III-45 Representation		Addiction Professionals and Organizations offering education, trainings, seminars, and workshops shall accurately and honestly represent their NAADAC-approved education provider status. Providers and organizations shall meet all requirements put forth by NAADAC if they intend to promote active provider status.	
III-46 Promotion		Addiction Professionals shall ensure that promotions and advertisements concerning their workshops, trainings, seminars, and products that they have developed for use in the delivery of services are accurate and provide ample information so consumers can make informed choices. Addiction Professionals shall not use their counseling, teaching, training or supervisory relationships to deceptively or unduly promote their products or training events.	
III-47 Testimonials		Addiction Professionals shall be thoughtful when they solicit testimonials from former clients or any other persons. Providers shall discuss with clients the implications of and potential concerns, regarding testimonials, prior to obtaining written permission for the use of specific testimonials. Providers shall seek consultation or supervision prior to seeking a testimonial.	
III-48 Reports		Addiction Professionals shall take care to accurately, honestly and objectively report professional activities and judgments to appropriate third parties (i.e., courts, probation/parole, healthcare insurance organizations and providers, recipients of evaluation reports, referral sources, professional organizations, regulatory agencies, regulatory boards, ethics committees, etc.).	
III-49 Advice		Addiction Professionals shall take reasonable precautions, when offering advice or comments (using any platform including presentations and lectures, demonstrations, printed articles, mailed materials, television or radio programs, video or audio recordings, technology-based applications, or other media), to ensure that their statements are based on academic, research, and evidence-based, outcome-driven literature and practice. The advice or comments shall be consistent with the NAADAC Code of Ethics.	
III-50 Dual Relationship		When Addiction Professionals are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, they shall clarify role expectations and the parameters of confidentiality with their colleagues.	
III-51 Illegal Practices		When Addiction Professionals become aware of inappropriate, illegal, discriminatory, and/or unethical policies, procedures and practices at their agency, organization, or practice, they shall alert their employers. When there is the potential for harm to clients or limitations on the effectiveness of services provided, Providers shall seek supervision and/or consultation to determine appropriate next steps and further action. Providers and Supervisors shall not harass or terminate an employee or colleague who has acted in a responsible and ethical manner to expose inappropriate employer employee policies, procedures and/ or practices.	
III-52 Supervision		Addiction Professionals, acting in the role of Supervisor or Consultant, shall take reasonable steps to ensure that they have appropriate resources and competencies when providing supervisory or consultation services. Supervisors or consultants shall provide appropriate referrals to resources when requested or needed.	
III-53 Supervision		Addiction Professionals offering supervisory or consultation services shall have an obligation to review with the consultee/supervisee, in writing and verbally, the rights and responsibilities of both the Supervisory/Consultant and supervisee/consultee. Providers shall inform all parties involved about the purpose of the services to be provided, costs, risks and benefits, and the limits of confidentiality.	
III-54 Credit		Addiction Professionals shall give appropriate credit to the authors or creators of all materials used in their course of their work. Providers shall not plagiarize another person's work.	

PRINCIPLE IV: WORKING IN A CULTURALLY DIVERSE WORLD			
IV-1 Knowledge		Addiction Professionals shall be knowledgeable and aware of cultural, individual, societal, and role differences amongst the clients they serve. Providers shall offer services that demonstrate appropriate respect for the fundamental rights, dignity and worth of all clients.	
IV-2 Cultural Humility		Addiction services along the continuum of care are offered in diverse settings to diverse clients. Addiction Professionals shall demonstrate cultural humility. Providers shall maintain an interpersonal stance that is other-oriented and accepting of the cultural identities of the other person (client, colleague, peer, employee, employer, volunteer, supervisor, supervisee, and others).	
IV-3 Meanings		Addiction Professionals shall recognize and be sensitive to the diverse cultural meanings associated with confidentiality and privacy. Providers shall be open to and respect differing opinions regarding disclosure of information.	
IV-4 Personal Beliefs		Addiction Professionals shall develop an understanding of their own personal, professional, and cultural values and beliefs. Providers shall recognize which personal and professional values may be in alignment with or conflict with the values and needs of the client. Providers shall not use cultural or values differences as a reason to engage in discrimination. Providers shall seek supervision and/or consultation to address areas of difference and to decrease bias, judgment, and microaggressions.	
IV-5 Heritage		Addiction Professionals practicing cultural humility shall be open to the values, norms, and cultural heritage of their clients and shall not impose his or her values/beliefs on the client.	
IV-6 Credibility		Addiction Professionals practicing cultural humility shall be credible, capable, and trustworthy. Providers shall use a cultural humility framework to consider diversity of values, interactional styles, and cultural expectations.	
IV-7 Roles		Addiction professionals shall respect the roles of family members, social supports, and community structures, hierarchies, values and beliefs within the client's culture. Providers shall consider the impact of adverse social, environmental, ad political factors in assessing concerns and designing interventions.	
IV-8 Methodologies		Addiction Professionals shall use methodologies, skills, and practices that are evidence-based and outcome-driven for the populations being serviced. Providers will seek ongoing professional development opportunities to develop specialized knowledge and understanding of the groups they serve. Providers shall obtain the necessary knowledge and training to maintain humility and sensitivity when working with clients of diverse backgrounds.	
IV-9 Advocacy		Addiction Professionals advocate for the needs of the diverse populations they serve.	
IV-10 Recruitment		Addiction Professionals support and advocate for the recruitment and retention of Professionals and other Service Providers who represent diverse cultural groups.	
IV-11 Linguistic Diversity		Addiction Professionals shall provide or advocate for the provision of professional services that meet the needs of clients with linguistic diversity. Providers shall provide or advocate for the provision of professional services that meet the needs of clients with diverse disabilities.	
IV-12 Needs Driven		Addiction Professionals shall recognize that conventional counseling styles may not meet the needs of all clients. Providers shall open a dialogue with the client to determine the best manner in which to service the client. Providers shall seek supervision and consultation when working with individuals with specific culturally-driven needs.	
PRINCIPLE V: ASSESSMENT, EVALUATION AND INTERPRETATION			
V-1 Assessment		Addiction Professionals shall use assessments appropriately within the counseling process. The clients' personal and cultural contexts are taken into consideration when assessing and evaluating a client. Providers shall develop and use appropriate mental health, substance use disorder, and other relevant assessments.	
V-2 Validity - Reliability		Addiction Professionals shall utilize only those assessment instruments whose validity and reliability have been established for the population tested, and for which they have received adequate training in administration and interpretation. Counselors using technology-assisted test interpretations are trained in the construct being measured and the specific instrument being used prior to using its technology- based application. Counselors take reasonable measures to ensure the proper use of assessment techniques by persons under their supervision.	
V-3 Validity		Addiction Professionals shall consider the validity, reliability, psychometric limitations, and appropriateness of instruments when selecting assessments. Providers shall use data from	

		several relevant assessment tools and/or instruments to form conclusions, diagnoses, and recommendations.	
V-4 Explanation		Addiction Professionals shall explain to clients the nature and purposes of each assessment and the intended use of results, prior to administration of the assessment. Providers shall offer this explanation in terms and language that the client or other legally authorized person can understand.	
V-5 Administration		Addiction Professionals shall provide an appropriate environment free from distractions for the administration of assessments. Providers shall ensure that technologically-administered assessments are functioning appropriately and providing accurate results.	
V-6 Cultural Influences		Addiction Professionals recognize and understand that culture influences the manner in which clients' concerns are defined and experienced. Providers are aware of historical traumas and social prejudices in the misdiagnosis and pathologizing of specific individuals and groups. Providers shall develop awareness of prejudices and biases within self and others, and shall address such biases in themselves or others. Providers shall consider the client's cultural experiences when diagnosing and treatment planning for mental health and substance use disorders.	
V-7 Diagnosing		Addiction Professionals shall provide proper diagnosis of mental health and substance use disorders, within their scope and licensure. Assessment techniques used to determine client placement for care shall be carefully selected and appropriately used.	
V-8 Results		Addiction Professionals shall consider the client's welfare, explicit understandings, and previous agreements in determining when and how to provide assessment results. Providers shall include accurate and appropriate interpretations of data when there is a release of individual or group assessment results.	
V-9 Misusing Results		Addiction Professionals shall not misuse assessment results and interpretations. Providers shall respect the client's right to know the results, interpretations and diagnoses made and strive to provide results, interpretations, and diagnoses in a manner that is understandable and does not cause harm. Providers shall adopt practices that prevent others from misusing the results and interpretations.	
V-10 Not Normed		Addiction Professionals shall select and use, with caution, assessment tools and techniques normed on populations other than that of the client. Providers shall seek supervision or consultation when using assessment tools that are not normed to the client's cultural identities.	
V-11 Referral		Addiction Professionals shall provide specific and relevant data about the client, when referring a client to a third party for assessment, to ensure that appropriate assessment instruments are used.	
V-12 Security		Addiction Professionals shall maintain the integrity and security of tests and assessment data, thereby addressing legal and contractual obligations. Providers shall not appropriate, reproduce, or modify published assessments or parts thereof without written permission from the publisher.	
V-13 Forensic		Addiction Professionals conducting an evaluation shall inform the client, verbally and in writing, that the current relationship is for the purposes of evaluation. The evaluation is not therapeutic. Entities or individuals who will receive the evaluation report are identified, prior to conducting the evaluation. Providers performing forensic evaluations shall obtain written consent from those being evaluated or from their legal representative unless a court orders evaluations to be conducted without the written consent of the individuals being evaluated. informed written consent shall be obtained from a parent or guardian prior to evaluation. when the child or adult lacks the capacity to give voluntary consent.	
V-14 Forensic		Addiction Professionals conducting forensic evaluations shall provide verifiable objective findings based on the data gathered during the assessment/evaluation process and review of records. Providers form unbiased professional opinions based on the data gathered and analysis during the assessment processes.	
V-15 Forensic		Addiction Professionals shall not evaluate, for forensic purposes, current or former clients, spouses or partners of current or former clients, or the clients' family members. Providers shall not provide counseling to the individuals they are evaluating. Providers shall avoid potentially harmful personal or professional relationships with the family members, romantic partners, and close friends of individuals they are evaluating.	
PRINCIPLE VI: E-THERAPY, E-SUPERVISION, AND SOCIAL MEDIA			
VI-1 Definition		"E-Therapy" and "E-Supervision" shall refer to the provision of services by an Addiction Professional using technology, electronic devices, and HIPAA-compliant resources. Electronic	

		platforms shall include and are not limited to: land-based and mobile communication devices, fax machines, webcams, computers, laptops and tablets. E-therapy and e-supervision shall include and are not limited to: tele-therapy, real-time video-based therapy and services, emails, texting, chatting, and cloud storage. Providers and Clinical Supervisors are aware of the unique challenges created by electronic forms of communication and the use of available technology, and shall take steps to ensure that the provision of e-therapy and e-supervision is safe and as confidential as possible.	
VI-2 Competency		Addiction Professionals who choose to engage in the use of technology for e-therapy, distance counseling, and e-supervision shall pursue specialized knowledge and competency regarding the technical, ethical, and legal considerations specific to technology, social media, and distance counseling. Competency shall be demonstrated through means such as specialized certifications and additional course work and/or trainings.	
VI-3 Informed Consent		Addiction Professionals, who are offering an electronic platform for e-therapy, distance counseling/case management, e-supervision shall provide an Electronic/Technology Informed Consent. The electronic informed consent shall explain the right of each client and supervisee to be fully informed about services delivered through technological mediums, and shall provide each client/supervisee with information in clear and understandable language regarding the purposes, risks, limitations, and costs of treatment services, reasonable alternatives, their right to refuse service delivery through electronic means, and their right to withdraw consent at any time. Providers have an obligation to review with the client/supervisee – in writing and verbally – the rights and responsibilities of both Providers and clients/supervisees. Providers shall have the client/ supervisee attest to their understanding of the parameters covered by the Electronic/Technology Informed Consent.	
VI-4 Informed Consent		A thorough e-therapy informed consent shall be executed at the start of services. A technology-based informed consent discussion shall include: • distance counseling credentials, physical location of practice, and contact information; • risks and benefits of engaging in the use of distance counseling, technology, and/or social media; • possibility of technology failure and alternate methods of service delivery; • anticipated response time; • emergency procedures to follow; • when the counselor is not available; • time zone differences; • cultural and/or language differences that may affect delivery of services; and • possible denial of insurance benefits; and social media policy.	
VI-5 Verification		Addiction Professionals who engage in the use of electronic platforms for the delivery of services shall take reasonable steps to verify the client's/supervisee's identity prior to engaging in the e-therapy relationship and throughout the therapeutic relationship. Verification can include, but is not limited to, picture ids, code words, numbers, graphics, or other nondescript identifiers.	
VI-6 Licensing Laws		Addiction Professionals shall comply with relevant licensing laws in the jurisdiction where the Provider/Clinical Supervisor is physically located when providing care and where the client/supervisee is located when receiving care. Emergency management protocols are entirely dependent upon where the client/supervisee receives services. Providers, during informed consent, shall notify their clients/supervisees of the legal rights and limitations governing the practice of counseling/supervision across state lines or international boundaries. Mandatory reporting and related ethical requirements such as duty to warn/notify are tied to the jurisdiction where the client/supervisee is receiving services.	
VI-7 State & Federal Laws		Addiction Professionals utilizing technology, social media, and distance counseling within their practice recognize that they are subject to state and federal laws and regulations governing the counselor's practicing location. Providers utilizing technology, social media, and distance counseling within their practice recognize that they shall be subject to laws and regulations in the client's/supervisee's state of residency and shall be subject to laws and regulations in the state where the client/supervisee is located during the actual delivery of services.	
VI-8 Non-Secured		Addiction Professionals recognize that electronic means of communication are not secure, and shall inform clients, students, and supervisees that remote services using electronic means of delivery cannot be entirely secured or confidential. Providers who provide services via electronic technology shall fully inform each client, student, or supervisee of the limitations and risks regarding confidentiality associated with electronical delivery, including the fact that electronic	

		exchanges may become part of clinical, academic, or professional records. Efforts shall be made to ensure privacy so clinical discussions cannot be overheard by others outside of the room where the services are provided. Internet-based counseling shall be conducted on HIPAA-compliant servers. Therapy shall not occur using text-based or email-based delivery.	
VI-9 Assess		Addiction Professionals shall assess and document the client's/supervisee's ability to benefit from and engage in e-therapy services. Providers shall consider the client's/supervisee's cognitive capacity and maturity, past and current diagnoses, communications skills, level of competence using technology, and access to the necessary technology. Providers shall consider geographical distance to nearest emergency medical facility, efficacy of client's support system, current medical and behavioral health status, current or past difficulties with substance abuse, and history of violence or self-injurious behavior.	
VI-10 Access		Addiction Professionals shall inform clients that other individuals (i.e., colleagues, supervisors, staff, consultants, information technologists) might have authorized or unauthorized access to such records or transmissions. Providers use current encryption standards within their websites and for technology-based communications. Providers take reasonable precautions to ensure the confidentiality of information transmitted and stored through any electronic means.	
VI-11 Multidisciplinary Care		Addiction Professionals shall acknowledge and discuss with the client that optimal clinical management of clients may depend on coordination of care between a multidisciplinary care team. Providers shall explain to clients that they may need to develop collaborative relationships with local community professionals, such as the client's local primary care provider and local emergency service providers, as this would be invaluable in case of emergencies.	
VI-12 Local Resources		Addiction Professionals shall be familiar with local in-person mental health resources should the Provider exercise clinical judgment to make a referral for additional substance abuse, mental health, or other appropriate services.	
VI-13 Boundaries		Addiction Professionals shall appreciate the necessity of maintaining a professional relationship with their clients/supervisees. Providers shall discuss, establish and maintain professional therapeutic boundaries with clients/supervisees regarding the appropriate use and application of technology, and the limitations of its use within the counseling/supervisory relationship.	
VI-14 Capability		Addiction Professionals shall take reasonable steps to determine whether the client/supervisee physically, intellectually, emotionally, linguistically and functionally capable of using e-therapy platforms and whether e-therapy/e-supervision is appropriate for the needs of the client/supervisee. Providers and clients/supervisees shall agree on the means of e-therapy/ e-supervision to be used and the steps to be taken in case of a technology failure. Providers verify that clients/supervisees understand the purpose and operation of technology applications and follow up with clients/supervisees to correct potential concerns, discover appropriate use, and assess subsequent steps.	
VI-15 Missing Cues		Addiction Professionals shall acknowledge the difference between face-to-face and electronic communication (nonverbal and verbal cues) and how these could influence the counseling/supervision process. Providers shall discuss with their client/supervisee how to prevent and address potential misunderstandings arising from the lack of visual cues and voice inflections when communicating electronically.	
VI-16 Records		Addiction Professionals understand the inherent dangers of electronic health records. Providers are responsible for ensuring that cloud storage sites in use are HIPAA compliant. Providers inform clients/supervisees of the benefits and risks of maintaining records in a cloud-based file management system, and discuss the fact that nothing that is electronically saved on a Cloud is confidential and secure. Cloud-based file management shall be encrypted, secured, and HIPAA-compliant. Providers shall use encryption programs when storing or transmitting client information to protect confidentiality.	
VI-17 Records		Addiction Professionals shall maintain electronic records in accordance with relevant state and federal laws and statutes. Providers shall inform clients on how records will be maintained electronically and/or physically. This includes, but is not limited to, the type of encryption and security used to store the records and the length of time storage of records is maintained.	
VI-18 Links		Addiction Professionals who provide e-therapy services and/or maintain a professional website shall provide electronic links to relevant licensure and certification boards and professional membership organizations (i.e., NAADAC) to protect the client's/supervisee's rights and address ethical concerns.	
VI-19 Friends		Addiction Professionals shall not accept clients' "friend" requests on social networking sites or email (from Facebook, My Space, etc.), and shall immediately delete all personal and email	

		accounts to which they have granted client access and create new accounts. When Providers choose to maintain a professional and personal presence for social media use, separate professional and personal web pages and profiles are created that clearly distinguish between the professional and personal virtual presence.	
VI-20 Social Media		Addiction Professionals shall clearly explain to their clients/supervisees, as part of informed consent, the benefits, inherent risks including lack of confidentiality, and necessary boundaries surrounding the use of social media. Providers shall clearly explain their policies and procedures specific to the use of social media in a clinical relationship. Providers shall respect the client's/supervisee's rights to privacy on social media and shall not investigate the client/supervisee without prior consent.	
PRINCIPLE VII: SUPERVISION AND CONSULTATION			
VII-1 Responsibility		Addiction Professionals who teach and provide clinical supervision accept the responsibility of enhancing professional development of students and supervisees by providing accurate and current information, timely feedback and evaluations, and constructive consultation.	
VII-2 Training		Addiction Professionals shall complete training specific to clinical supervision prior to offering or providing clinical supervision to students or other professionals.	
VII-3 Code of Ethics		Supervisors and supervisees, including interns and students, shall be responsible for knowing and following the NAADAC Code of Ethics.	
VII-4 Informed Consent		Informed consent is an integral part of setting up a supervisory relationship. Supervisory informed consent shall include discussion regarding client privacy and confidentiality, etc. Terms of supervisory relationship and fees shall be negotiated by supervisor and supervisee, and shall be documented in the supervisory contract.	
VII-5 Informed Consent		Supervisees shall provide clients with a written professional disclosure statement. Supervisees shall inform clients about how the supervision process influences the limits of confidentiality. Supervisees shall inform clients about who shall have access to their clinical records, and when and how these records will be stored, transmitted, or otherwise reviewed.	
VII-6 Informed Consent		Clinical Supervisors shall communicate to the supervisee, during supervision informed consent, procedures for handling client/clinical crises. Alternate procedures are also communicated and documented in the event that the supervisee is unable to establish contact with the supervisor during a client/clinical crisis.	
VII-7 Policies		Clinical Supervisors shall inform supervisees of policies and procedures to which supervisors shall adhere. Supervisors shall inform supervisees regarding the mechanisms for due process appeal of supervisor actions.	
VII-8 Multiculturalism		Clinical Supervisors shall be cognizant of and address the role of multiculturalism in the supervisory relationship between supervisor and supervisee.	
VII-9 Multiculturalism		Educators and site supervisors shall offer didactic learning content and experiential opportunities related to multiculturalism and cultural humility throughout their programs.	
VII-10 Diversity		Educators and site supervisors shall make every attempt to recruit and retain a diverse faculty and staff. Educators and site supervisors shall make every attempt to recruit and retain a diverse student body, demonstrating their commitment to serve a diverse community. Educators and site supervisors shall recognize and value the diverse talents and abilities that students bring to their training experience.	
VII-11 Diversity		Educators and site supervisors shall provide appropriate accommodations that meet the needs of their diverse student body and support well-being and academic performance.	
VII-12 Boundaries		Clinical Supervisors shall intentionally develop respectful and relevant professional relationships and maintain appropriate boundaries with clinicians, students, interns, and supervisees, in all venues. Supervisors shall strive for accuracy and honesty in their assessments of students, interns, and supervisees.	
VII-13 Boundaries		Clinical Supervisors clearly define and maintain ethical professional, personal, and social boundaries with their supervisees. Supervisors shall not enter into a romantic/sexual/nonprofessional relationship with current supervisees, whether in-person and/or electronically.	
VII-14 Confidentiality		Clinical Supervisors shall not disclose confidential information in teaching or supervision without the expressed written consent of a client, and only when appropriate steps have been taken to protect client's identity and confidentiality.	
VII-15 Monitor		Clinical Supervisors shall monitor the services provided by supervisees. Supervisors shall monitor client welfare. Supervisors shall monitor supervisee performance and professional development.	

		Supervisors shall empower and support supervisees as they prepare to serve a diverse client population. Supervisors shall have an ethical and moral responsibility to understand, adhere to, and promote the NAADAC Code of Ethics.	
VII-16 Treatment		Educators and site supervisors shall assume the primary obligation of assisting students to acquire ethics, knowledge, and skills necessary to treat substance use and addictive behavioral disorders	
VII-17 Impairment		Supervisees, including interns and students, shall monitor themselves for signs physical, psychological, and/or emotional impairment. Supervisees, including interns and students, shall seek supervision and refrain from providing professional services while impaired. Supervisees, interns and students shall notify their institutional program of the impairment and shall seek appropriate guidance and assistance.	
VII-18 Clients		Supervisees, interns and students, shall disclose to clients their status as students and supervisees, and shall provide an explanation as to how their status affects the limits of confidentiality. Supervisees, interns and students shall disclose to clients contact information for the Clinical Supervisor. Informed consent is obtained in writing, and includes the client's right to refuse to be treated by a person-in-training.	
VII-19 Disclosures		Supervisees, interns and students shall seek and document clinical supervision prior to disclosing personal information to a client.	
VII-20 Observations		Clinical Supervisors shall provide and document regular supervision sessions with the supervisee. Supervisors shall regularly observe the supervisee in session using live observations or audio or video tapes. Supervisors shall provide ongoing feedback regarding the supervisee's performance with clients and within the agency. Supervisors shall regularly schedule sessions to formally evaluate and direct the supervisee.	
VII-21 Gatekeepers		Clinical Supervisors are aware of their responsibilities as gatekeepers. Through ongoing evaluation, Supervisors shall track supervisee limitations that might impede performance. Supervisors shall assist supervisees in securing timely corrective assistance as needed, including referral of supervisee to therapy when needed. Supervisors may recommend corrective action or dismissal from training programs, applied counseling settings, and state or voluntary professional credentialing processes when a supervisee is unable to demonstrate that they can provide competent professional services. Supervisors shall seek supervision-of-supervision and/or consultation and document their decisions to dismiss or refer supervisees for assistance.	
VII-22 Education		Educators and site supervisors shall ensure that their educational and training programs are designed to provide appropriate knowledge and experiences related to addictions that meet the requirements for degrees, licensure, certification, and other program goals.	
VII-23 Education		Educators and site supervisors shall provide education and training in an ethical manner, adhering to the NAADAC Code of Ethics, regardless of the platform (traditional, hybrid, and/or online). Educators and site supervisors shall serve as professional roles models demonstrating appropriate behaviors.	
VII-24 Current		Educators and site supervisors shall ensure that program content and instruction are based on the most current knowledge and information available in the profession. Educators and site supervisors shall promote the use of modalities and techniques that have an empirical or scientific foundation.	
VII-25 Evaluation		Educators and site supervisors shall ensure that students' performances are evaluated in a fair and respectful manner and on the basis of clearly stated criteria.	
VII-26 Dual Relationships		Educators and site supervisors shall avoid dual relationships and/or nonacademic relationships with students, interns, and supervisees.	
VII-27 Dual Relationships		Clinical Supervisors shall not actively supervise relatives, romantic or sexual partners, nor personal friends, nor develop romantic, sexual, or personal relationships with students or supervisees. Consultation with a third party will be obtained prior to engaging in a dual supervisory relationship.	
VII-28 e-supervision		Clinical Supervisors, using technology in supervision (e-supervision), shall be competent in the use of specific technologies. Supervisors shall dialogue with the supervisee about the risks and benefits of using e-supervision. Supervisors shall determine how to utilize specific protections (i.e., encryption) necessary for protecting the confidentiality of information transmitted through any electronic means. Supervisors and supervisees shall recognize that confidentiality is not guaranteed when using technology as a communication and delivery platform.	
VII-29 Harassment		Clinical Supervisors shall not condone or participate in sexual harassment or exploitation of current or previous supervisees.	

VII-30 Distance		Issues unique to the use of distance supervision shall be included in the documentation as necessary.	
VII-31 Termination		Policies and procedures for terminating a supervisory relationship shall be disclosed in the supervision informed consent.	
VII-32 Counseling		Clinical Supervisors shall not provide counseling services to supervisees. Supervisors shall assist supervisee by providing referrals to appropriate services upon request.	
VII-33 Endorsement		Clinical Supervisors shall recommend supervisees for completion of an academic or training program, employment, certification and/or licensure when the supervisee demonstrates qualification for such endorsement. Clinical Supervisors shall not endorse supervisees believed to be impaired. Clinical Supervisors shall not endorse supervisees who were unable to provide appropriate clinical services.	
PRINCIPLE VIII: RESOLVING ETHICAL CONCERNS			
VIII-1 Code of Ethics		Addiction Professionals shall adhere to and uphold the NAADAC Code of Ethics, and shall be knowledgeable regarding established policies and procedures for handling concerns related to unethical behavior, at both the state and national levels. Providers strive to resolve ethical dilemmas with direct and open communication among all parties involved and seek supervision and/or consultation when necessary. Providers incorporate ethical practice into their daily professional work. Providers engage in ongoing professional development regarding ethical and legal issues in counseling. Providers are professionals who act ethically and legally. Providers are aware that client welfare and trust depend on a high level of professional conduct. Addiction Professionals hold other providers to the same ethical and legal standards and are willing to take appropriate action to ensure that these standards are upheld.	
VIII-2 Understanding		Addiction Professionals shall understand and endorse the NAADAC Code of Ethics and other applicable ethics codes from professional organizations or certification and licensure bodies of which they are members. Lack of knowledge or misunderstanding of an ethical responsibility is not a defense against a charge of unethical conduct.	
VIII-3 Decision Making Model		Addiction Professionals shall utilize and document, when appropriate, an ethical decision-making model when faced with an ethical dilemma. A viable ethical decision-making model shall include but is not limited to: (a) supervision and/or consultation regarding the concern; (b) consideration of relevant ethical standards, principles, and laws; (c) generation of potential courses of action; (d) deliberation of risks and benefits of each potential course of action; (e) selection of an objective decision based on the circumstances and welfare of all involved; and (f) reflection, and re-direction if necessary, after implementing the decision.	
VIII-4 Jurisdiction		The NAADAC and NCC AP Ethics Committees shall have jurisdiction over all complaints filed against any person holding or applying for NAADAC membership or NCC AP certification.	
VIII-5 Investigations		The NAADAC and NCC AP Ethics Committees shall have authority to conduct investigations, issue rulings, and invoke disciplinary action in any instance of alleged misconduct by an addiction professional.	
VIII-6 Participation		Addiction Professionals shall be required to cooperate with the implementation of the NAADAC Code of Ethics, and to participate in, and abide by, any disciplinary actions and rulings based on the Code. Failure to participate or cooperate is a violation of the NAADAC Code of Ethics.	
VIII-7 Cooperation		Addiction Professionals shall assist in the process of enforcing the NAADAC Code of Ethics. Providers shall cooperate with investigations, proceedings, and requirements of the NAADAC and NCC AP Ethics Committees, ethics committees of other professional associations, and/or licensing and certification boards having jurisdiction over those charged with a violation.	
VIII-8 Agency Conflict		Addiction Professionals shall seek and document supervision and/or consultation in the event that ethical responsibilities conflict with agency policies and procedures, state and/or federal laws, regulations, and/or other governing legal authority. Supervision and/or consultation shall be sued to determine the next best steps.	
VIII-9 Crossroads		Addiction Professionals may find themselves at a crossroads when the demands of an organization where the Provider is affiliated poses a conflict with the NAADAC Code of Ethics. Providers shall determine the nature of the conflict and shall discuss the conflict with their supervisor or other relevant person at the organization in question, expressing their commitment to the NAADAC Code of Ethics. Providers shall attempt to work through the appropriate channels to address the concern.	
VIII-10		When there is evidence to suggest that another provider is violating or has violated an ethical standard and harm has not occurred, Addiction Professionals shall attempt to first resolve the	

Violations without Harm		issue informally with the other provider if feasible, provided such action does not violate confidentiality rights that may be involved.	
VIII-11 Violations with Harm		Addiction Professionals shall report unethical conduct or unprofessional modes of practice - leading to harm - which they become aware of to the appropriate certifying or licensing authorities, state or federal regulatory bodies, and/or NAADAC. Providers shall seek supervision/consultation prior to the report. Providers shall document supervision/consultation and report if made.	
VIII-12 Non-Respondent		Members of the NAADAC or NCC AP Ethics Committees, Hearing Panels, Boards of Directors, Membership Committees, Officers, or Staff shall not be named as a respondent under these policies and procedures as a result of any decision, action, or exercise of discretion arising directly from their conduct or involvement in carrying out adjudication responsibilities.	
VIII-13 Consultation		Addiction Professionals shall seek consultation and direction from supervisors, consultants or the NAADAC Ethics Committee when uncertain about whether a particular situation or course of action may be in violation of the NAADAC Code of Ethics. Providers consult with persons who are knowledgeable about ethics, the NAADAC Code of Ethics, and legal requirements specific to the situation.	
VIII-14 Retaliation		Addiction Professionals shall not initiate, participate in, or encourage the filing of an ethics or grievance complaint as a means of retaliation against another person. Providers shall not intentionally disregard or ignore the facts of the situation.	
PRINCIPLE IX: RESEARCH AND PUBLICATION			
IX-1 Research		Research and publication shall be encouraged as a means to contribute to the knowledge base and skills within the addictions and behavioral health professions. Research shall be encouraged to contribute to the evidence-based and outcome-driven practices that guide the profession. Research and publication provide an understanding of what practices lead to health, wellness, and functionality. Researchers and Addiction Professionals make every effort to be inclusive by minimizing bias and respecting diversity when designing, executing, analyzing, and publishing their research.	
IX-2 Participation		Addiction Professionals support the efforts of researchers by participating in research whenever possible.	
IX-3 Consistent		Researchers plan, design, conduct, and report research in a manner that is consistent with relevant ethical principles, federal and state laws, internal review board expectations, institutional regulations, and scientific standards governing research.	
IX-4 Confidentiality		Researchers are responsible for understanding and adhering to state, federal, agency, or institutional policies or applicable guidelines regarding confidentiality in their research practices. Information obtained about participants during the course of research is confidential.	
IX-5 Independent		Researchers, who are conducting independent research without governance by an institutional review board, are bound to the same ethical principles and federal and state laws pertaining to the review of their plan, design, conduct, and reporting of research.	
IX-6 Protect		Researchers shall seek supervision and/or consultation and observe necessary safeguards to protect the rights of research participants, especially when the research plan, design and implementation deviates from standard or acceptable practices.	
IX-7 Welfare		Researchers who conduct research are responsible for their participants' welfare. Researchers shall exercise reasonable precautions throughout the study to avoid causing physical, intellectual, emotional, or social harm to participants. Researchers take reasonable measures to honor all commitments made to research participants.	
IX-8 Informed Consent		Researchers shall defer to an Institutional Review Board or Human Subjects Committee to ensure that Informed Consent is obtained, research protocols are followed, participants are free of coercion, confidentiality is maintained, and deceptive practices are avoided, except when deception is essential to research protocol and approved by the Board or Committee.	
IX-9 Accurate		Researchers shall commit to the highest standards of scholarship, and shall present accurate information, disclose potential conflicts of interest, and make every effort to prevent the distortion or misuse of their clinical and research findings.	
IX-10 Students		Researchers shall disclose to students and/or supervisee who wish to participate in their research activities that participation in the research will not affect their academic standing or supervisory relationship.	
IX-11 Clients		Researchers may conduct research involving clients. Researchers shall provide an informed consent process allowing clients to freely, without intimidation or coercion, choose whether to	

		participate in the research activities. Researchers shall take necessary precautions to protect clients from adverse consequences if they choose to decline or withdraw from participation.	
IX-12 Consents		Researchers shall provide appropriate explanations regarding the research and obtain applicable consents from a guardian or legally authorized representative prior to working with a research participant who is not capable of giving informed consent.	
IX-13 Explanation		Once data collection is completed, Researchers shall provide participants with a full explanation regarding the nature of the research in order to remove any misconceptions participants might have regarding the study. Researchers shall engage in reasonable actions to avoid causing harm. Scientific or human values may justify delaying or withholding information. Researchers shall seek and document supervision and/or consultation prior to delaying or withholding information from a participant.	
IX-14 Outcomes		Upon completion of data collection and analysis, Researchers shall inform sponsors, institutions, and publication entities regarding the research procedures and outcomes. Researchers shall ensure that the appropriate entities are given pertinent information and acknowledgment.	
IX-15 Transfer Plan		Researchers shall create a written, accessible plan for the transfer of research data to an identified colleague in the event of their incapacitation, retirement, or death.	
IX-16 Diversity		Researchers shall report research findings accurately and without distortion, manipulation, or misrepresentation of data. Researchers shall describe the extent to which results are applicable to diverse populations.	
IX-17 Verification		Researchers shall not withhold data, from which their research conclusions were drawn, from competent professionals seeking to verify substantive claims through reanalysis. Researchers are obligated to make available sufficient original research information to qualified professionals who wish to replicate or extend the study.	
IX-18 Data Availability		Researchers, who supply data, aid in research by another researcher, report research results, or make original data available, shall intentionally disguise the identity of participants in the absence of written authorization from the participants allowing release of their identity.	
IX-19 Errors		Researchers shall take reasonable steps to correct significant errors found in their published research, using a correction erratum or through other appropriate publication avenues.	
IX-20 Publication		Addiction Professionals who author books, journal articles, or other materials which are published or distributed shall not plagiarize or fail to cite persons for whom credit for original ideas or work is due. Providers shall acknowledge and give recognition, in presentations and publications, to previous work on the topic by self and others.	
IX-21 Theft		Addiction Professionals shall regard as theft the use of copyrighted materials without permission from the author or payment of royalties.	
IX-22 e-publishing		Addiction Professionals shall recognize that entering data on the internet, social media sites, or professional media sites constitutes publishing.	
IX-23 Advertising		Addiction Professionals who author books or other materials distributed by an agency or organization shall take reasonable precautions to ensure that the organization promotes and advertises the materials accurately and factually.	
IX-24 Credit		Addiction Professionals shall assign publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with customary professional publication practices.	
IX-25 Student Material		Addiction Professionals shall seek a student's permission and list the student as lead author on manuscripts or professional presentations, in any medium, that are substantially based on a student's course papers, projects, dissertations, or theses. The student reserves the right to withhold permission.	
IX-26 Submissions		Addiction Professionals and Researchers shall submit manuscripts for consideration to one journal or publication at a time. Providers and researchers shall obtain permission from the original publisher prior to submitting manuscripts that are published in whole or in substantial part in one journal or published work to another publisher.	
IX-27 Proprietary		Addiction Professionals who review material submitted for publication, research, or other scholarly purposes shall respect the confidentiality and proprietary rights of those who submitted it. Providers who serve as reviewers shall make every effort to only review materials that are within their scope of competency and to review materials without professional or personal bias.	

If you should decide to file an ethics complaint, please make sure to provide the Ethics Committee with all relevant documentation, explanations, and data. If the case has been filed with a state agency, the Ethics Committees need a copy of the complaint and the corresponding documentation submitted to the state. The Ethics Committees' are not able to act on complaints that do not fall within the scope of NAADAC's/NCC AP's Code of Ethics. The Complainant's and Respondent's contact information (name, address, email, phone numbers) is crucial if a complaint is to be investigated. In your letter to the Ethics Committee signaling a formal complaint, please include: the specifics of the case, the players involved (all information sent to the Ethics Committee is deemed confidential, i.e., client names, etc.), an explanation of your concerns, a run-down on what you have tried previously to remedy the situation, and which NAADAC/NCC AP Code of Ethics Principles have been violated. Missing information keeps the Ethics Committees' from acting in a timely manner. Every effort is made to make sure all the necessary information has been gathered prior to rendering a decision. All complaints filed with NAADAC or NCC AP are taken seriously.

To read the newly updated 2016 Code of Ethics, please visit www.naadac.org/code-of-ethics.

Mita M. Johnson, EdD, LAC, MAC, SAP, has a doctorate in Counselor Education and Supervision, an MA in Counseling, and a BA in Biology. She is a licensed professional counselor, licensed marriage and family therapist, and licensed addiction counselor, along with earning the national Master Addiction Counselor (MAC) and Department of Transportation Substance Abuse Professional (SAP) certifications. Johnson has two supervisory credentials (ACS and AAMFT) and is a NCC. She is a core faculty member at Walden University, and she maintains a private practice where she works with supervisees who are working on credentialing. Johnson is the Past-President of the Colorado Association of Addiction Professionals (CAAP), and is currently NAADAC Treasurer and Ethics Chair. She previously served as NAADAC's Southwest Regional Vice-President. In Colorado, Johnson is involved in regulatory and credentialing activities as well as workforce recruitment and retention initiatives. She speaks and trains regionally and nationally on a variety of topics. Her passions beyond workforce retention include pharmacology of drugs of addiction, infectious diseases, ethics, motivational interviewing, and clinical supervision.

Ethical Decision Making Tree

1. **IDENTIFY the ethical dilemma and/or legal issues**
   - *Gather specific and objective information; clarify and clearly articulate the problem(s)*
2. **APPLY the NAADAC/NCC AP Code of Ethics and applicable laws**
   - *Find the applicable Principle(s) in the Code, apply Principle, and apply standard where possible*
3. **EXAMINE the nature and dimensions of the dilemma**
   - *Examine Principles, seek supervision/consultation; contact NAADAC and other applicable associations, and state regulatory agencies for guidance*
4. **GENERATE list of potential options/solutions**
   - *Brainstorm all potential options/solutions; consult with supervisor or consultant*
5. **CONSIDER potential consequences of each option/solution generated in Step #4**
   - *Evaluate each option's pros and cons, ponder implications, and eliminate problematic options*
6. **EVALUATE the selected options and develop a course of action**
   - *Make sure option(s) are fair, can pass public scruitiny, and are a course of action another counselor might consider for this particular dilemma; if option(s) pass test, move on to implementation*
7. **IMPLEMENT the chosen course of action**
   - *Carry out the plan; taking necessary steps regarding ethical dilemma may be difficult or easy*
8. **ANALYZE the implementation of the plan**
   - *Determine if actions had anticipated effect and consequences; if plan worked, continue on*
9. **RE-ASSESS if implementation was not successful. Begin decision-making process again**
   - *Complex ethical dilemmas require more time to thoroughly analyze all aspects of the issue*
   - *Reach out to NAADAC and/or NCC AP Ethics Committee when unclear about potential options and actions*

Appendix A: Ethics, Boundaries and Duel Relationships. Professional Issues for Addiction Professionals

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFFERENT ORDER IN THE ONLINE EXAM

Answer the following questions by selecting the most appropriate response.

1. Which of the following can an addiction counselor break client's confidentiality without a release form?
   a. To the client's lawyer: the divorce lawyer needs evaluation records to present in court
   b. To the client's wife: she wants to know the diagnosis so she can call their health insurance company
   c. To the emergency room: The client fell, suffered a concussion and had to be rushed to the emergency room
   d. None of the above

2. A treatment facility had a security breech in one of their computer systems where assessments and diagnosis are kept. Which of the following statements is true?
   a. All clients sign a form advising the impact of electronic records and use of electronic devices and the possibility of breach. Therefore, they are not obligated to inform clients.
   b. Since the client signed a form advising the impact/danger of electronic records, the counselor decides not to inform the client during treatment to avoid harm
   c. The addiction counselor does not want IT to disturb patients
   d. The facility informs affected clients about the breach

3. Which of the following is not an example of dual relationship?
   a. A counselor asks one of his clients who is a painter to do some painting in his office and cuts a special deal for the counseling sessions
   b. A counselor sells his new book to patients from his office and charges an extra $1 for his autograph
   c. A counselor starts dating one of his interns
   d. A counselor refuses to provide treatment to Muslims because his wife died during 9/11 terrorist attack

4. An addiction counselor suspects that a nurse is under the influence. He follows ethical protocol and reports the incident. This is an example of principal/standard:
   a. Principal IV Professional responsibility, standard 4
   b. Principal VII, Supervision and Consultation
   c. Principal VI Workplace Standards
   d. All the above

5. Telling the truth and keeping promises is at the core of which:
   a. Justice
   b. Fidelity
   c. Autonomy
   d. Competence

6. To be an ethnically sensitive addiction professional one must have:
   a. friends who are of different ethnic groups
   b. an awareness of his limits in terms of knowledge and skills
   c. an in-depth knowledge about all the different customs, religions and values of the population he/she serves
   d. the same ethnicity and religion of the client group they serve

7. Codes of ethics represent:
   a. consensus standards of conduct, reflecting the professions' expectations, obligations, and conduct
   b. a guideline for evaluation of situations and choices that more clearly fit values and behavior of the profession
   c. none of the above
   d. a and b

8. Ethics codes often play an important role in
   a. the criminal law system
   b. The judicial law system
   c. civil law actions and in administrative law proceedings
   d. None of the above

9. What entity generally investigates and determines the outcome of an ethics code violation?
   a. Universities
   b. Certification and/or Licensing boards
   c. The Police
   d. The Ethics Committee of the credentialing authority

10. What are the potential ethical risks that a counselor could face when using social media such as Facebook?
    a. A client may seek personal information such as the counselor's address and show up at the counselor's house
    b. A client can post a friend request: If the counselor denies, it could lead to feelings of rejection. Or If the counselor approves, it could lead to the development of dual relationship
    c. The court system will incarcerate the counselor
    d. a and b

11. Knowing what to do in a possible unethical situation should be an instinct for addiction counselors
    a. True
    b. False

12. What precautions should an addiction counselor take when using social media?
    a. Use available privacy settings, customize the possible visibility, minimize the exposure of personal information, and tag in personal photos
    b. Ask social media company authority to block his/her clients. Provide an updated client list monthly
    c. Deny all friend's requests from client
    d. Invest in a spyware for his/her personal computer to receive a warning

13. An impaired professional is obligated to seek help. The professional has a responsibility to determine if the problem is affecting his/her professional competency. However, an impaired person cannot make this determination because of that very impairment.
    a. True
    b. False

14. When feelings about, from or toward a client arise, either like or dislike, this and related issues need to be discussed:
    a. With NAADAC ethics committee
    b. During supervision
    c. With another addiction counselor
    d. With their sponsor

15. Addiction counselors will attempt to resolve ethical dilemmas:
    a. with direct and open communication among all parties involved
    b. by seeking supervision and/or consultation as appropriate.
    c. By hiring a lawyer
    d. a and b

16. It is an addiction counselor's responsibility to terminate a client's treatment when:
    a. When a client can't afford services any longer
    b. Transference is occurring by a client's family member
    c. The client is no longer benefiting from treatment
    d. The client wants to stop participating in the treatment

17. Informed consent procedures do not include:
    a. motivating the client to seek additional treatment in writing
    b. inform the client of his/her confidentiality rights in writing
    c. informing the client of any areas likely to affect the client's confidentiality
    d. explain the impact of electronic records and use of electronic devices to transmit confidential information

18. Stewardship is:
    a. to work hard in the chosen profession
    b. a protective services agency has been involved with anyone who lives in the home
    c. the use of good judgment, honoring confidentiality and the privacy of others
    d. to use available resources in a judicious and conscientious manner, to give back

19. An addiction counselor must inform a client if he/she is going to record or video a session
    a. True
    b. False

20. A client must inform the counselor if he/she is planning on recording a session
    a. True
    b. False

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Welcome to the growing family of coursework participants at CEU Matrix - The Institute for Addiction and Criminal Justice Studies.

This distance learning course package was developed for CEU Matrix by John H. Tinsley, Ph.D. It is based on information found in the manual *The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs* from the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. This manual can be obtained free of charge from the DHHS.

This package contains the DHHS course materials, along with the post test and evaluation that are required to obtain the certificate of completion for the course. You may submit your answers online to receive the fastest response and access to your online certificate of completion. To take advantage of this option, simply access the Student Center at http://www.ceumatrix.com/studentcenter; login as a Returning Customer by entering your email address, password, and click on 'Take Exam'. For your convenience, we have also enclosed an answer sheet that will allow you to submit your answers by mail or by fax.

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About the Instructor:

Dr. John H. Tinsley is a former assistant professor of Medical Physiology at the Texas A&M University System College of Medicine. He received his Ph.D. from Texas A&M University, College Station, Texas; M.S. from the University of North Carolina; and his B.S. from the University of Oklahoma.

He has been teaching, training, consulting and conducting research in the fields of Medical Physiology and Behavioral Biology for over twenty-nine years. Dr. Tinsley has authored over twenty-five professional and refereed articles, including invited reviews. He has been a member of the American Society for Physiology, and work done in 2001 led to an international award from The European Society on Microcirculation. Dr. Tinsley has received research funding from the Veteran's Administration, American Heart Association, and Scott and White Hospital. In addition, he has served on numerous review committees for national grant-funding agencies and scientific journals.

Using the Homepage for CEU Matrix - The Institute for Addiction and Criminal Justice Studies

The CEUMatrix – The Institute for Addiction and Criminal Justice Studies homepage (www.ceumatrix.com) contains many pieces of information and valuable links to a variety of programs, news and research findings, and information about credentialing – both local and national. We update our site on a regular basis to keep you apprised of any changes or developments in the field of addiction counseling and credentialing. Be sure to visit our site regularly, and we do recommend that you bookmark the site for fast and easy return.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS REGULATION AND THE HIPAA PRIVACY RULE

Course Summary and Description

This course is based on information found in the manual *The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs* from the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. This manual can be obtained free of charge from the DHHS.

In the early 1970's, Congress recognized that the stigma associated with substance abuse and fear of prosecution deterred people from entering treatment and enacted legislation that gave patients a right to confidentiality. The Department of Health and Human Services (HHS) issued the "Standards for Privacy of Individually Identifiable Health Information" in 2000. This privacy rule applies to substance abuse treatment programs that are subject to HIPAA. This manual is for substance abuse treatment programs that are subject to and already complying with confidentiality requirements. It explains which programs must also comply with the Privacy Rule and outlines what compliance will require. To comply with the Privacy Rule programs should apply this guidance to their individual situations. Programs may also want to call upon state agencies, provider organizations and legal counsel for assistance in establishing and implementing the practices and policy changes required by the Privacy Rule.

THE CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS REGULATION AND THE HIPAA PRIVACY RULE: IMPLICATIONS FOR ALCOHOL AND SUBSTANCE ABUSE PROGRAMS

June 2004

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

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This is an educational document from the Substance Abuse and Mental Health Services Administration and the U.S. Department of Health and Human Services. It was prepared by SAMHSA staff and contractors in consultation with the Office of the General Counsel, the Office for Civil Rights and other offices and agencies within the U.S. Department of Health and Human Services, Washington, D.C.

The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs

Introduction

In the early 1970's, Congress recognized that the stigma associated with substance abuse and fear of prosecution deterred people from entering treatment and enacted legislation that gave patients a right to confidentiality. For the almost three decades since the Federal confidentiality regulations (42 CFR Part 2 or Part 2) were issued, confidentiality has been a cornerstone practice for substance abuse treatment programs across the country.

In December, 2000, the Department of Health and Human Services (HHS) issued the "Standards for Privacy of Individually Identifiable Health Information" final rule (Privacy Rule), pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, Subparts A and E.[1] Substance abuse treatment programs that are subject to HIPAA must comply with the Privacy Rule.[2] [3] Substance abuse treatment programs that already are complying with Part 2 should not have a difficult time complying with the Privacy Rule, as it parallels the requirements of Part 2 in many areas. Programs subject to both sets of rules must comply with both, unless there is a conflict between them. Generally, this will mean that substance abuse treatment programs should continue to follow the Part 2 regulations. In some instances, programs will have to establish new policies and procedures or alter existing policies and practices. In the event a program identifies a conflict between the rules, it should notify the Substance Abuse and Mental Health Services Administration of HHS immediately for assistance in resolving the conflict.

This guidance is for substance abuse treatment programs that are subject to and already complying with the confidentiality requirements of Part 2.[4] It explains which programs must also comply with the Privacy Rule and outlines what compliance will require. The guidance is not a legal opinion. To comply with the Privacy Rule, programs should apply this guidance to their individual situations; programs may also want to call upon State agencies, provider organizations and legal counsel for assistance in establishing and implementing the practices and policy changes required by the Privacy Rule.

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[1] In August 2002, HHS adopted modifications to the Privacy Rule.

[2] The compliance date for the Privacy Rule was April 14, 2003. However, small health plans, as defined by the Privacy Rule, are not required to be in compliance until April 14, 2004.

[3] This guidance applies to substance abuse treatment programs that are also covered entities as defined by the Privacy Rule. Programs should seek legal counsel for assistance in determining whether they are covered entities.

[4] The Part 2 regulations apply to substance abuse treatment "programs" as defined by 42 CFR §2.11 that are "federally assisted" as defined by 42 CFR §2.12(b).

I. Applicability

A. Programs to which the Privacy Rule applies

The Privacy Rule applies to "covered entities" which are health plans, health care clearinghouses and health care providers[5] who transmit health information in electronic form (*i.e.*, via computer-based technology) in connection with transactions for which HHS has adopted a HIPAA standard in 45 CFR Part 162. See 45 CFR §160.103. HIPAA transactions that a substance abuse treatment program[6] might engage in include:

- Submission of claims to health plans
- Coordination of benefits with health plans
- Inquiries to health plans regarding eligibility, coverage or benefits or status of health care claims
- Transmission of enrollment and other information related to payment to health plans
- Referral certification and authorization (*i.e.,* requests for review of health care to obtain an authorization for providing health care or requests to obtain authorization for referring an individual to another health care provider)

If a substance abuse treatment program transmits health information electronically in connection with one or more of these Part 162 transactions, then it must comply with the Privacy Rule. Part 162 may be amended in the future to cover additional transactions.[7]

B. Information that is protected under Part 2 and the Privacy Rule

Part 2 protects any and all information that could reasonably be used to identify an individual and requires that disclosures be limited to the information necessary to carry out the purpose of the disclosure. See 42 CFR §§2.11 and 2.13(a). Under the Privacy Rule, a program may not use or disclose "protected health information" (PHI) except as permitted or required by the Rule.[8] See 45 CFR §164.502(a). Neither rule applies to information that has been de-identified.[9] See 45 CFR §164.514(a) (de-identification of

[5] The Privacy Rule generally defines a health care provider to include a person or organization who furnishes, bills or is paid for health care in the normal course of business, which would include substance abuse treatment programs.

[6] A substance abuse treatment program is defined as an individual or entity that provides alcohol or drug abuse diagnosis, treatment or referral. For the purposes of this document, the term "program" includes both individual substance abuse providers and substance abuse provider organizations.

[7] Neither Part 2 nor the Privacy Rule protects employment records held by a program in its role as employer. Note that while 42 CFR Part 2 arguably applies to substance abuse patient records covered by the Family Educational Rights and Privacy Act (FERPA) (20 USC §1232g; 34 CFR Part 99), the Privacy Rule does not.

[8] PHI is defined as individually identifiable health information held or transmitted by a covered entity or its "business associate," with limited exceptions. See 45 CFR §160.103.

[9] The Privacy Rule includes numerous elements that make information identifiable, such as, but not limited to, information regarding employers, relatives and household members that are not necessarily

PHI) and 42 CFR §2.11 (definition of "patient identifying information"). The Privacy Rule permits programs to assign a code or other means of record identification to allow information that has been de-identified to be re-identified, as provided in 45 CFR §164.514(c).

The two regulations have some differences in the definition of what information is protected. For instance, the Privacy Rule treats medical record numbers as PHI, subject to all the same requirements as other PHI. Part 2 would permit a program to disclose a medical record number because the regulation does not apply to "a number assigned to a patient by a program, if that number does not consist of, or contain numbers . . . which could be used to identify a patient with reasonable accuracy and speed from sources external to the program." See 42 CFR §2.11. Programs subject to both rules must follow the Privacy Rule's protection of a medical record number.

C. When protections begin for someone seeking substance abuse treatment

Part 2 protects all information about any person who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program. See 42 CFR §2.11 (definition of a "patient"). Information is subject to the Privacy Rule if it is individually identifiable information created, received, or maintained by the covered entity. Former patients and deceased patients are protected under both Part 2 and the Privacy Rule. See 42 CFR §§2.11 and 2.15 and 45 CFR §§164.501 and 164.502(f). Programs should generally continue to follow Part 2, but note that if PHI is received prior to a patient applying to a program, under the Privacy Rule, such information is protected.

II. How the Privacy Rule affects disclosures of information

A. The General Rule

The "general rules" established by Part 2 and the Privacy Rule regarding uses and disclosures of patient health information are very different.[10]

Substance abuse treatment programs must comply with both rules. Generally, this will mean that they will continue to follow Part 2's general rule and not disclose information unless they can obtain consent or point to an exception to that rule that specifically permits the disclosure. Programs must then make sure that the disclosure is also permissible under the Privacy Rule.

B. When disclosures are permitted

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identifiable information under Part 2. Such information should be protected consistent with the Privacy Rule requirements.

[10] Part 2 uses the term "disclosure" to cover what the Privacy Rule refers to as "uses" and "disclosures." See the definition of these terms in 45 CFR §160.103. Some Privacy Rule provisions differ for "uses" and "disclosures." For convenience, we generally use the Part 2 term "disclosure" throughout to encompass both uses and disclosures under the Privacy Rule. In some instances, however, specific uses or disclosures are discussed.

1. Part 2 Consent[11] and Privacy Rule Authorization

42 CFR Part 2	The Privacy Rule
Programs may not use or disclose any information about any patient unless the patient has consented in writing (on a form that meets the requirements established by the regulations) or unless another very limited exception specified in the regulations applies. Any disclosure must be limited to the information necessary to carry out the purpose of the disclosure.	The Privacy Rule permits uses and disclosures for "treatment, payment and health care operations" as well as certain other disclosures without the individual's prior written authorization. Disclosures not otherwise specifically permitted or required by the Privacy Rule must have an authorization that meets certain requirements. With certain exceptions, the Privacy Rule generally requires that uses and disclosures of PHI be the minimum necessary for the intended purpose of the use or disclosure.

Substance abuse treatment programs most often make disclosures after a patient has signed a consent form that meets the requirements of 42 CFR §2.31. Note that a disclosure under Part 2 includes the acknowledgment that someone has applied to or is enrolled in the program, and thus is only permitted if the patient has signed a consent form (or another of the regulations' narrow exceptions applies). See 42 CFR §§2.11 and 2.13. A Part 2 consent form must include the following elements:

- Name or general designation of the program or person permitted to make the disclosure;
- Name or title of the individual or name of the organization to which disclosure is to be made;
- Name of the patient;
- Purpose of the disclosure;
- How much and what kind of information is to be disclosed;
- Signature of patient (and, in some States, a parent or guardian);
- Date on which consent is signed;
- Statement that the consent is subject to revocation at any time except to the extent that the program has already acted on it; and
- Date, event, or condition upon which consent will expire if not previously revoked.

[11] This document uses the term "consent" when referring to any written permission provided by a patient for the use or disclosure of identifiable health information. The Privacy Rule uses the term "authorization" for certain permissions, and also permits, but does not require, programs to obtain "consent" for the use and disclosure of PHI for purposes of treatment, payment, or health care operations.

When programs operating under Part 2 disclose information pursuant to a consent form, they must include a written statement that the information cannot be redisclosed. See 42 CFR §2.32.

The core required elements for the Privacy Rule written authorization are similar to those of Part 2. However, to comply with the Privacy Rule authorization requirements, the Part 2 consent must also contain a statement reflecting the ability or inability of the substance abuse treatment program to condition treatment on whether the patient signs the form as described in 45 CFR §164.508(c)(2)(ii). In addition, the consent may be signed by a personal representative, and if so, must include a description of such representative's authority to act for the patient. See 45 CFR §164.508(c)(1)(vi). Finally, the consent must be written in plain language. See 45 CFR §164.508(c)(3).

The requirements above must be met with respect to the Part 2 consent form when the purpose of the disclosure is *not* for "treatment, payment or health care operations" or for any other permitted or required disclosure under the Privacy Rule. See 45 CFR §164.502(a).[12] The statements would have to be added when the consent form authorizes a program to make a disclosure for which an authorization is required under the Privacy Rule, e.g., those disclosures addressed by 45 CFR §164.508.

The Privacy Rule imposes three additional steps programs must take when disclosing information pursuant to a patient's written consent:

- Programs must ensure that the consent complies with the applicable requirements of 45 CFR §164.508.
- Programs must give patients a copy of the signed form (45 CFR §164.508(c)(4)).
- Programs must keep a copy of each signed form for six (6) years from its expiration date (45 CFR §164.508(b)(6)).

Therefore, substance abuse treatment programs should generally continue to use the consent form for disclosures subject to Part 2. If the Privacy Rule requires authorization for the disclosures, the substance abuse treatment program may use the Part 2 consent form with additional elements required by the Privacy Rule as listed above.

<u>Minors</u>

[12] See the Privacy Rule's definitions of "treatment," "payment," and "health care operations" at 45 CFR §164.501. When a substance abuse treatment program obtains information about a patient from a school, relatives, health care providers and health plans for treatment or payment activities, when it refers a patient to other providers and services and when it coordinates care with other health care providers, it almost always makes an implicit disclosure that the patient has applied for or has received alcohol or drug abuse treatment services and thus the program is required to treat these contacts as disclosures and obtain patient consent prior to such contact. In most of these instances, the disclosure from the program is for treatment purposes and the additional Privacy Rule statements would not have to be added to the consent forms. Note that programs may add the Privacy Rule statements in all circumstances, and programs may find it more convenient to use only one kind of consent form.

The Privacy Rule defers to requirements in other applicable laws regarding the use or disclosure of health information regarding minors and, thus, does not change the rules in Part 2 regarding minors and consent. See 45 CFR §164.502(g). A minor must always sign the consent form for a program to release information even to his or her parent or guardian (42 CFR §2.14).[13] Some States require programs to obtain parental permission before providing treatment to a minor. In these States only, programs must get the signatures of both the minor and a parent, guardian, or other person legally responsible for the minor (42 CFR §2.14(c)(2)).

Revocation of Consent

Part 2 permits a patient to revoke consent orally (see 42 CFR §2.31(a)(8)); the Privacy Rule requires written revocation of an authorization (45 CFR §164.508(b)(5)). Substance abuse treatment programs must continue to honor verbal revocations but may want to obtain written revocation when possible or at a minimum document the revocation in the patient's record. Both Part 2 and the Privacy Rule allow the program to make a disclosure for services already rendered in reliance on a signed consent or authorization form. See 42 CFR §2.31(a)(8) and 45 CFR §164.508(b)(5)(i).

2. Other permissible disclosures under Part 2

Substance abuse treatment programs are accustomed to complying with Part 2's general rule prohibiting disclosure, unless the patient has consented in writing or the disclosure falls within one of the regulations' limited exceptions (*e.g.*, child abuse reporting, medical emergencies). In some instances, the Privacy Rule does not require a change in these practices. In others, the Privacy Rule will require some modification of programs' practices.

a. When little or no changes may be needed

Programs should generally continue to follow the rules in Part 2 regarding:

i. Internal program communications

Both Part 2 and the Privacy Rule allow for communications within programs on a "need to know" basis. Part 2 requires that the communication of information within the program (or to an entity with direct administrative control over the program)[14] be

[13] The only exception to this rule is when the program director determines that a minor applying for services lacks capacity for rational choice and that the minor applicant's situation poses a substantial threat to life or physical well being of the minor or any other person that may be reduced by communicating relevant facts to the minor's parent or guardian. See 42 CFR §2.14(d).

[14] In applying the Privacy Rule, programs should consider whether the program and the entity with "direct administrative control" over the program are two separate legal entities. If they are two separate legal entities, PHI flowing between the program and the other entity will generally be governed by the Privacy Rule's requirements regarding "disclosure" rather than "use" of PHI. However, the Privacy Rule recognizes that health care providers may have different organizational arrangements and has established different rules to reflect such arrangements. See the Privacy Rule's provisions regarding hybrid entities

limited to those persons who have a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment or referral for treatment of alcohol or drug abuse. See 42 CFR §2.12(c)(3). Similarly, the Privacy Rule requires programs to identify the staff persons or classes of persons in its workforce who need access to PHI, the categories of PHI they need access to, and any conditions appropriate to such access. See 45 CFR §164.514(d)(2)(i). The program must then make reasonable efforts to limit access of such persons or classes of persons to PHI based on these determinations. See 45 CFR §164.514(d)(2)(ii). Substance abuse treatment programs subject to the Privacy Rule will have to establish written policies to comply with the minimum necessary requirement of the Privacy Rule, although in practice, the programs should be able to operate as they have under Part 2 in this regard.

ii. Crimes on program premises or against program personnel

Part 2 permits programs to disclose limited information to law enforcement officers. Such disclosures must be directly related to crimes and threats to commit crimes on program premises or against program personnel and must be limited to the circumstances of the incident and the patient's status, name, address and last known whereabouts. See 42 CFR §2.12(c)(5). The Privacy Rule permits programs to disclose to law enforcement officials PHI that the program believes in good faith constitutes evidence of a crime that occurred on the program's premises. See 45 CFR §164.512(f)(5). It also permits any member of the program's staff who is the victim of a crime to report certain information about the suspected perpetrator to law enforcement officials. See 45 CFR §164.502(j)(2). Programs should continue to follow the rules established by Part 2.

iii. Child abuse reporting

Part 2 permits programs to comply with State laws that require the reporting of child abuse and neglect. See 42 CFR §2.12(c)(6). The Privacy Rule also permits such reporting. See 45 CFR §164.512(b)(1)(ii). However, Part 2 limits programs to making only an initial report; it does not allow programs to respond to follow-up requests for information or to subpoenas, unless the patient has signed a consent form or a court has issued an order that complies with the rule (see "Subpoenas and court-ordered disclosures," below). Programs should continue to follow the rules established by Part 2.

iv. Medical emergencies

Part 2 allows patient-identifying information to be disclosed to medical personnel who have a need for the information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires

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(45 CFR §164.105(a) and (c)), affiliated covered entities (45 CFR §164.105(b) and (c)), and organized health care arrangements (OHCAs) (45 CFR §160.103 (definition of "business associate" and "OHCA"), 45 CFR §164.506(c)(5), and 45 CFR §164.520(d)).

immediate medical intervention. See 42 CFR §2.51. A program can disclose information only to medical personnel and must limit the amount of information to that which is necessary to treat the emergency medical condition. Immediately following the disclosure, the program must document the following in the patient's records:

- The name and affiliation of the medical personnel to whom disclosure was made;
- The name of the individual making the disclosure;
- The date and time of the disclosure; and
- The nature of the emergency.

These practices are not affected by the Privacy Rule.

v. Subpoenas and court-ordered disclosures

Part 2 permits programs to release information in response to a subpoena if the patient signs a consent permitting release of the information requested in the subpoena. When the patient does not consent, Part 2 prohibits programs from releasing information in response to a subpoena, unless a court has issued an order that complies with the rule. See 42 CFR Part 2, Subpart E. Subpart E sets out the procedure the court must follow, the findings it must make, and the limits it must place on any disclosure it authorizes.

The Privacy Rule permits a program to disclose PHI pursuant to a subpoena without a prior written authorization, if it receives satisfactory assurance from the party seeking the information that reasonable efforts have been made to ensure that the individual has been given notice of the request for PHI and the opportunity to object, or reasonable efforts have been made to secure a qualified protective order. See 45 CFR §164.512(e)(1)(ii). The Privacy Rule has different requirements regarding court orders, but programs can comply with both Part 2 and the Privacy Rule by continuing to follow the Part 2's court order requirements. Unless the disclosure requires authorization under the Privacy Rule, the Part 2 consent form can be used.

b. When some change is required

i. Disclosures that do not reveal patient-identifying information

Part 2 permits a substance abuse treatment program to disclose information about a patient if the disclosure does not identify the patient as an alcohol or drug abuser or as someone who has applied for or received substance abuse assessment or treatment services. See 42 CFR §§2.11 and 2.12(a). This allows a program that is part of a larger entity, such as a hospital, to disclose information about a patient so long as it does not explicitly or implicitly disclose the fact that the patient is an alcohol or drug abuser. For example, a program that is part of a hospital could disclose to a public health department that a named patient has TB by identifying itself only as part of the hospital and not as a substance abuse treatment program and by taking care not to mention that the patient is in substance abuse treatment.

Many programs that are part of larger entities are accustomed to using this exception in Part 2 to gather information about patients from, for example, other health care providers, schools, and employers, or to refer patients to other providers.[15] Some of these practices by programs that are part of larger entities will continue to be permissible under the Privacy Rule, which does not require patients to authorize disclosures for purposes of treatment, payment or health care operations. The Privacy Rule also permits programs to share information about an individual's treatment or payment related to the individual's health care with persons involved in the individual's care. See 45 CFR §164.510(b).

The Privacy Rule also allows for certain disclosures to be made without authorization that are not for treatment, payment or health care operations. See 45 CFR §164.512. For example, the Privacy Rule permits a program to disclose, without the patient's prior authorization, to a public health department that the patient has TB when the health department is authorized to collect such information. However, any program that is accustomed to making "non-patient identifying" disclosures of information that do not identify the subject as a substance abuser and that are not for treatment purposes should consult the Privacy Rule directly to determine whether those disclosures continue to be permissible.

Part 2 does not permit freestanding programs to make inquiries about patients or refer patients to other providers without written consent. The Privacy Rule does not change this prohibition.

ii. Disclosures to agencies that provide services to programs

Disclosures to Qualified Service Organizations

Both Part 2 and the Privacy Rule recognize that substance abuse treatment programs sometimes need to disclose information about patients to persons or agencies that provide services to the program, such as legal or accounting services. The Part 2 regulations call such service providers "qualified service organizations" and permit programs to sign "qualified service organization agreements" (QSOAs) allowing them to disclose patient-identifying information needed by the organization to provide services to the program. See 42 CFR §2.12(c)(4). In the agreements, the outside service providers acknowledge that in receiving, storing, processing or otherwise dealing with patients' records they are fully bound by Part 2 and promise to safeguard the information, including resisting in judicial proceedings any effort to obtain access to the information, except as permitted by the Part 2 regulations.

Under the Privacy Rule, such outside service providers are "business associates" of the substance abuse treatment program and the program must have a business associate agreement with the business associate in order to share PHI needed by the organization

[15] As noted above, when a program makes an inquiry about, or refers, a patient, it is often making an implicit disclosure that the patient is in substance abuse treatment.

to provide services (see 45 CFR §§160.103 and 164.502(e)).[16] The Privacy Rule has different requirements regarding the content of the business associate contract (the HHS Office for Civil Rights has published sample contract language). See 67 Federal Register 53264 (August 14, 2002).

Substance abuse treatment programs must meet the requirements of both Part 2 and the Privacy Rule if they are going to continue to share information with lawyers, accountants and others that provide services to the program.

Transition Provisions: The Privacy Rule permits programs to continue to use current contracts with service providers until April 14, 2004, if the contract existed prior to October 15, 2002, and the contract is not subsequently renewed or modified. Any contract that is renewed or modified after October 15, 2002, must comply with the business associate contract requirements. See 45 CFR §164.532(d).

Disclosures to accreditation bodies

Part 2 permits disclosures to accreditation bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under either the QSO provision or the "audit and evaluation" exception, discussed below. The Privacy Rule, however, considers accreditation bodies business associates conducting health care operations on behalf of the covered entity. See 45 CFR §§160.103; 164.501. Substance abuse treatment programs subject to the Privacy Rule who undergo accreditation will have to sign business associate contracts with accreditation organizations. Additionally, substance abuse treatment programs must comply with Part 2, either by ensuring that the business associate contract contains all the requirements of a QSOA or by fulfilling the mandates of the audit and evaluation provisions.

iii. Audit and evaluation

Both Part 2 and the Privacy Rule permit programs to disclose patient-identifying information to qualified persons who are conducting an audit or evaluation of the program, without patient consent, provided that certain safeguards are met. The Privacy Rule requires that uses and disclosures be limited to the minimum necessary to accomplish the audit or evaluation. Each rule has its own additional requirements. Substance abuse treatment programs subject to both Part 2 and the Privacy Rule must combine those requirements. Three options result:

- If the audit or evaluation is conducted by a program or its employees, it is permissible under both sets of regulations; no patient consent or authorization is required. See 42 CFR §2.12(c)(3) and 45 CFR §164.502(a)(1)(ii).

[16] A memorandum of understanding would generally be used between government entities rather than a business associate contract.

- If the audit or evaluation is conducted by a "health oversight agency,"[17] the program may disclose patient-identifying information so long as the health oversight agency makes the written commitments required by 42 CFR §2.53(d) and the disclosure meets the requirements in 45 CFR §164.512(d). If the health oversight agency copies or removes patient records from the program, it must agree in writing to abide by the requirements of 42 CFR §2.53(b).
- If an audit or evaluation is conducted by an outside entity on behalf of the program as opposed to a "health oversight agency," the program must have a signed a business associate contract with the auditor or evaluator that satisfies the requirements of both the Privacy Rule and Part 2 by incorporating either the necessary QSO agreement requirements (as discussed above in II.B.2.b.ii) or the appropriate provisions of 42 CFR §2.53.

iv. Research

The Part 2 regulations and the Privacy Rule have different requirements for disclosures of health information to researchers. See 42 CFR §2.52 and 45 CFR §164.512(i). This will be the subject of additional guidance.

III. Other Changes Required by the Privacy Rule[18]

A. Patient Notice/Notice of Privacy Practices

Part 2 requires that programs notify patients that Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records and give them a written summary of the regulations' requirements. See 42 CFR §2.22. The Privacy Rule requires that patients be given a notice of the program's privacy practices as well as their rights under the Privacy Rule. See 45 CFR §164.520. Programs subject to both rules can combine their requirements into a single notice.

1. Notice content

Accordingly, the combined notice must contain all the elements required by 42 CFR §2.22, and in addition, contain the following:

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[17] Under the Privacy Rule, a "health oversight agency" is an agency or authority or the United States, a State, a territory, a political subdivision of a State or a territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such a public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance or to enforce civil rights laws for which health information is relevant (45 CFR §164.501). Disclosures to health oversight agencies when an individual is the subject of the investigation are prohibited under certain circumstances by the Privacy Rule (45 CFR §164.512(d)(2)).

[18] This last section addresses issues on which Part 2 is largely silent. Thus, these can be seen as new requirements imposed by the Privacy Rule to which programs now must adhere.

- A statement, prominently displayed stating: "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY;"
- A description in sufficient detail of the types of uses and disclosures that the program may make without the patient's consent or authorization.[19] For substance abuse treatment programs, these would include uses and disclosures:
    - In connection with treatment, payment or health care operations (include at least one example of each);
    - To qualified service organizations or business associates who provide services to the program's treatment, payment or health care operations;
    - In medical emergencies;
    - Authorized by court order;
    - To auditors and evaluators;
    - To researchers if the information will be protected as required by Federal regulations;
    - To report suspected child abuse or neglect; and
    - To report a crime or a threat to commit a crime on program premises or against program personnel.
- A statement that other disclosures will be made only with the patient's written consent or authorization which can be revoked, unless the program has taken action in reliance on the consent or authorization. ;[20]
- A statement that the program may contact the patient to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the patient;[21]
- A statement that it is required by law to maintain the privacy of PHI and to notify patients of its legal duties and privacy practices, including any changes to its policies;
- A statement that the program must abide by the terms of the notice currently in effect; a statement that the program reserves the right to change the terms of its notice and to make the new notice provisions effective for all information it maintains;[22] and a statement describing how it will provide patients with a revised notice of its practices;

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[19] The Privacy Rule also requires that the notice contain information about any more restrictive law. For example, if State law further limits disclosure of HIV-related information, that restriction should also appear in the notice.

[20] Programs often need to provide PHI to criminal justice agencies that mandate patients into treatment. Under Part 2, such disclosures may be made pursuant to a non-revocable consent that complies with 42 CFR §2.35. Under the Privacy Rule, such disclosures may be made pursuant to an authorization or pursuant to a court order. In order to comply with both rules, programs may find it helpful to ask the court in such a situation to issue an order that the program disclose necessary information to the court and other law enforcement personnel.

[21] A substance abuse treatment program engaging in these kinds of activities must be careful in contacting the patient that it does not make any patient-identifying disclosures to others. If the program does not intend to contact the patient, they do not need to include this statement.

[22] This is also voluntary. However, if this statement is not included, any changes in privacy practices described in the notice will apply only to PHI the program created or received after issuing a revised notice reflecting such changes. 45 CFR §164.520(b)(1)(v)(C).

- The name or title and telephone number of a person or office the patient can contact for further information;
- A statement of the patient's rights with respect to PHI and a brief description of how the patient may exercise those rights, including:
    - The right to request restrictions on certain uses and disclosures of PHI, including the statement that the program is not required to agree with requested restrictions;
    - The right to receive confidential communications of PHI (such as having mail and telephone calls be limited to home or office location);
    - The right to access and amend PHI;
    - The right to receive an accounting of the program's disclosures of PHI;
    - The right to complain—free from retaliation—to the program and to the Secretary of Health and Human Services (HHS) about violations of privacy rights, and information on how to file a complaint with the program; and
    - The right to obtain a paper copy of the notice upon request.
- The effective date of the notice.

See 45 CFR §164.520(b).

2. Distribution of the Notice

Part 2 requires that programs provide the notice at the time of admission or as soon thereafter as the patient is capable of rational communication. See 42 CFR §2.22(a). The Privacy Rule requires that the substance abuse treatment program must provide the notice to a patient on the date of the first service delivery, including service delivered electronically, after April 14, 2003.[23] The program must also have the notice available on site for patients to request to take with them and posted in a clear and prominent location where it is reasonable to expect patients to be able to read it. Whenever there is a material change to the notice, the notice must be promptly revised, made available upon request, and re-posted as previously referenced. See 45 CFR §§164.520(c)(2); 164.530(i)(4)(i)(C).

The program must make a good faith effort to obtain patients' written acknowledgment of receipt of the notice, except in an emergency treatment situation, on the date of the first service delivery. If written acknowledgment is not obtained, the program must document its efforts and the reason it was not able to obtain the acknowledgement. See 45 CFR §164.520(c)(2)(ii).

Any program that maintains a web site that provides information about its services or benefits must prominently post its notice on the site and make it available electronically through the site. When patients agree, the program can provide the notice by e-mail. See 45 CFR §164.520(c)(3).

[23] There is an exception in emergency situations. If treatment is provided on an emergency basis, the program must provide the notice as soon as practicable after the emergency is resolved. See 45 CFR §164.520(c)(2)(i)(B).

B. Patient rights

The Privacy Rule provides patients with new Federal privacy rights, including the right to request restrictions of uses and disclosures of PHI, and the right to access, amend, and receive an accounting of disclosures of PHI. See 45 CFR §§164.522, 164.524, 164.526,164.528.

1. Right to request a restriction of uses and disclosures

The Privacy Rule requires that programs allow patients to request that the program restrict uses or disclosures of PHI for the purpose of treatment, payment or health care operations and for involvement in the patient's care and notification under 45 CFR §164.510(b). The program is not required to agree to a requested restriction. If, however, a program agrees to a restriction, the program may not then violate the agreed-upon restriction, except for emergency treatment purposes, so long as the program requests that the emergency treatment provider not further use or disclose the PHI. A covered entity may terminate the agreement to a restriction, effective after the patient has been informed of the termination. See 45 CFR §164.522(a).

The Privacy Rule gives the individual the right to request that communication of PHI be done by alternative means or to alternative locations (confidential communications). See 45 CFR §164.522(b)(1)(i). This might include the right to request that mail and telephone calls be limited to home or office location. The Privacy Rule requires programs to accommodate reasonable requests.

2. Right to access PHI

Neither Part 2 nor the Privacy Rule requires programs to obtain written consent from individuals before permitting them to see their own records. Likewise, neither rule prohibits a program from giving a patient access to his or her own records, including the opportunity to inspect and copy any records that the program maintains about the patient. 42 CFR §2.23. However, the Privacy Rule permits programs to require that such requests be in writing. See 45 CFR §164.524(b)(1). The Privacy Rule provides patients with a right of access to inspect and obtain a copy of their PHI. See 45 CFR §164.524(a)(1).[24] Certain information, however, is exempt from this right of access:

[24] The Privacy Rule requires access to information in a designated record set for as long as the PHI is maintained in the designated record set. "Designated record set" is defined as "[a] group of records maintained by or for a covered entity that is: (i) The medical records and billing records about individuals maintained by or for a covered health care provider; (ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) Used, in whole or in part, by or for the covered entity to make decisions about individuals." 45 CFR §164.501. The program must document the designated record sets that are subject to access and the titles of the persons or offices responsible for receiving and processing requests for access (45 CFR §164.524(e)). It must retain the documentation for six (6) years from the date it was last effective, whichever is later (45 CFR §164.530(j)). Under Part 2, the information need not be contained in a designated record set. Thus, programs could permit access to all disclosable patient records.

- Psychotherapy notes;[25]
- Information compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding; and
- Information that may be subject to or exempt from certain Clinical Laboratory Improvement Amendment (CLIA) provisions.

See 45 CFR §164.524(a)(1).

The Privacy Rule requires that programs respond to a patient's request for access within 30 days after receipt of the request (within 60 days if the information is not maintained or accessible on-site). The program may extend the deadline once by not more than 30 days, if within 30 days of the receipt of the request (or 60 days of receipt if the information is not on-site), the patient is provided with a written statement containing the reasons for the delay and the date by which it will permit access. See 45 CFR §164.524(b). If the program does not maintain the requested information, but knows where the requested information is maintained, it must inform the patient where to direct his or her request. See 45 CFR §164.524(d)(3).

If a program grants the patient's request for access to his or her records, it can charge the patient a reasonable, cost-based fee, consistent with the restrictions on fees as provided in the Privacy Rule. See 45 CFR §164.524(c)(4).[26]

Denial of Access

The Privacy Rule allows a program to deny a patient access without providing an opportunity for review of the denial, on the following grounds:

- The information is specifically exempted from the right of access by the Privacy Rule. See 45 CFR §164.524(a)(1);
- The program is a correctional institution or a provider acting under the direction of the correctional institution and denies in whole or in part an inmate's request to obtain a copy of his or her records if doing so would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of an officer, employee or other person at the correctional institution or responsible for transporting the inmate. See §164.524(a)(2)(ii));
- The requested information was created or obtained by a program in the course of research that includes treatment. The individual's access to such information

[25] The Privacy Rule defines "psychotherapy notes" as "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. *Psychotherapy notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date." 45 CFR §164.501.

[26] Information obtained by patient access to his or her own record is subject to Part 2's restriction on use of the information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient. See 42 CFR §2.23(b).

may be temporarily suspended for as long as the research is in progress, provided that the individual has agreed to the denial of access when consenting to participate in the research and the program has informed him or her that the right of access will be reinstated upon completion of the research. See 45 CFR §164.524(a)(2)(iii);
- The requested information is subject to the Privacy Act and would be denied under the access provisions of the Privacy Act, 5 USC §522a. See 45 CFR §164.524(a)(2)(iv); or
- The requested information was obtained under a promise of confidentiality from someone other than a health care provider and such access would be likely to reveal the source of the information. See 45 CFR §164.524(a)(2)(v).

The Privacy Rule permits a program to deny patient access, provided that the patient is given the right to have such a denial reviewed, on the following grounds:

- A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the patient or another person;
- The information makes reference to another person (other than a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person; or
- The request for access is made by the patient's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the patient or another person.

See 45 CFR §164.524(a)(3).

If the program's denial is based on one of the last three reasons, the patient has the right to have that denial reviewed by a licensed health care professional who is designated by the program to act as a reviewing official and who did not participate in the original decision to deny access. See 45 CFR §164.524(a)(4).

If the program denies a patient access to all or parts of his or her PHI, it must give the patient a timely denial written in plain language containing:

- The basis for the denial;
- If applicable, a statement of the patient's review rights, including a description of how the patient may exercise those rights; and
- A description of how the patient may complain to the program or to the Secretary of HHS. The description must include information regarding how the patient may complain to the program pursuant to the program's complaint procedures or to the Secretary, and must include the name or title, and telephone number of the contact person or office designated by the program to receive complaints.

See 45 CFR §164.524(d)(2).

A program that denies a patient access in part must give the patient access to any other PHI requested after excluding the information to which the program had reason to deny access. See 45 CFR §164.524(d)(1).

3. The right to amend PHI

The Privacy Rule gives patients the right to have the program amend their PHI or a record about the patient in a designated record set. See 45 CFR §164.526. The program must act on a patient's request for amendment within 60 days after it receives the request. The program may extend the deadline once by not more than 30 days if, within the 60 days, the patient is provided with a written statement of the reasons for the delay and the date by which it will respond. See 45 CFR §164.526(b)(2).

A program that accepts a patient's request to amend PHI must:

- Timely inform the patient of its decision to accept the amendment;
- Make the appropriate amendment by identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment; and
- If the patient agrees, make reasonable efforts to notify and provide the amendment within a reasonable period of time to:
    - Persons identified by the patient as having received the patient's PHI and needing the amendment; and
    - Persons, including business associates, that the program knows to have received the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely on such information to the detriment of the patient.

See 45 CFR §164.526(c).

A program must obtain patient consent on forms that comply with 42 CFR §2.31 before it provides any copies of the amendment to other persons or organizations.

Denial of Amendment

A program may deny a patient's request for amendment if it determines that:

- It did not create the information, unless the patient provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;
- The information or record is accurate and complete; or

- The information that is the subject of the request is not part of a designated record set or would not otherwise be available for inspection under the Privacy Rule's request for access provisions.

See 45 CFR §164.526(a)(2).

If a program denies a patient's request to amend records, it must give him or her a timely denial, written in plain language, and contain:

- The basis for the denial;
- Notice of the patient's right to file a written statement of disagreement with the denial and how the patient may file such a statement;
- Notice that, if the patient does not submit a statement of disagreement, the patient may request that the program include his or her request for amendment and its denial with any future disclosures of the PHI that is subject to the amendment; and
- A description of how the patient may complain about the program's actions to the program or to the Secretary of HHS. The description must include information regarding how the individual may complain to the program pursuant to its complaint procedures or to the Secretary, and must include the name or title, and telephone number of the contact person or office designated by the program to receive complaints.

See 45 CFR §164.526(d)(1).

The program may prepare a written rebuttal to the patient's statement of disagreement. If it prepares such a rebuttal, it must provide a copy to the patient who submitted the statement of disagreement. This information (e.g. the statement of disagreement and rebuttal), or in some cases, a summary, must all be included in any subsequent disclosures of the information to which the disagreement relates as provided in 45 CFR §164.526(d)(3), (4), and (5).

The program must document the titles of the persons or offices responsible for receiving and processing requests for amendment. It must retain the documentation for six (6) years from the date it was created or last effective, whichever is later. See 45 CFR §164.526(f).

4. Right to an accounting of disclosures of PHI

The Privacy Rule provides individuals with the right to obtain an accounting of certain disclosures of PHI made by a program during the six (6) years prior to the request. See 45 CFR §164.528(a).

A program does not have to provide an accounting for any disclosures that were made:

- For treatment, payment, and health care operations as provided in 45 CFR §164.506;
- To the patient as provided in 45 CFR §164.502;
- Incident to a use or disclosure that is otherwise permitted as provided in 45 CFR §164.502;
- Pursuant to the patient's written consent (an "authorization" meeting the Privacy Rule's requirements at 45 CFR §164.508);
- For the facility's directory or to persons involved in the patient's care or other notification purposes as set forth by the rule at 45 CFR §164.510;
- For national security or intelligence purposes as provided by the rule at 45 CFR §164.512(k)(2);
- To correctional institutions or law enforcement officials having custody of an inmate or individual and as specified under 45 CFR §164.512(k)(5);
- As part of a limited data set in accordance with the rule at 45 CFR §164.514(e); and
- Before April 14, 2003.

See 45 CFR §164.528(a)(1). In addition, a program must temporarily suspend a patient's right to receive an accounting of disclosures to a health oversight agency or law enforcement official if the program receives notification that it would be reasonably likely to impede the activities of the agency or official. See 45 CFR §164.528(a)(2).

The accounting must be in writing[27] and include:

- The date of each disclosure;
- The name and address (if known) of the entity or person who received the PHI;
- A brief description of the PHI disclosed; and
- A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of a written request for disclosure, if any.

See 45 CFR §164.528(b)(2).

For substance abuse treatment programs, the following disclosures are typically made without patient consent and must therefore be included in an accounting of disclosures:

- Disclosures to health oversight agencies;
- Disclosures to researchers that include patient-identifying information;[28]
- Disclosures to public health authorities;[29]

[27] There are special provisions under the Privacy Rule that are applicable to accounting for recurrent disclosures and certain research disclosures. See 45 CFR §§164.528(b)(3) and (b)(4).
[28] There are special provisions under the Privacy Rule that are applicable to accounting for research. See 45 CFR §164.528(b)(4)).
[29] When a program authorizes access to an entire universe of records, e.g., for public health surveillance activities, the Privacy Rule's accounting requirement can be met without the program having to make a

- Court-ordered disclosures;
- Reports of patient crimes on program premises or against program personnel; and
- Child abuse and neglect reports.

Programs should establish mechanisms to document all disclosures for which they must account.

The accounting must be made within 60 days of the program's receipt of the request. The program may extend the deadline once by not more than 30 days if, within the 60 days, the patient is provided with a written statement of the reasons for the delay and the date by which it will provide the accounting. A program must respond to a patient's request for one accounting within any 12-month period without charge. For any subsequent request within a 12-month period, it may charge a patient a reasonable, cost-based fee. If the program imposes a fee, it must inform the patient of the fee in advance and give the patient an opportunity to withdraw or modify the request. See 45 CFR §164.528(c).

The program must also document the following:

- The information it was required to provide the patient;
- The written accounting it provided the patient; and
- The titles of the persons or offices responsible for receiving and processing requests for an accounting.

This documentation must be retained for six (6) years from the date created or last effective, which ever is later. See 45 CFR §164.528(d).

C. Administrative Requirements

1. Complaints about the program's privacy practices

Part 2 allows violations of those regulations to be reported to the United States Attorney for the judicial district in which the violation occurs. See 42 CFR §2.5.

The Privacy Rule establishes a process for individuals to file a complaint with the Secretary of HHS if they believe a program violated the Privacy Rule. The complaint must be written, either on paper or electronically, and filed with HHS' Office for Civil Rights within 180 days of when the complainant knew, or should have known, that the act or omission complained of occurred, unless a waiver is granted. The complaint must name the program and describe the violation of the Privacy Rule. See 45 CFR §160.306. Programs must also establish a process for individuals to make complaints about the program's privacy policies and procedures or the program's compliance with

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notation in each medical record that has been accessed by public health authorities. See Office for Civil Rights, Frequently Asked Questions, http://www.hhs.gov/ocr/hipaa.

such policies and procedures or with the requirements of the Privacy Rule. See 45 CFR §164.530(d).

2. Other administrative requirements

Programs subject to the Privacy Rule are required to meet administrative requirements including:

- Designate a privacy official who is responsible for the development and implementation of its policies and procedures and a contact person or office responsible for receiving complaints and able to provide further information. See 45 CFR §164.530(a).
- Train all members of the workforce on the program's policies and procedures. Each new member of the workforce must receive training within a reasonable period of time after s/he joins the workforce. Whenever a workforce member's functions are affected by a material change in privacy policies or procedures, that person must receive additional training within a reasonable period of time after the material change becomes effective. The program must document all training and retain the records for a period of six (6) years after the training. See 45 CFR §164.530(b).
- Have in place appropriate administrative, technical, and physical safeguards to protect the privacy of PHI. See 45 CFR §164.530(c).
- Establish written policies and procedures that identify the staff persons or classes of persons who need access to patients' PHI, the categories of PHI they need access to, and any conditions appropriate to such access. The program must make reasonable efforts to limit access based on these determinations. See 45 CFR §164.514(d)(2).
- Establish policies and procedures to ensure that, for disclosures of information that occur on a routine and recurring basis, reasonable efforts are made to limit disclosures to the minimum necessary to accomplish the intended purpose of the disclosure. See 45 CFR §§164.502(b) and 164.514(d)(3)(i). For "all other disclosures," the program must develop criteria designed to limit the information it discloses to the information reasonably necessary to accomplish the purpose for which disclosure is sought and review requests for disclosure on an individual basis in accordance with those criteria. See 45 CFR §164.514(d)(3)(ii). Programs must also develop policies, procedures and criteria to ensure that requests to other entities subject to the Privacy Rule for PHI are limited to information "which is reasonably necessary to accomplish the purpose for which the request is made." See 45 CFR §164.514(d)(4). The written polices and procedures must be retained for six (6) years after the last time they were effective. See 45 CFR §164.530(j).
- Establish and apply appropriate sanctions against members of its workforce who fail to comply with its privacy policies and procedures. See 45 CFR §164.530(e).

- Mitigate, to the extent practicable, any harmful effect that is known to the program that results from a use or disclosure in violation of its policies and procedures. See 45 CFR §164.530(f).
- Refrain from taking intimidating, threatening, coercing, discriminating, or other retaliatory action against any individual who exercises rights under the Privacy Rule, including filing a complaint, assisting in an investigation, compliance review, proceeding or hearing pursuant to the Privacy Rule, as well as any individual who opposes any act or practice made unlawful by the Privacy Rule, provided that he or she has a good faith belief that the practice is unlawful and the manner of opposition is reasonable and does not invoke an impermissible disclosure of PHI. See 45 CFR §164.530(g).
- Not require patients to waive their rights to complain to the Secretary of HHS or their other rights under the Privacy Rule as a condition of treatment, payment, enrollment in a health plan, or eligibility for benefits. See 45 CFR §164.530(h).
- Implement policies and procedures regarding PHI that are designed to comply with the standards, implementation specifications, and other requirements of the Privacy Rule, and maintain the policies and procedures in written or electronic form for six years from the date the document was created, or last effective, whichever is later. See 45 CFR §164.530(i) and (j).

D. Security of information

Part 2 requires programs to maintain patient written records in a secure room, locked file cabinet, safe or other similar container. The regulations also require programs to adopt written procedures to regulate access to patients' records. See 42 CFR §2.16.

Section 164.530(c) of the Privacy Rule requires programs to maintain reasonable and appropriate administrative, technical and physical safeguards to protect the privacy of PHI. The issue of security has been addressed in more detail through a separate Security Rule issued by HHS on February 20, 2003 that established the physical and technical security standards required to guard the integrity, confidentiality and availability of confidential information that is electronically stored, maintained or transmitted. See 68 Federal Register 8334. Covered entities must be in compliance with the Security Rule by April 20, 2005, except small health plans which have until April 20, 2006.

Conclusion

Compliance with Part 2 has given the substance abuse treatment programs extensive experience with protecting patient confidentiality. Although substance abuse programs will need to make some changes to their business practices, they have a good starting point to work from in achieving compliance with the HIPAA Privacy Rule. Substance abuse treatment programs should contact their respective State substance abuse agencies and/or provider organizations, as well as legal counsel for assistance in implementing practices that will comply with both Part 2 and the Privacy Rule.

For more information about the HIPAA Standards

http://www.hipaa.samhsa.gov is the SAMHSA website which provides information and links for all HIPAA standards.

Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164)
More information can be obtained from the Office for Civil Rights HIPAA website
http://hhs.gov/ocr/hipaa

Standards for Electronic Transactions (45 CFR Parts 160 and 162)
The Standards for Electronic Transactions can be obtained from the Center for Medicare and Medicaid Services (CMS) website at
http://cms.gov/hipaa/hipaa2/default.asp

Standard Unique Employer Identifier (45 CFR Parts 160 and 162)
http://cms.gov/hipaa/hipaa2/default.asp

Security Standards (45 CFR Parts 160, 162 and 164)
http://cms.gov/hipaa/hipaa2/default.asp

Appendix A: Confidentiality of Alcohol and Drug Abuse Patient Record Regulation and the HIPAA Privacy Rule

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFFERENT ORDER IN THE ONLINE EXAM

Answer the following questions by selecting the most appropriate response.

1. HIPAA transactions that a substance abuse treatment program might engage in include:
   a. coordination of benefits with health plans
   b. transmission of enrollment and other information related to payment to health plans
   c. submission of claims to health plans
   d. referral certification and authorization
   e. all of the above

2. Information is subject to the Privacy Rule if it is individually identifiable information created, received, or maintained by the covered entity.
   a. true
   b. false

3. Deceased patients are not necessarily protected under the Privacy Rule.
   a. true
   b. false

4. When disclosing information pursuant to a patient's written request, programs must do all of the following except:
   a. give patients a copy of the signed form
   b. provide a copy to the patient's next of kin when requested
   c. ensure that the consent complies with the applicable requirements
   d. keep a copy of each signed form for 6 years

5. Communication within programs regarding a patient is allowed:
   a. at all times
   b. when the receptionist needs to schedule future appointments
   c. to all members of a group therapy session
   d. on a "need to know" basis
   e. if in writing

6. An example of a permitted disclosure would be to law enforcement officials when a patient commits robbery at a store next to the treatment center.
   a. true
   b. false

7. Following disclosure to medical personnel in emergency situations the program must document the following in the patient's records:
   a. date and time of disclosure
   b. name and affiliation of the medical personnel
   c. nature of the emergency
   d. name of individual making the disclosure
   e. all of the above

8. If subpoenaed, a program must release information even if the patient does not sign a consent form.
   a. true
   b. false

9. Disclosure to accreditation bodies such as the JCAHO required programs to _____ with accreditation bodies.
   a. merge
   b. incorporate
   c. sign business associate contracts
   d. sign privacy agreements
   e. break relationships

10. All but ____ are types of uses and disclosures that a program may make without the patient's consent.
    a. authorized by court order
    b. to report child abuse
    c. to auditors and evaluators
    d. to patient creditors
    e. to researchers if the information will be protected

11. The Privacy Rule does not require that the programs allow patients to request that the program restrict uses or disclosures of information.
    a. true
    b. false

12. The Privacy Rule does not provides patients right of access to obtain their information for all of the following except _____
    a. court orders
    b. information subject to Clinical Laboratory Improvement Amendment provisions.
    c. psychotherapy notes
    d. information complied for use in a civil or criminal proceeding

13. If a program grants the patient's request for access to his/her records, the program must provide the records at no charge to the patient.
    a. true
    b. false

14. If a patient is denied access to his/her information, a program must give a written denial containing:
    a. the statement of the patient's review rights
    b. the basis for the denial
    c. description of how the patient may complain to the Secretary of HHS
    d. the name of the contact person designated to receive complaints
    e. all of the above

15. A program may deny a patient's request for amendment of his/her information if:
    a. the program is federally funded
    b. the program did not create the information
    c. the information is accurate and complete
    d. the information is part of a designated record set
    e. both b and c

16. The Privacy Rule provides individuals with the right to obtain an accounting of certain disclosures of information made by a program during the ____ years prior to the request.
    a. 4
    b. 5
    c. 6
    d. 7
    e. 8

17. A program must have in place appropriate administrative, technical, and physical safeguards to protect the privacy of information.
    a. true
    b. false

18. Programs must maintain written records _____
    a. in triplicate
    b. for 25 years
    c. available in the "clouds"
    d. in a secure, locked manner
    e. at the director's home

CEU Matrix

Course Evaluation – Hard Copy Format

The final step in the process required to obtain your course certificate is to complete this course evaluation. These evaluations are used to assist us in making sure that the course content meets the needs and expectations of our students. Please fill in the information completely and include any comments in the spaces provided. **If you submit your evaluation online, you do not need to return this form.**

NAME: _____

COURSE TITLE: _____

DATE: _____

COURSE CONTENT		
Information presented met the goals and objectives stated for this course	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was relevant	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was interesting	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information will be useful in my work	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Format of course was clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
POST TEST		
Questions covered course materials	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Questions were clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Answer sheet was easy to use	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good

COURSE MECHANICS		
Course materials were well organized	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Materials were received in a timely manner	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Cost of course was reasonable	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
OVERALL RATING		
I give this distance learning course an overall rating of:	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
FEEDBACK		
How did you hear about CEU Matrix?	☐ Web Search Engine ☐ Mailing ☐ Telephone Contact ☐ E-mail posting ☐ Other Linkage ☐ FMS Advertisement ☐ Other: _____	
What I liked BEST about this course:		
I would suggest the following IMPROVEMENTS:		
Please tell us how long it took you to complete the course, post-test and evaluation:	_____ minutes were spent on this course.	
Other COMMENTS:		