ETHICS, BOUNDARIES AND DUAL RELATIONSHIPS: PROFESSIONAL ISSUES FOR ADDICTION PROFESSIONALS

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ABOUT THE INSTRUCTOR

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Professional Boundaries in Addiction Treatment: Current Evidence and Evolving Context

The ethical framework for managing boundaries and dual relationships described in this course has taken on new dimensions as the addiction treatment field has evolved. The expansion of telehealth, the integration of peer support specialists with lived experience of recovery, the CARES Act changes to confidentiality regulations, and the growing recognition of gender-specific stigma have all introduced boundary considerations that the original course content did not anticipate.

The telehealth expansion created novel boundary challenges that practitioners must navigate deliberately. A 2023 study of 18 front-line substance use counselors found that the pandemic shift to telehealth introduced "novel ethical dilemmas around confidentiality, informed consent, and the therapeutic relationship." The physical boundaries that clinic settings provide — separate professional and personal spaces, controlled environments, structured session transitions — dissolved when sessions moved to counselors' homes and clients' living rooms. Some adaptations created challenges for maintaining professional boundaries, while others enabled more flexible, client-centered approaches that programs have continued post-pandemic (McCuistian et al., 2023). For the boundary framework described in this course, the telehealth context requires practitioners to establish virtual equivalents of the physical boundaries that clinic settings previously provided by default — including explicit agreements about session location privacy, camera-on expectations, who else may be present in the room, and how to handle the informal relational dynamics that can emerge when therapist and client each see into the other's personal environment.

The integration of peer support specialists — individuals with lived experience of substance use and recovery — into treatment teams has created a new category of dual relationship that the traditional boundary literature did not address. A 2025 study of 167 addictions professionals found that supervision quality directly affects workforce retention, with professionals who have "a negative relationship with their supervisor" more likely to leave (Aristy, 2025). For peer specialists, the boundary question is structurally different from that of credentialed clinicians: their professional value derives partly from the personal experience that traditional boundary frameworks would classify as a dual relationship. The challenge for programs is establishing boundaries that preserve the therapeutic value of shared experience while preventing the exploitation, role confusion, and confidentiality breaches that boundary standards are designed to prevent.

The confidentiality dimension of professional boundaries — central to this course — has undergone its most significant regulatory change since 42 CFR Part 2 was enacted. A 2022 survey of 40 representatives from 30 SUD treatment organizations found that only 63% were "somewhat knowledgeable" about the CARES Act's changes to confidentiality regulations, and 65% anticipated implementation barriers (Ivanova et al., 2022). For practitioners navigating the boundary issues described in this course, the regulatory uncertainty creates a practical problem: if organizations themselves are unsure about what confidentiality rules apply, individual counselors face heightened risk of inadvertent boundary violations in information sharing — particularly in the integrated care settings where SUD treatment records now flow more freely alongside general medical records.

The gender dimension of boundary-related stigma was documented in a 2025 qualitative study of 27 individuals in SUD treatment. Most participants "were unaware of how their substance use treatment

records were protected or who had access to their records." Female participants specifically reported that "health care professionals, particularly in emergency or perinatal care contexts, treated them differently or negatively" upon learning of their substance use history (Aluri et al., 2025). For the boundary framework described in this course, this finding highlights that boundary violations can occur not only within the therapeutic relationship but across the healthcare system when confidential information moves beyond the treatment setting. The practitioner's responsibility to maintain boundaries extends to advocating for appropriate information handling by other providers who receive SUD records — a systemic boundary function that individual-level ethics training often underemphasizes.

A 2022 qualitative study of 77 women and 38 men in group therapy for substance use disorders found that women uniquely identified stigma as significant to their experience of addiction and recovery, and that women in mixed-gender groups reported less comfort with the group composition (Sugarman et al., 2022). For the boundary and dual relationship considerations described in this course, the gender dynamics in group settings represent a specific boundary challenge: the group itself can become a context where boundary violations occur between members, and the group leader's responsibility includes monitoring and managing the relational dynamics that create vulnerability — particularly for women whose experience of stigma may already be heightened by their gender.

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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."

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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
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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.

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.	

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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