Ethics: Cases and Commentary II

Presented by CONTINUING PSYCHOLOGY EDUCATION INC.

6 CONTINUING EDUCATION CONTACT HOURS

Course Objective
The purpose of this course is to provide an understanding of the concept of ethics as related to mental health professionals. Various standards within the Code of Ethics are presented along with commentary and case scenarios which support the standards. Major topics include: ethics principles, conflict of interest, third-party requests for services, informed consent, informed consent to organizations, services to or through organizations, advertising and public statements, media presentations, testimonials and solicitation, in-person solicitation, record keeping, and representative legal/ethics case scenarios suggesting thought-processes and actions leading to resolution of ethical dilemmas.

Accreditation
Continuing Psychology Education Inc. is recognized by the New York State Education Department's State Board for: Social Work as an approved provider of continuing education for licensed social workers #SW-0387; Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors #MHC-0080, and licensed marriage and family therapists #MFT-0043; Psychology as an approved provider of continuing education for licensed psychologists #PSY-0006.

Mission Statement
Continuing Psychology Education Inc. provides the highest quality continuing education designed to fulfill the professional needs and interests of mental health professionals. Resources are offered to improve professional competency, maintain knowledge of the latest advancements, and meet continuing education requirements mandated by the profession.

Learning Objectives
Upon completion, the participant will be able to:
1. Acknowledge the ethics principles to which practitioners should aspire.
2. Understand and apply the Code of Ethics to various ethical dilemmas.
3. Explain that practitioners should avoid conflicts of interest that interfere with professional judgment.
4. Realize the importance of clarifying the professional relationship with all involved in the case of a third-party request for services.
5. Recognize the essential nature of informed consent between practitioner and client.
6. Describe pertinent informed consent and confidentiality requirements when working with an organization.
7. Affirm that advertising and public statements must be accurate.
8. Comprehend that practitioners are prohibited from expressing that a professional relationship exists with the recipients of a media presentation.
9. Acknowledge the restrictions of testimonials and solicitation.
10. Articulate that documentation in record keeping must be accurate and reflect the services provided.

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INTRODUCTION

Rules, regulations, and a method for resolving dilemmas convey a public nature. Mental health practitioners earn a license to practice, which is a public document, through performing public acts such as completing an accredited degree program and passing various examinations. Practitioners may be required to justify their actions in a public venue, hence, their decision-making can be susceptible to public scrutiny in relation to laws, regulations, standards of care, and ethics codes. In sum, professional decisions are not limited only to therapist and client, rather, decision making can be a matter of public accountability.

The public nature of the mental health field transports decision making from subjective, personal morality to a broader public domain concern. This transition requires professionals to employ the texts of the profession as official standards of conduct, and to have a method of resolving difficulties and dilemmas that can be exposed to public scrutiny. Therefore, ethical practice entails a systematic complying with the Ethics Code rather than abiding by solely individual morality or intuition.

Many of the standards within the Ethics Code allow for a sense of reasonableness. The concepts of "reasonable" and "appropriate" grant a degree of professional judgment and deliberation which, in turn, promote a proactive, rather than reactive position. Being proactive involves looking ahead and anticipating possible benefits versus anticipating issues resulting from different actions with the intent of avoiding difficulties. Being reactive is responding after the mishap has occurred and when the danger is already present. The Introduction and Applicability section of the APA Ethics Code explains the value of the words, reasonable and appropriate:

> The modifiers used in some of the standards of this Ethics Code (e.g., *reasonably, appropriate, potentially*) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term *reasonable* means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge psychologists had or should have had at the time.

The words, "reasonable" and "appropriate" instill a measure of flexibility in the Ethics Code such that along with clear expectations of conduct, practitioners can utilize professional judgment within their area of expertise.

The Ethics Code is the main text for illuminating ethical practice but other sources exist as well, as articulated by the following associations: The introductory material for NASW, in the section entitled, Purpose of the NASW Code of Ethics, states:

> For additional guidance social workers should ... seek appropriate consultation when faced with ethical dilemmas. This may involve consultation with an agency based or social work organization's ethics committee, a regulatory body, knowledgeable colleagues, supervisors, or legal counsel.

The Introduction and Applicability section of the APA Ethics Code indicates the following additional sources for assistance:

> In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field.

The Preamble of the AAMFT Code of Ethics notes these additional sources of guidance:

> Marriage and family therapists who are uncertain about the ethics of a particular course of action are encouraged to seek counsel from consultants, attorneys, supervisors, colleagues, or other appropriate authorities.
>
> Both law and ethics govern the practice of marriage and family therapy. When making decisions regarding professional behavior, marriage and family therapists must consider the AAMFT Code of Ethics and applicable laws and regulations.

The Purpose section of the ACA Code of Ethics responds to this theme as follows:

> When counselors are faced with ethical dilemmas that are difficult to resolve, they are expected to engage in a carefully considered ethical decision-making process. Reasonable differences of opinion can and do exist among counselors with respect to the ways in which values, ethical principles, and ethical standards would be applied when they conflict. While there is no specific ethical decision-making model that is most effective, counselors are expected to be familiar with a credible model of decision making that can bear public scrutiny and its application.

The development and continued implementation of ethical practice evolves over time, is a dynamic rather than static process, and endures over the entire professional life span. The associations address this concept, for example, the Preamble to the APA Ethics Code expresses:

> The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

NASW responds to this lifelong process by commenting within the section entitled, Purpose of the NASW Code of Ethics:

> Social workers' ethical behavior should result from their personal commitment to engage in ethical practice. The

NASW Code of Ethics reflects the commitment of all social workers to uphold the profession's values and to act ethically. Principles and standards must be applied by individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments.

This course presents various standards within the Code of Ethics, commentary supporting the standards, and case scenarios designed to bring the standards in unison and to life.

Conflict of Interest

The standard pertaining to conflict of interest requires practitioners to avoid undertaking a professional situation or responsibility given a reasonable likelihood that other interests or relationships could reduce competency or impartiality, or expose that individual or organization to harm, mistreatment, or exploitation. Trust is vital to a professional relationship and practitioners may violate that trust if they assume professional roles when competing professional, personal, financial, legal, or other interests or relationships could reasonably be anticipated to affect objectivity, competence, or proficiency to perform this professional role.

This standard also restricts practitioners from assuming a role that would subject a person or organization with which the clinician already works to harm or exploitation. Though the standard does not require rejection of the added role in all situations, caution is advised. The standard promotes avoidance of assuming responsibilities for which previous, present, or future relationships could possibly be exploitative or harmful. The conflict of interest standards are as follows:

Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation (APA, 2010, 3.06).

Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client (NASW, 2008, 1.06.a.).

... If it becomes apparent that the counselor may be called upon to perform potentially conflicting roles, the counselor will clarify, adjust, or withdraw from roles appropriately (ACA, 2014, A.8).

Marriage and family therapists do not abuse their power in therapeutic relationships (AAMFT, 2015, 1.7).

Case 1: Conflict of Interest

Case Scenario - Therapist I provides assessment and treatment services to children and adolescents in an academic teaching hospital psychiatry department. She specializes in working with youth with attention deficit disorder (ADD) and she works closely with psychiatrists on a team that focuses on this population and diagnosis. Therapist I knows that several of the psychiatrists receive large research grants from a pharmaceutical manufacturer to conduct clinical trials with medications to treat ADD, and that some medications have been marketed globally. She receives no financial remuneration from the pharmaceutical company, but she is aware that her position at the hospital is supported by the large case flow of youth presenting with ADD, which is partly due to the funded research department's lofty reputation. Therapist I acknowledges that her assessment and treatment approaches over time have been positively influenced, in part, by the clinical presentations of clients engaged in the medication trials, and she believes that the medications used in the research trials have been helpful to her clients.

Therapist I is invited to give a day-long workshop to a medical school on assessment and treatment models for ADD and she will be paid well. She must complete a form which includes whether she has a financial or other commercial interest in any medication or product that will be discussed at the workshop. The form is unambiguously designed for physicians who may be receiving research support or other remuneration by medication or medical device manufacturers and does not request disclosure of any indirect financial interests or support.

Ethical Concern - Therapist I has extensive experience in the assessment and treatment of youth with ADD and will be quite informative to the workshop participants. She does not receive direct financial support through fees or research grants from commercial entities that develop ADD medications. In contrast, Therapist I works in an organization whose medication and research program has influenced her approaches to assessment and treatment. She has no direct financial interest in medication development, but her position is indirectly supported by funds provided for medication research (it is part of the department's general operating budget) along with the large case flow of youth with ADD who are referred due to the strong reputation for clinical services offered to ADD youth, partly because of the academic affiliation with a respected medical school and reputation for cutting-edge research.

Decision-Making Considerations- Standard 1.06.a. obligates social workers to "avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment." Standard 3.06 requires psychologists to "refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships" might "impair their objectivity, competence, or effectiveness" when performing the role of psychologist or may "expose the person or organization with whom the professional relationship exists to harm or exploitation."

Therapist I will need to ascertain whether her indirect financial interests emanating from the Department of Psychiatry medication research funding reasonably

establishes a conflict of interest that could undermine her "professional discretion and impartial judgment" or "objectivity, competence, or effectiveness" when teaching the workshop on assessment and treatment of ADD youth, or "expose" her department or the medical school making the workshop invitation to "harm or exploitation." Further, she may consider whether her professional and/or personal relationships with her Department of Psychiatry colleagues may have impacted her "exercise of professional discretion and impartial judgment" in providing the workshop on the topic of ADD youth.

Standard 1.06.a. instructs social workers that "in some cases, protecting clients' interests may require termination of the professional relationship..." and Standard 3.06 prohibits psychologists from assuming a professional role if there can be negative impact from a conflict of interest. The standards do not indicate that practitioners can proceed given their disclosure of the conflict of interest or if the organization or person involved agrees to accept the risk of possible harm or exploitation.

Decision Options - Therapist I must determine whether her interests or relationships affect her "professional discretion and impartial judgment," or "objectivity, competence, or effectiveness" at the exact time when her objectivity in making such an evaluation is in question. Specifically, her work experience with the Department of Psychiatry, and professional and personal relationships with colleagues with direct financial interests in funded medication research, may have fundamentally molded her perception and working model of assessment and treatment of ADD youth. Therapist I may be lacking an unbiased view regarding the influence of her organization's culture and activities relative to the medication trials, similar to the possibility of a physician who receives drug company representative perquisites, incentives, or gratuities being unaware of how this determines prescription choices. Therapist I has already decided that her clients benefited from medications that underwent clinical trials in her department, in turn, she may unmindfully favor prescribing medication for ADD as opposed to therapy.

Therapist I arranges an ethics consultation focusing on the progression of her clinical views on assessment and treatment of ADD youth within the milieu of her research-oriented psychiatry department, and ways her therapeutic perspectives may have been influenced by that department over the years.

The ethics consultation convinces Therapist I that she can provide an objective and fair workshop. She resolves to address possible bias due to undisclosed real or perceived conflicts of interest by informing the medical school representatives who hired her of her indirect financial interests in the department's funded medication research, and the possible influence of her professional and personal relationships with department colleagues who run medication trials. She decides to do so even though such information is not requested on the medical school disclosure form.

If the medical school hires her, Therapist I elects to start the workshop by announcing her indirect financial interests and possible colleague-influence on workshop content (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Third-Party Requests for Services

When a third party (e.g., a parent, teacher, court, employer, human resources office, training institution, referral source, or commanding officer) requests a mental health procedure, it is essential that both the third-party requester and the person receiving the services, be informed of the therapist's roles at the outset. Further, the AAMFT standard, Relationships with Third Parties, includes the need to clarify "the nature of the relationship with each party and the limits of confidentiality" and the APA standard, Third-Party Requests for Services, indicates the need for "an identification of who is the client." It is vital to identify who the client is, otherwise, one or more persons can wrongly believe that they are the therapist's client which can create issues (i.e., collateral contacts, employer, organization, family, school psychologist, family member).

The term "client" sometimes can relate to individuals or organizations other than the person who is the direct subject of the services. For instance, if an attorney hires a therapist to examine a defendant, the attorney is generally labeled as the "client," and the defendant is the recipient of services. The attorney provides the questions to be answered and can authorize, direct, and terminate the professional relationship, inclusive of handling the work product or any confidentiality matters. Standards such as 3.04, Avoiding Harm, reflect this concept by including phrases such as "others with whom (therapists) work" along with referring to "clients." In relation to legal minors, the client is the child, partly due to insurance procedures, despite the fact that it is the parents who authorize treatment. In situations when one or more individuals are identified as clients, that information must be clarified to all the parties, along with the therapist's role regarding all parties.

Therapists must also clarify who controls the release of a report or which parties can receive other confidential information. In turn, Standard 3.07 (indicated below) requires clarification from the beginning of the service who the client is and the possible use of the information created by the procedures, which necessitates forethought. Ethical and legal analysis is prompted by who the client is, and disclosing this information to the relevant parties involved can facilitate the avoidance of problems and productive mental health services.

Regarding confidentiality, privacy, and who will receive information, although not mandated by the standards, it is suggested to have a written release to inform clients of the nature of the information to be released and the purpose of its release, and to document the authorization - including acquiring written releases as circumstances arise. A written authorization to release information can foster clarification of

the nature, extent, duration, and purpose of the information to be released or exchanged.

Standard 3.07 necessitates disclosure to all parties involved, including the third party and the recipient of services, the nature of the relationship with all involved parties. This disclosure includes information about the role of therapist, who is receiving services, who will receive information about the services, and how the use of information will be utilized. The standards for third party relationships are as follows:

Marriage and family therapists, upon agreeing to provide services to a person or entity at the request of a third party, clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality (AAMFT, 2015, 1.13).

When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality (APA, 2010, 3.07).

Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality (NASW, 2008, 1.07.e.).

At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify situations in which confidentiality must be breached (ACA, 2014, B.1.d.).

Case 2: Third-Party Requests for Services

Case Scenario - Therapist J provides contract testing and evaluation for the Department of Family and Child Services (DFACS). Her evaluations for DFACS involve placement or decisions to be made, such as fitness to parent, foster placement, placement in rehabilitation groups (i.e., substance abuse), and back-to-work assessment.

At Ms. B's initial client interview at DFACS, the caseworker tells her that DFACS provides counseling groups, individual counseling, vocational development, and addiction counseling. Ms. B tells the caseworker of her interest in several of these services, including parenting assistance because she acknowledges being somewhat negligent in this role, learning job interviewing skills, and receiving assistance for her substance abuse. Therapist J contacts Ms. B to schedule an evaluation and Ms. B assumes she will be assessed for counseling for her stated goals. At the evaluation, Therapist J gives Ms. B a uniform informed consent to sign, states she works at DFACS, and that disclosures by Ms. B will not be confidential and could be included in the report. Therapist J informs every examinee of this same information. DFACS actually asked Therapist J to evaluate Ms. B for her capability to function independently, to parent effectively, and to determine if her children should be placed in foster care due to her substance abuse, neglect charges, and inability to parent.

In the completed report to DFACS, Therapist J recommends temporary foster care for the children until Ms. B receives rehabilitation. Ms. B is outraged to hear this determination because she declares that she was not informed that fitness for parenting was the purpose of the evaluation and that she would not have cooperated had she known. She blames Therapist J for not being truthful with her and she threatens to register a formal complaint with the licensing board.

Ethical Concern - It appears that Therapist J had a routine of consultation with DFACS such that she completed assessments and the informed consent and assumed that DFACS prepared clientele for evaluations or other services they would receive with all needed and appropriate information. Therapist J recognizes her role as a contract counselor for DFACS and feels she sufficiently described her role, but she also senses that she may have violated Standard 3.07, Third-Party Requests for Services. Standard 3.07 requires practitioners to clarify their roles to all persons they are working with. Therapist J did clarify her role by indicating she would be performing an evaluation. She also told Ms. B that DFACS was her client, confidentiality would be limited, and several staff members could access her report. Therapist J reviews Standard 3.07 and recognizes that she did not make clear the fact that the likely use of the services and disclosed information was for fitness to parent which could also affect custody of Ms. B's children, at this point in time. Compliance with Standard 3.07 requires that practitioners "clarify at the outset of the service the nature of the relationship with all individuals or organizations involved," and compliance with AAMFT Standard 1.13 requires practitioners to "clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality." Though Therapist J did discuss the nature of her relationship with DFACS and with Ms. B in that Ms. B was being evaluated by Therapist J, the probable use of the information - an essential variable for elucidation of the third-party request expectation along with appropriate informed consent - was not explained to Ms. B. It may be assumed that Ms. B was mandated for testing since the welfare of a child is involved, but practitioners must inform the individual about the nature and purpose of the evaluation in a mandated-evaluation situation.

Decision-Making Considerations - Therapist J reflects on the procedures that DFACS and herself had organized when she took the consultant position. Due to the large number of people to be tested, it was determined that Therapist J would complete the essentials of testing administration and the standard DFACS informed consent. It was understood that each client has a caseworker that performs an interview, assesses client's needs, and determines the needed action for DFACS to fulfill its responsibilities to the state. A large percent of the clients at DFACS are mandated for services and for evaluation, therefore, DFACS has in place a customary protocol for informed consent and for interacting with mandated clients in legally required ways. Therapist J now understands that she and other consultants were assuming that DFACS was providing complete informed consent and third-party request information while DFACS

was assuming that consultants were fulfilling these responsibilities.

Therapist J understands the intent of the Third-Party Requests for Services standard and that her intent is to offer ethical and professional services, but she did not confirm that all aspects of the standard were enacted. She would have provided all informed consent, explanation of purpose and use of services herself if this case was within her private practice or an agency setting whereby the examinee was her client. Given her consulting role with DFACS, she had not assumed responsibility for disclosing essential elements of the services to the examinees, instead she deferred to DFACS. Therapist J recognizes that DFACS did not dictate to her a required level of thoroughness of the explanation of services to clients, rather, she made assumptions that contributed to the present dilemma.

Decision Options - Therapist J assesses her options in relation to three circumstances: a) addressing DFACS regarding this case and future cases, b) confronting Ms. B and her complaint, and c) determining how to improve her consulting practice in light of this experience. She first contacts the DFACS administrator with whom she worked to explore the role of DFACS, her role, and the court's role, when applicable, in evaluation cases. Therapist J reveals the ethical dilemma resulting from the communication gap between DFACS and herself. She advises that transparency and full information disclosure between herself and DFACS is needed in future cases, and a protocol is required enlightening her of what DFACS has told the clients, both mandated and voluntary, about the services they are going to receive. Therapist J tells DFACS that she will be providing a full informed consent and explanation of the purpose and use of information obtained from her evaluations even if DFACS provides such in their informed consent.

Therapist J establishes her own methodology for future consultations, including procedural steps when offering services to a third party. She realizes that a dilemma was imminent since she had not assessed the differing role responsibilities implicit in third-party request for services.

Therapist J ponders whether and how to contact Ms. B. She receives feedback from the caseworker of how to proceed and she recognizes that her determination for foster care of the children will probably be honored by the court, unrelated to the case having been mandated or not. She does not question her recommendation and would not change her clinical decision, because the welfare of the children is involved. Therapist J regrets that her management of the communication with Ms. B will likely cause suspicion in Ms. B to work with DFACS and that she may feel exploited. Therapist J hopes that Ms. B will work with DFACS on her issues of substance abuse and parenting skills culminating in a custody decision in which the welfare of the children will be ensured (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Informed Consent

Informed consent offers assurance that the trust required from the practitioner's clientele is justified, therapist power is not abused, and therapist care is understood and agreed to. The concept of and right to informed consent emphasizes respect for individual freedom, autonomy, and dignity and it is essential in relationships between practitioner and client. Informed consent is the end-result of therapist and client reaching an agreement to work together. It ensures that all parties involved sufficiently understand the collaboration, and it facilitates communication and clarification. It is a process that recurs in order to clarify or renegotiate the therapeutic process.

The informed consent standard is essentially based upon the principles of fidelity and responsibility along with respect for people's rights and dignity. Fidelity includes factors such as faithfulness, loyalty, and promise keeping, which are fundamental to trust. The professional relationship between practitioner and client relies on fidelity and honest communication and the understanding that the contract that unites the parties requires those involved to fulfill certain functions and responsibilities. Practitioners must also respect their clientele's dignity, worth, privacy, confidentiality, and self-determination to choose a course of action. The fact that clientele must consent to treatment and be informed of its consequences and implications reflects the value of respecting people's rights and dignity.

As a brief reminder regarding confidentiality, in New York, resulting from recent mass shootings, including in Aurora, Colorado, and Newtown, Connecticut, a New York law was enacted on January 15, 2013, changing from a permissive to a mandatory duty for mental health professionals to report when they have determined that a client presents a serious and imminent danger to self or others.

Additionally, mental health professionals are mandated to report clients who may pose a danger to self or others to local mental health officials with the goal of preventing gun violence. The reason(s) for the disclosure must be documented in the clinical record. Specifically, the Secure Ammunition and Firearms Security (SAFE) Act, effective March 16, 2013, is a gun control statute that regulates access to firearms and ammunition and requires mental health professionals, including physicians, psychologists, registered nurses, and licensed clinical social workers to make a report given client behavior that would yield serious harm to self or others, regardless of a legal firearm being implicated or not.

The following "SAFE Act" information is applicable to New York LCSWs and psychologists (as indicated in the first paragraph of the SAFE Act text), not to New York LMSWs, LMHCs or LMFTs.

The SAFE Act adds new provisions, entitled Mental Health Law Section 9.46 - Reporting Requirements for Mental Health Professionals, including the following:

When a mental health professional currently providing

treatment services to a person determines, in the exercise of reasonable professional judgment, that such person is likely to engage in conduct that would result in serious harm to self or others, he or she shall be required to report, as soon as practicable, to the director of community services, or the director's designee, who shall report to the division of criminal justice services whenever he or she agrees that the person is likely to engage in such conduct. Information transmitted to the division of criminal justice services shall be limited to names and other non-clinical identifying information, which may only be used for determining whether a [gun] license issued... should be suspended or revoked...

Nothing in this section shall be construed to require a mental health professional to take any action which, in the exercise of reasonable professional judgment, would endanger such mental health professional or increase the danger to a potential victim or victims.

The decision of a mental health professional to disclose or not to disclose in accordance with this section, when made reasonably and in good faith, shall not be the basis for any civil or criminal liability of such mental health professional.

Once the therapist, utilizing reasonable professional judgment, determines that a client represents a serious and imminent risk to self or others that requires a warning to law enforcement or to a potential victim, then the therapist must also submit a SAFE Act report. Procedurally, the therapist would contact law enforcement, notify a potential victim, where applicable, and send a report to the online Integrated SAFE ACT Reporting Site (ISARS) at this Web address: http://www.omh.ny.gov/omhweb/safe_act/index.html

SAFE Act reporters must be currently treating the individual being reported and the report should be made to the Director of Community Services (Mental Health Director), or the director's designee, of the County where the person being reported lives. The criterion for reporting is the standard "likelihood to result in serious harm" which is defined as threats of, or attempts at, suicide/serious bodily harm to self or homicidal/violent behavior toward others. This standard authorizes a need for immediate action, promoting public safety and preventing harm.

The information to be reported includes:

a) Client identifying information: name, address, date of birth or approximate age, gender, race, and social security number, if available.
b) Axis I and Axis II diagnoses
c) The reason(s) the reporting therapist has concluded that the client is likely to present a serious and imminent danger to self or others.
d) The treatment relationship of the reporting therapist to the client, and the last date seen by the therapist.
e) The reporting therapist's identifying information: name, licensed profession and license number, last four digits of social security number, phone number and email address where therapist can be reached if more information is required.
f) An affirmation that you are the professional indicated as the submitter of the report, and the report is truthful to the best of your knowledge.

If the county mental health official agrees with the Section 9.46 report, then he or she will report "non-clinical identifying information" (i.e., name, gender, date of birth, social security number, race, and address) to the New York State Division of Criminal Justice Services (DCJS). The reported individual's identifying information is added to a DCJS database of persons disqualified for five years from obtaining or retaining a firearms license and from possessing a firearm. DCJS determines if the reported person holds a firearms license, if so, they inform the local licensing official who will suspend or revoke the license 'as soon as practicable.' The reported person must surrender such license and firearms to the licensing officer, and if the reported person does not voluntarily surrender the guns then the police are authorized to seize them. Hence, the SAFE Act is designed to identify and disarm licensed gun owners who have had their Section 9.46 report accepted.

The SAFE Act reporting requirement only limits access to legal firearms, as such, it does not serve to notify law enforcement or to warn that the client presents a serious and imminent danger to self or others.

The decision making process whether to submit a Section 9.46 report involves a clinical determination that the client's mindset presents either "(a) a substantial risk of physical harm to the person, as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself, or (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior which places others in reasonable fear of serious physical harm."

SAFE Act confidentiality and liability concerns are addressed by the following points:

1. Mental health professionals will not be subject to any civil or criminal liability when the decision to report or the decision to not report was made "reasonably and in good faith."
2. Mental health professionals are not required to report if their reasonable professional judgment concludes that reporting would endanger the mental health professional or increase danger to the potential victim(s).
3. Due to the SAFE Act report disclosure being required by law (upon the conditions for making a report being met), the mandated report can legally be submitted without requiring the client's consent. Mental health professionals may, but are not required to, inform the client of their determination to file a SAFE Act report.
4. Clients will not have access to the SAFE Act report or to the reporter's name or contact information, but clients may become aware that a report was filed upon requesting a copy of their medical record.

Given that ethical codes of associations may be different from New York law, psychologists must comply with the rules and regulations compiled by the Board of Regents and the State Education Department which are accessible at a number of websites, including:
www.nics.ny.gov/sa-guidance-documents.html

Given that ethical codes of associations may be different from New York law, LMSWs and LCSWs must comply with the rules and regulations compiled by the Board of Regents and the State Education Department which are accessible at this Website:
http://www.op.nysed.gov/prof/sw/swlaw.htm

Given that ethical codes of associations may be different from New York law, a New York State LMHC is responsible for complying with New York laws, rules and regulations. LMHCs can access the laws, rules and regulations that define the practice of mental health counseling and continuing education at this Website:
http://www.op.nysed.gov/prof/mhp/mhplaw.htm

Given that ethical codes of associations may be different from New York law, a New York State LMFT is responsible for complying with New York laws, rules and regulations. LMFTs can access the laws, rules and regulations that define the practice of marriage and family therapy and continuing education at this Website:
http://www.op.nysed.gov/prof/mhp/mhplaw.htm

Individuals who provide their informed consent to the practitioner must have the capacity to do so, must have received information relevant to the decision, be aware of the voluntary nature of the participation, have been given the chance to ask questions about the processes and procedures, and be able to exercise a voluntary choice. The depth and nature of the communication may change depending on the person's capacity, level of sophistication, and needs. Practitioners must communicate to clients, in clear and understandable language, what they can expect before and throughout the process.

The standard also requires informed consent be obtained if the services are performed face to face, or by Internet, videoconference, or other forms of electronic communication. When using electronic forms of communication, therapists are advised to ensure that the person who gave consent is the one who received services; for example, a password can be used. Further, limits of confidentiality must be included in the information to clientele when electronic communication is involved.

Implied within the informed consent standard is that therapists should trust their client's ability level to decide what will be helpful to them, inclusive of their involvement in treatment decisions collaboratively with therapist. Having informed-consent forms, which generally include information about billing practices, scheduling appointments, cancellation policies, and common confidentiality exceptions, can be helpful. Such forms should contribute to, but not replace communication between therapist and client, and communication should allow for clients to discuss their expectations, needs, and concerns before and during the process.

When providing services to persons who cannot legally give consent, such as children, legally incompetent adults, or those who are not mentally or psychologically able to give consent, practitioners must try to communicate with the individual at a level equal with his or her capacity, and they must protect the best interest of the client. The informed consent standards are listed below:

Marriage and family therapists obtain appropriate informed consent to therapy or related procedures and use language that is reasonably understandable to clients. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substituted consent is legally permissible The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented (AAMFT, 2015, 1.2).

Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to review in writing and verbally with clients the rights and responsibilities of both counselors and clients. Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship (ACA, 2014, A.2.a.).

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code.
(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.
(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.
(d) Psychologists appropriately document written or oral consent, permission, and assent (APA, 2010, 3.10).

Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers (APA, 2010, 9.03.a.).

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to

inform clients of the purpose of the services, risks related to the services, limits to services, limits to services because of the requirements of a thirdparty payer, relevant costs, reasonable alternatives, clients' right to refuse of withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.
(b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible. (c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent.
(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service.
(e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.
(f) Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party (NASW, 2008, 1.03).

Case 3: Informed Consent

Case Scenario - Therapist K, a child specialist, is contacted by Ms. C regarding issues with her 12-year-old daughter, D.C. Therapist K completes an intake interview with Ms. C and D.C, acquires informed consent for services from Ms. C, and explains to D.C the nature of services in a manner she understands, including limits of confidentiality. Ms. C reports that D.C is experiencing bullying at school, in turn, she is hesitant to attend school, her grades are falling, and she is depressed at home. At the intake interview, Ms. C expresses that she had never married D.C's father, they permanently separated before the child was born, and she does not know of his whereabouts since the separation. Therapy with D.C begins and over time, the child is gaining benefit from the experience.

After four months of therapy, Therapist K is phoned by Mr. E, who identifies himself as the father of D.C and insists that Therapist K stop treatment until he meets with Therapist K. He demands Therapist K to email him a summary of D.C's intake information, diagnosis, and course of treatment. Therapist K immediately informs Ms. C of the phone call. The mother requests that Therapist K continue to see her daughter uninterruptedly because any break in the process would be detrimental, moreover, the child has never even met her biological father.

Ethical Concern - Therapist K began psychotherapy appropriately by ethically conducting informed consent procedures and explaining confidentiality with mother and daughter. The mother agreed to receive only general information about her daughter's progress and would not inquire about disclosures that D.C wanted kept confidential. The daughter was assured that her disclosures would not be shared with her mother, accordingly, she was open and candid.

Despite Therapist K having been ethical at the time, she is now uncertain of the biological father's legal rights regarding consent for treatment. Though D.C's parents never married, the mother did state that Mr. E is D.C's father. Therapist K realizes that she did not ask the mother if she had received custodial rights, because it appeared that Mr. E did not pursue custody rights, visitation, or any contact with his daughter over the past 12 years. Therapist K feels she upheld the informed consent standard in good faith when therapy began. She understands that if D.C's father does have a right to the records then she would be breaking the confidentiality agreement with her client and the mother if she complies with Mr. E's requests. Therapist K is also concerned about the Avoiding Harm standard because the child is at a delicate time in the therapeutic process whereby an interruption could be harmful. Therapist K thinks she also may not be honoring the principles of Beneficence and Nonmaleficence, along with Fidelity and Responsibility if she shares the requested information because she senses the client would experience harm by the invasion into her privacy and the evolving therapeutic trust would be threatened.

Decision-Making Considerations - Practitioners typically do not have a duty to perform an independent investigation regarding the legal custody of children unless there is reasonable suspicion about the information disclosed by parents on whom the therapist is relying to obtain informed consent or make professional decisions. If legal custody is an issue, for instance, after a parental marital separation or divorce, therapists would be wise to request to see a copy of a final divorce decree describing the legal custody, at least to confirm that the parent understands the decree's determination. In this case, the parent states there was no marriage so a final divorce decree does not exist. Given Ms. C's statement that the whereabouts of Mr. E are not known, it is not expected that Therapist K would seek permission to contact D.C's father, or would delay providing therapeutic services until he is contacted. Since Mr. E contacted Therapist K, however, there is reason to question the historical information shared by Ms. C on which Therapist K relied as a treatment authorization for D.C.

Therapist K wants to meet as soon as possible with Ms. C to learn of the status of the client and the custodial status of the parents. Therapist K knows that Ms. C has custodial rights but does not know the rights of Mr. E in this situation. If Therapist K learns that Mr. E does not have legal rights to D.C's psychotherapy records, Therapist K is optimistic that she could help D.C manage her father's sudden appearance in her life. If Mr. E does have the right to see the psychotherapy notes, then Therapist K will need to consider her response. She could refuse to share the records with Mr. E on the grounds of protecting the child from harm but she would have to accept the possibility of going to court if a subpoena were issued. She would then potentially also be in violation of the informed consent standard if she continued treatment with D.C against the will of the father.

Decision Options - Therapist K would contact Ms. C, as soon as possible, and express the communication by Mr. E and his demands. She would ask Ms. C to share pertinent information about Mr. E, how he became aware of D. C's therapy, and how Ms. E wants Therapist K to respond to his request for treatment suspension and an e-mailed summary of the treatment notes. Therapist K would document the communication with Ms. C in the treatment record.

Therapist K would learn how laws governing paternity and the rights of unmarried biological parents may apply in her jurisdiction. Therapist K would document in the treatment record any legal or consultation assistance she received to address any uncertainty about relevant law.

If a relevant law indicates that Mr. E must be involved in obtaining a sufficient informed consent for continuing therapy, then Therapist K would meet Mr. E to discuss D.C's clinical needs and the course of treatment. The attempt to obtain Mr. E's informed consent for the therapy of D.C should be noted and documented in a manner compliant with the informed consent standard.

If Mr. E authorizes therapy to continue, Therapist K can continue D.C's treatment, but is required to submit records and summaries to Mr. E if he requests such. Therapist K would need to tell D.C that her disclosures may have less confidentiality than earlier and it depends on the limits of confidentiality agreed to by Mr. E.

If a relevant law requires Mr. E's informed consent for the child's therapy, but he refuses to offer informed consent and authorization for continuing therapy, then Therapist K will be in a comparable situation when two divorced parents with legal custody disagree regarding authorizing treatment of a child. Therapist K should suspend therapy until resolution of the parental conflict, unless the child's clinical status is so fragile and the risk of harm from immediately ending therapy is so severe that the child's situation would qualify for the exceptions that authorize "emergency" care without informed consent under the law. This situation may require Ms. C to go to court and seek sole legal custody or obtain a court order authorizing treatment of this minor child despite the lack of informed consent and authorization by Mr. E. If Therapist E continues therapy in the interim, she is advised to receive and document consultation in relation to the urgent need for ongoing therapy, and whether Mr. E's refusal to authorize urgent care necessitates a mandate report to the state child protection agency.

If a relevant law does not require Mr. E's informed consent, then the confidentiality of the child's therapy should continue, unless Ms. C authorizes communication between Therapist K and Mr. E, or until Mr. E obtains a court order instructing Therapist K to act otherwise
(Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Informed Consent to Organizations

The informed consent procedures for clients of therapy or evaluation services may differ somewhat from organizations. The standard regarding provision of services to organizations requires that the organizational client, employees, staff, or others involved in the practitioner's activities be given information about the nature, objectives, and intended recipients of the services. Practitioners must specify which individuals are the clients and the type of relationship that will exist with all who are involved. Practitioners indicate the likely uses of the obtained information, those who will have access to the information, applicable limits to privacy and confidentiality, and they provide results and conclusions to appropriate persons in a timely manner.

In situations when practitioners are not allowed to provide informed consent, or results of the work, they are required to discuss these restrictions with the involved parties. This implies that, within an organizational setting, practitioners should clearly understand their role, and any limitations to informing recipients of services the outcome of the work. Such disclosure of information restrictions generally occur in organizational or forensic environments but may arise in other settings as well. For instance, a corporation may have a policy to not disclose personality assessment results for security reasons if the assessments were requested by the corporation.

When employed by or consulting with an organization, the clients are organizational entities, not individuals, therefore, it is vital to determine the intended recipient, specify which individuals are clients, and define the relationship of the practitioner with each of these persons. A forensic setting may prohibit practitioners from sharing the report with the client, if so, practitioners must inform the individual that he or she may not have access to the written report through the practitioner. Related standards to provision of services to organizations, and consultation, include the following:

Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons
(APA, 2010, 3.11.a.).

If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service (APA, 2010, 3.11.b.).

Information shared in a consulting relationship is discussed for professional purposes only with persons directly involved with the case. Written and oral reports present only data germane to the purposes of the consultation, and every effort is made to protect client identity and to avoid undue invasion of privacy (ACA, 2014, B.7.a.).

When providing formal consultation services, counselors have an obligation to review, in writing and verbally, the rights and responsibilities of both counselors and consultees. Counselors use clear and understandable language to inform all parties involved about the purpose of the services to be provided, relevant costs, potential risks and benefits, and the limits of confidentiality (ACA, 2014, D.2.b.).

Counselors take reasonable steps to ensure that they have the appropriate resources and competencies when providing consultation services. Counselors provide appropriate referral resources when requested or needed (ACA, 2014, D.2.a.).

Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and

should do so only within their areas of knowledge and competence (NASW, 2008, 3.01. a.).
Social workers who provide supervision or consultation are responsible for setting clear, appropriate and culturally sensitive boundaries (NASW, 2008, 3.01. b.).
Marriage and family therapists, upon agreeing to provide services to a person or entity at the request of a third party, clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality (AAMFT, 2015, 1.13).

Case 4: Services To or Through Organizations

Case Scenario - Therapist L specializes in consulting with corporations for the evaluation of job-candidates for high-level management positions. The CEO of a computer company, which Therapist L has worked with several times, contacts Therapist L and indicates the company is seeking a research and development vice president, with expertise in computer software innovations and management experience in production. Over time, Therapist L has developed a reliable interview protocol for distinguishing individual traits, characteristics, and other variables relevant in high-ranking management. She has also developed some instruments that provide information about the executive-level potential of examinees, including personality type measures, workplace temperament, decision-making skills, creativity, independence versus collaboration, coping with stress, and other factors.

The company picks four individuals for Therapist L to evaluate. She informs the candidates that the CEO and other management representatives would have access to the evaluation, that the candidates are not her clients, therefore, their disclosures will not have confidentiality, and she communicates how the evaluation is used in making the vice president choice. Therapist L completes her full battery with each candidate and then gives the four evaluations to the CEO who uses the evaluations to select the vice president. Two of the other candidates are hired as well, but for different positions. Mr. F, one of the candidates, learns that he was not hired for any position.

Mr. F contacts Therapist L and demands a copy of his evaluation because he questions whether the process was objectively and fairly conducted by Therapist L and also he wants to receive feedback on improving his job application performance for future interviews. Mr. F is upset that he was not selected for any position, wants to address that "there must have been something negative conveyed about him" and is contemplating filing a complaint with the state licensing board.

Ethical Concern - Therapist L is surprised by Mr. F's response, additionally, she did not know that two candidates were hired for other positions. She is knowledgeable of the ethical requirements related to working with organizations as clients versus individuals, and with contemplating the relevant factors in organizational services. In this case, she understands that this examinee knows that management had access to the testing information and there was no confidentiality, evidently, he fails to understand that he is not privy to the information. The results and conclusions of the evaluation services were given to the appropriate persons, as required by the standard on services delivered to organizations, and such disclosure did not include the examinees.

Therapist L understands that she cannot defend herself against the allegation that she was not objective because she does not want to present the information to Mr. F. Unfortunately, the hiring of the two other candidates could strengthen Mr. F's perception that something was wrong in the evaluation process. With respect to Mr. F's second demand of receiving evaluation performance feedback, Therapist L never uses her battery as preparation for other interviews. Therapist L is concerned that if Mr. F pursues his complaint then she may have to reveal her test battery.

Decision-Making Considerations - Therapist L considers her attempts to uphold the services to organizations standard and how she communicated the evaluation conditions to each candidate. Therapist L believes that she properly expressed the nature and purpose of the service, including the persons who would receive the evaluations, the CEO was her client, ways in which the evaluation would be used to choose the vice president, and that all senior executives may access the information. Therapist L thinks she gave thorough information sufficient to uphold the services to organizations standard, but now senses that she had not explicitly told the candidates that they could not access their own evaluation. The standard requires practitioners to provide information to clients at the outset and, when appropriate, those directly affected by the services about the "probable uses of services provided and information obtained." Therapist L ponders that she did not tell the candidates that the evaluation could not be used for other purposes (i.e., feedback for instructive or corrective purposes). Further, Therapist L is concerned that her evaluations were used to choose two candidates for unrelated positions to vice president. Though some of the information is applicable to other vocational positions, her evaluations were precisely designed for the vice president position as defined by the CEO. Therapist L is uneasy over the possibility that if the two other candidates' job performance is poor, then her evaluations were used improperly.

Therapist L had an ongoing agreement with this software company that they would view her test materials as proprietary. It took years to evolve her evaluation protocol. Hence, she was anxious about the unintended repercussions of her evaluations along with the proprietary status of her evaluation battery being jeopardized.

Decision Options - Therapist L resolves to speak with the company and Mr. F. She will talk to the CEO about risks involved in using her battery for reasons other than as designed, and indicate that the evaluation needs to specifically match individual characteristics with the job. Therapist L understands that she cannot control the use of her evaluations upon their release, but she wants to clarify their

exact use and to inquire about usage of her battery for choosing people for other positions.

Therapist L will contact Mr. F and discuss the use of her evaluations and the reasons for her inability to disclose the information to any of the candidates, including Mr. F. In this case, Mr. F comprehended the confidentiality limitations and that others had access to the information for decision-making purposes but he did not understand the limitations of the examinee's personal access. Yet, it is safe to assume that this request for personal access to information when one is being assessed for specific performance reasons can arise. For instance, when examining fitness for duty or necessary skills for an executive management position, some individuals who are not selected may challenge or dispute the objectivity of the examiner and/or the accuracy of the assessment material. Hence, addressing this issue at the outset can prevent issues later. Though Therapist L had been conducting organizational work for some time, she misjudged and downplayed the necessity of thoroughly addressing the factors cited in Standard 3.11, specifically, pertaining to the use of information obtained and who will have access to the information (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Case 5: Services To or Through Organizations

Case Scenario - Therapist M is contacted by a vice president of a large corporation and hired to conduct an organizational consultation designed to improve communications between management and employees and mutual decision making among middle-level managers at a regional office managed by that vice president. The vice president hopes that Therapist M's objective perspective will improve the organizational relationships within that office resulting in better productivity and a healthier work environment. A meeting is arranged with Therapist M, the vice president who hired her, the director of the regional office, and the manager of the human resources division, at which time the nature of the organizational problem is reviewed. It is resolved that Therapist M will provide a written consultation report to the vice president, she will not discuss the consultation process or results with anyone other than the vice president, the process will be completed within 30 days, and a fee is negotiated. The vice president will then use the information as his upper-level management team had previously agreed upon. Therapist M informs the group of her consultation process which involves interviews with the regional office employees and several important employees in the vice president's office. Therapist M conducts the consultation by communicating with 14 regional office employees and 4 key central office executives, devising recommended steps to improve internal communications and management decision making, and giving a report to the vice president. The report included a synopsis of information and specific remarks that each individual disclosed during the interview to highlight their different perspectives and roles within the regional and central offices.

Several days later, Therapist M is called by a regional office employee who blames Therapist M for causing his being fired by the vice president. The disgruntled ex-employee states that after the consultation report was given to the vice president he was accused of being a "problem employee" who was "the cause of most of the problems" in the regional office "according to that (therapist)." The caller innocently declares that "her observations and complaints should have stayed confidential since 'what you tell a (therapist) is supposed to stay confidential - everybody knows that!'" Therapist M is alarmed by this phone call because she never thought the report would result in an employee termination and the intent of the report was to reveal patterns of organization perspective rather than depicting any person as a "problem employee."

Ethical Concern - The standard on Third-Party Requests for Services requires that when providing services at the request of a third party, MFTs "clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality" (Standard 1.13), and psychologists must clarify " the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality (Standard 3.07). In this case, Therapist M is providing services for an oversight office of the corporate organization relative to another office within the same organization. Therapist M did not comply with the requirements of Standard 3.07 by not explaining her role and the nature of her work to all parties that she interacted with. She did not explain that the vice president was her client and not the employees or the management staff of the office that she was evaluating. She did not express that the vice president was planning to use the information to improve organizational functioning and human interaction among the employees, and, most critically, she did not disclose that her individual interviews were not confidential. Standard 3.11, Psychological Services Delivered To or Through Organizations, also was not upheld because Therapist M was providing services "to or through" an organization. Standard 3.11 requires psychologists to inform others of the nature and objectives of the services, identify the intended recipients, and disclose who will have access to the information.

Therapist M acknowledges ACA Standard A.4.a., Avoiding Harm, which requires counselors to "avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm." Had Therapist M discussed with the CEO and senior managers the potential consequences to individual employees, she could have potentially prevented or minimized harm to the employees.

Decision-Making Considerations - Therapist M acknowledges that she did not consider key ethical factors of organizational consultation regarding the organizational

structure she was going to work within and in upholding consultation ethical standards . Therapist M retraces her actions and their ramifications on ethical conduct and she recognizes several errors in her consultation process. Therapist M realizes that she did not comply with the standard on Third-Party Requests for Services (i.e., AAMFT, 1.13; APA, 3.07) because the nature of the confidentiality complaint and the repercussion of her omission was clearly expressed by the ex-employee. Therapist M recognizes her breach of the principle on Fidelity and Responsibility in that people with whom she worked thought confidential disclosure was a given, and she senses her betrayal of their trust in her as a professional.

In hindsight, Therapist M acknowledges that she perceived the regional office as part of the same corporate entity and did not categorize the work a third-party request for professional services. She did not contemplate the needed action she should have taken to protect confidentiality of employee statements or to inform participants of the limits of confidentiality. Therapist M reconsiders the reasons she included employee names in the report; she initially construed that it would clarify organizational communication and work collaboration patterns.

Therapist M regrets the consequences to the employees and will seek more education and consultation on organizational consultation. Unrelated to whether her services were initiated by a third-party request, Therapist M could have been guided by the standard on Psychological Services To or Through Organizations, and the standard on limits of confidentiality (i.e. NASW, 1.07.e - previously cited). As noted earlier, the standard on delivering services to or through organizations indicates ethical requirements such as including disclosure of the identified client, the nature and objectives of the services, the probable uses of the services and information obtained, and any limits of confidentiality.

Decision Options - Therapist M feels somewhat overwhelmed by this experience and admits she is not fully aware of the ethical guidelines of consultation work. She decides that consultation and more preparation are requisite for her competency. Several of the Ethics Codes become more pronounced to Therapist M. The standards on Third-Party Requests for Services and Psychological Services Delivered to or Through Organizations foster sound decision making when the practitioner's client is not an individual or the recipient of services. She also learned that informed consent and confidentiality have different meanings and applications. By example, there is a distinction between the obligation of confidentiality and the limits of confidentiality, and there are different applications of informed consent for various recipient groups and in specific legal, health, and institutional contexts.

Therapist M writes a letter of clarification to the vice president regarding the fired employee explaining that her intent was not to label any individual as a problem employee largely responsible for the regional office problems. She articulates her view that the problems were collective, not solvable by termination of a single individual, and the statements by the terminated employee (as with all the other employees) were included in the report to simply show different ways the employees in the regional office subjectively perceived the problems. She emphasizes the integrity of an employee who discloses valuable information during the consultation, especially if the information was provocative or distressing to management. She explicitly asks the vice president to reconsider the termination of the employee if the termination was primarily based on her consultation report. She then calls the terminated employee and reveals she sent the letter to the vice president and specifies the content. Therapist M feels obligated to inform the ex-employee of her attempt to minimize the damage to him. She believes that notifying the employee of the letter allows for compliance of the agreement to not discuss facts or results of the consultation process with anyone outside of the central and regional office without the vice president's authorization. This case highlights the need for practitioner forethought and fairness in providing professional reports or other communication (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Advertising, Soliciting Clients, Media Presentations, and Other Public Statements

Practitioners are granted latitude regarding advertisements and public statements about their services and activities but the communications cannot be false, deceptive, or fraudulent. The principles of Beneficence and Nonmaleficence, Integrity, and Respect for People's Rights and Dignity underlie ethical conduct involved in advertising and other public statements. These principles reflect that professional activities that are not classified as direct service, such as advertising and media engagement, can potentially result in unintended exploitation or manipulation of others. Specifically, the principle of Beneficence and Nonmaleficence promotes nonexploitation, the principle of Integrity expresses the need to promote accuracy, honesty, and truthfulness in all public representations which fosters public trust and confidence in the field of psychology and individual practitioners,.and the principle of Respect for People's Rights and Dignity values self-determination. Also, the concept of informed consent assures that the public has sufficient information to make a fully informed decision. Public statements include everything that practitioners write, publish, broadcast, articulate, or communicate in any fashion. The standards within this concept require practitioners to attempt to "correct, whenever possible, false, misleading, or inaccurate information and representations made by others" (AAMFT, 2015, 9.8); "Social workers should ensure that their representations to clients, agencies, and the public of professional qualifications… are accurate"… and "…should take steps to correct any inaccuracies or misrepresentations of their credentials by others" (NASW 2008, 4.06.c.);

"When… representing their services to the public, counselors identify their credentials in an accurate manner…" (ACA, 2014, C.3.a.), and "Counselors… correct any known misrepresentations of their qualifications by others" (ACA, 2014, C.4.a.).

The standards relative to advertising and public statements are designed to prevent the public from making uninformed decisions and choices. Due to their positions of greater power, practitioners make reasonable efforts to inform of services and procedures, and they do not intentionally or unintentionally cause disadvantage to others.

Regarding media presentations, the standard affirms that practitioners' statements are not sensationalized, exaggerated, or establish a misleading impression, instead, statements must be founded upon practitioners' professional knowledge, training, or experience compliant with appropriate psychological literature and practice. Further, practitioners are prohibited from expressing that a professional relationship exists with the recipients of the media presentation. Generally, practitioners should narrow their comments and advice to generic information, because little, if anything, is actually known about the individuals attending to the media presentation, the depth of his or her issues, or history, as would be prerequisite in standard assessment and treatment. Whereas disseminating general psychoeducational information is allowed, providing direct treatment via specific advice or guidance in a public venue challenges the ethics of various standards. Hence, it is misleading to tell recipients of the public information that a professional relationship exists. Practitioners can avoid confusion and misunderstanding relative to their role as media advice-giver or educator by suggesting that the recipient talk to a psychotherapist. The standards on advertising, soliciting clients, media presentations, and other public statements include the following:

Social workers should ensure that their representations to clients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, or results to be achieved are accurate. Social workers should claim only those relevant professional credentials they actually possess and take steps to correct any inaccuracies or misrepresentations of their credentials by others (NASW, 2008, 4.06.c.).

Social workers should not engage in uninvited solicitation of potential clients who, because of their circumstances, are vulnerable to undue influence, manipulation, or coercion (NASW, 2008, 4.07.a.).

Social workers should not engage in solicitation of testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from current clients or from other people who, because of their particular circumstances, are vulnerable to undue influence (NASW, 2008, 4.07.b.).

When advertising or otherwise representing their services to the public, counselors identify their credentials in an accurate manner that is not false, misleading, deceptive, or fraudulent (ACA, 2014, C.3.a.).

Counselors claim or imply only professional qualifications actually completed and correct any known misrepresentations of their qualifications by others. Counselors truthfully represent the qualifications of their professional colleagues...

ACA, 2014, C.4.a.).

When counselors provide advice or comment by means of public lectures, demonstrations, radio, or television programs, recordings, technology-based applications, printed articles, mailed material, or other media, they take reasonable precautions to ensure that 1) the statements are based on appropriate professional counseling literature and practice, 2) the statements are otherwise consistent with the ACA Code of Ethics, and 3) the recipients of the information are not encouraged to infer that a professional counseling relationship has been established (ACA, 2014, C.6.c.).

Counselors do not exploit others in their professional relationships (ACA, 2014, C.6.d.).

Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise special care when making public their professional recommendations and opinions through testimony or other public statements (AAMFT, 2015, 3.11).

Marriage and family therapists accurately represent their competencies, education, training, and experience relevant to their practice of marriage and family therapy in accordance with applicable law (AAMFT, 2015, 9.1).

Marriage and family therapists ensure that advertisements and publications in any media are true, accurate, and in accordance with applicable law (AAMFT, 2015, 9.2).

Marriage and family therapists claim degrees for their clinical services only if those degrees demonstrate training and education in marriage and family therapy or related fields (AAMFT, 2015, 9.5).

Marriage and family therapists correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist's qualifications, services, or products (AAMFT, 2015, 9.8).

Marriage and family therapists represent themselves as providing specialized services only after taking reasonable steps to ensure the competence of their work and to protect clients, supervisees, and others from harm (AAMFT, 2015, 9.7).

Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated (APA, 2010, 5.01.a.).

Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings (APA, 2010, 5.01.b.).

Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice (APA, 2010, 5.01.c.).

When psychologists provide public advice or comment via print, Internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient (APA, 2010, 5.04).

Case 6: Media Presentations

Case Scenario - Therapist N, a therapist in private practice, understands that media psychology has become more popular in the public sector and she desires a public media aspect to her professional work. She genuinely enjoys being interviewed and sharing her opinion on public issues. Over time, Therapist N is called for various events, which leads to expansion of her practice in two ways. She includes her perspectives on psychological matters on her Web site and opens two-way communication through a chat feature. Secondly, she gives interviews on the radio and ultimately obtains a regular time spot on the local radio station. Therapist N appreciates the increased visibility of her private practice and fulfillment of an innate interest in media work.

Ethical Considerations - Therapist N routinely answers questions on her radio show, gives advice and professional opinions through the chat feature of her Web site, and provides articles on her Web site on different psychological subjects that she has written. Therapist N has a loyal listener named Jane who believes in this therapist's competency and understanding of her specific issues. Jane has a history of several suicide attempts the past years and is presently challenged by an abusive domestic partner and an eating disorder. She has seen several therapists but Therapist N is her favorite.

While on the radio show, Therapist N announces her Web site and the services offered there, including that she gives advice to people who log in and ask questions. Jane reads the therapist's articles and asks questions, which Therapist N answers, and Jane calls the radio show asking questions which Therapist N always answers. Jane feels understood by the therapist and appreciates having someone who can tell her what to do.

Therapist N is aware that Jane has called the radio show several times because she identifies herself. The therapist believes this is acceptable because several people have called in more than once. Therapist N, however, does not know that Jane is also writing to her chat room, nor how, or how often, Jane is implementing the advice of the therapist.

The arguments between Jane and her partner escalate, leading to fights, despite Jane trying to implement some of Therapist N's advice for people in her situation. Then, a violent argument leads to Jane being assaulted by her partner. She is distressed and confused because following the advice of Therapist N is worsening the situation; she responds by taking an overdose of sleeping pills. Her sister finds her and takes Jane to the emergency room. The hospital intake interviewer asks Jane if she is receiving any professional care, and she replies, "Yes, Therapist N."

Decision-Making Considerations - Three criteria for making decisions regarding media activity are expressed in ACA Standard C.6.c., and APA Standard 5.04, as well as NASW Standard 4.06.c. Therapist N acknowledges that she must incorporate these criteria into her future decision making and into the current dilemma.

Therapist N is alarmed to receive the emergency room phone call. She remembers someone named Jane calling the radio show and the general issue she presented with, but Therapist N did not know how Jane exaggerated the role of the therapist in Jane's life, nor how Jane combined the therapist's radio show, articles, and chat feature into a subjectively perceived personal therapist-client relationship.

Therapist N intended to be ethically sound while expanding her scope of practice, but she did not fully contemplate the criteria for media presentations. First, she did not consistently tell her listening public that her advice and points-of-view were not designed to be direct services and she was not providing services for individuals. During her radio show, she did not infer that direct and individual services were offered, but she did not specifically tell listeners to avoid perceiving the radio show as provision of direct services to the public.

Second, Therapist N understands that her knowledge of domestic abuse and eating disorders is general and accurate, but it is not specialized expertise, and her practice does not include either of these issues. This does not comply with the first criterion of the standard for counselors on media presentations whereby, "the statements are based on appropriate professional counseling literature and practice," or for psychologists, such that "statements are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice," or for social workers, in that “representations to clients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, or results to be achieved are accurate.” Therapist N resolves to seek consultation when providing services in a new area or activity in which she lacks established expertise.

Third, Therapist N was not aware of the boundaries of electronic services. Her intent was to have an electronic version of her radio show, comparable to a newspaper advice column. Unfortunately, she underestimated how much Jane was perceiving the radio advice as being individualized and the chat communication as even more personal advice. It is reasonable to assume that a needy, possible client, such as Jane, could view Therapist N's media communications as psychological services, and Therapist N's continual media presence as an ongoing relationship between therapist and client. This standard does not exclude conducting psychological services in public, but it does express the need to comply with all other standards in the Ethics Code. For instance, continued work of this type would probably not comply with the standards of informed consent, competence, appropriate assessment and diagnosis and treatment planning, which would do harm to Jane by depriving her of needed services.

Decision Options - Therapist N acknowledges that she needs to modify her radio show essentially by being very clear and specific in clarifying the limitations of her shared information. She needs to monitor and limit repeat callers as best she can. In the future, Therapist N must limit statements and information to areas in which she has claimed expertise, in other words, despite the fact that she is not offering a psychological service on the radio show, she should not express general statements regarding clinical diagnoses, treatment plans, or etiology of conditions that are outside her area of expertise.

Therapist N resolves to close her chat feature because the risk of misinterpretation is high, even though it increased her practice and referral sources. She will continue to upload her articles and other information on her Web site, but she chooses to limit activity to being one-directional information as opposed to interactive material.

Therapist N is aware that some of her colleagues are providing Internet services, and are conducting therapy on

the Internet. Her plan, however, was to support media psychology and not expand her Internet practice.

Therapist N chooses not to see Jane as an Internet client or a conventional client and refers her to a therapist with expertise in Jane's issues. After consultation with informed colleagues, Therapist N could decide to personally meet with Jane, without a charge, to address the misunderstandings about her services and role as a media psychologist, and to correct Jane's view and expectations of Therapist N as her personal therapist; or not to meet in person but instead to write a letter or call; or to not communicate at all. The suggested action is for Therapist N to consider a clinical decision about how, and if, to communicate with Jane. This ethical decision will evaluate risk management and Jane's best interests (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

The standards on Internet/Electronic Therapy include the following:

Prior to commencing therapy services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that electronically-assisted services or supervision are appropriate for clients or supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform clients or supervisees of the potential risks and benefits associated with electronically-assisted services; (c) ensure the security of their communication medium, and (d) only commence electronic therapy or supervision after appropriate education, training or supervised experience using the relevant technology (AAMFT, 2015, 6.1).

Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality (APA, 2010, 4.02.c.).

Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information... (NASW, 2008, 1.07.l).

Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible (NASW, 2008, 1.07.m.).

Counselors inform clients of the benefits and limitations of using technology applications in the provision of counseling services. Such technologies include, but are not limited to, computer hardware and/or software, telephones and applications, social media and Internet-based applications and other audio and/or video communication, or data storage devices or media (ACA, 2014, H.4.a.).

When providing technology-assisted services, counselors make reasonable efforts to determine that clients are intellectually, emotionally, physically, linguistically, and functionally capable of using the application and that the application is appropriate for the needs of the client. Counselors verify that clients understand the purpose and operation of technology applications and follow up with clients to correct possible misconceptions, discover appropriate use, and assess subsequent steps (ACA, 2014, H.4.c.).

When distance counseling services are deemed ineffective by the counselor or client, counselors consider delivering services face to face. If the counselor is not able to provide fact-to-face services (e.g., lives in another state), the counselor assists the client in identifying appropriate services (ACA, 2014, H.4.d.).

Testimonials and Solicitation

The standard on testimonials prohibits solicitation of testimonials from all current therapy clients because such individuals may be susceptible to undue influence in the therapy relationship. Likewise, this standard forbids solicitation of testimonials from former therapy clients if their life circumstances can cause vulnerability to undue influence. The ban on solicitation of testimonials from all current therapy clients reflects that the nature of the therapeutic relationship between therapist and client creates a power differential, dependence on the therapist for treatment of issues relevant to the client, possible transference, and other factors, which could produce undue influence. The boundary that the standard on testimonials creates is functional because it prevents potential client exploitation due to unfulfilled therapist needs possibly affecting treatment. The potential for undue influence can endure after therapy ends, based on the length and intensity of treatment, and client's mental status. This implies that therapists must be cautious in asking former clients for testimonials and they must assess client's vulnerability to undue influence.

The testimonials standard does not prohibit the use of testimonials, however, proof of therapist exploitation of client would violate the Ethics Code.

The testimonials standard does not address testimonials from participants in activities unrelated to psychotherapy, therefore, testimonials in relation to a therapist's workshops, seminars, or organizational/industrial work are not prohibited by this standard.

The standard on In-Person Solicitation is meant to prohibit "ambulance chasing." The vulnerability factor includes all actual or potential therapy clients, and any other individual whose specific circumstances cause him or her to be susceptible to undue influence. The standard does not ban solicitation if the factor of vulnerability is not extant. For instance, it is prohibited to solicit mourners at a funeral home, or to visit homes of survivors identified through the obituaries. In contrast, the Federal Trade Commission (FTC) assures that this standard does not prohibit placing professional cards or flyers on tables at shopping malls.

There is an implied conflict of interest when one solicits services and profit or personal gain is involved. The standard does not prevent responding to individuals in urgent distress or when a risk to self or others exists.

The standard's prohibition only applies to contacts that are uninvited and occur in person (which includes telephone contacts, based on case law), whether by the therapist or through the therapist's agent. Contacts invited by the potential client or executed through general mailings or other methods are allowed.

The standard allows therapists to invite a collateral contact (e.g., family member, or significant other) of a current client to become involved in treatment to benefit the client, but therapists cannot solicit collaterals for treatment.

The standard allows for provision of community outreach or disaster services. For example, therapists can offer their services through a community program for the homeless, older adults, or other groups who do not generally self-refer for mental health services, and they can offer their services to people who are vulnerable due to natural disasters, such as hurricanes, tornadoes, earthquakes, or terrorist attacks. The standards on testimonials and solicitation include:

Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence (APA, 2010, 5.05).
Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services (APA, 2010, 5.06).
Counselors who use testimonials do not solicit them from current clients, former clients, or any other persons who may be vulnerable to undue influence. Counselors discuss with clients the implications of and obtain permission for the use of any testimonial (ACA, 2014, C.3.b.).
When feasible, counselors make reasonable efforts to ensure that statements made by others about them or about the counseling profession are accurate (ACA, 2014, C.3.c).
(NASW, 2008, 4.07.a. - previously cited).
(NASW, 2008, 4.07.b. - previously cited).
Marriage and family therapists ensure that advertisements and publications in any media are true, accurate, and in accordance with applicable law (AAMFT, 2015, 9.2).

Case 7: In-Person Solicitation

Case Scenario - Therapist O is in private practice and is conducting therapy with a client named David, who is working on several interpersonal and work-related issues, and most importantly, the care of his aging father. His father was very active and had continued to live in his own home after David's mother died, unfortunately, his father began showing signs of dementia several years ago and has recently been diagnosed with Alzheimer's disease and he cannot live in his home alone. David has been the primary caregiver for his father the past several years but he does not want to make key decisions alone for his father because David has two brothers whom he believes should be involved in decision-making as well. David understands that Therapist O cannot make decisions about his father, but he thinks that Therapist O can stimulate communication between the three brothers regarding care of their father.

Therapist O and David address the issue and Therapist O feels that he could be of assistance in attempting to improve communication and closeness among David and his brothers. Therapist O is aware of the difference between conducting therapy with multiple individuals as clients (i.e., families and couples) versus with an individual client with whom multiple individuals (e.g., collaterals) participate in the therapy for the welfare of the client. Therapist O's plan is to have the two brothers participate in David's sessions as collaterals, and he will explain such as well as the roles of everyone before the sessions. David talks with his brothers about joining him in session and articulates their roles and the therapist's intentions and role.

Ethical Concern - Therapist O schedules a series of three sessions with the three brothers and rapidly discovers that several unforeseen issues exist that challenge the goal of improving communication and closeness among the brothers and that necessitate complex decision making for the therapist. David's brother, Jim, is experiencing marital difficulties and behavioral problems with their teenage son, thus, he feels unable to help their father. Jim feels overwhelmed to the point he uses the sessions to talk about his own marital problems and family dynamics.

David's second brother, Tim, was diagnosed with schizophrenia ten years earlier and has lived independently with the help of his parents and he has been in a group home offering supervision of his medications and activities. For various reasons, Tim was taken out of the group home which puts his living arrangements in question and he is now homeless. Tim's social and financial resources have diminished since their mother died and their father became ill. He is very concerned about his future. David is also concerned about his brother but he cannot offer financial assistance, and he does not know how to attain public assistance or mental health treatment for Tim.

Therapist O has professional experience with couples in distress, similar to Jim's situation, and with outpatient community-based health centers that offer assistance for people in Tim's circumstances. Therapist O also knows that he arranged for the two brothers to be collaterals and not clients, and he is motivated to make an ethical decision as to how to proceed with therapy.

Decision-Making Considerations - Therapist O is aware of the standard that prohibits uninvited solicitation of business from potential clients and other individuals who are vulnerable to undue influence. The exceptions to this ban include collateral contact to benefit a current client and disaster or community outreach services. Therapist O believes that Jim and Tim need professional help for their issues. Therapist O acknowledges that if he had known of the significant issues affecting Jim and Tim, although he had the professional capability to help each of them, he would not have invited them as collaterals due to the prohibition of soliciting business from potential clients who are vulnerable. Therapist O assesses Jim and Tim as being vulnerable and perhaps unable to make an informed decision, and both might accept Therapist O's professional services because of their vulnerable circumstances.

Therapist O also considers the two exceptions of this standard - collateral inclusion for current client benefit, and community outreach service. He reflects that he is seeing Jim, who has mental and financial resources to acquire his own psychological services, under the collateral conditions. Tim is also involved in the therapy process as collateral but requires immediate help, and Therapist O believes that Tim would qualify under the exception of providing community outreach services. Therapist O will ascertain whether Tim is in current treatment and with whom, so services will be coordinated. The standard pertaining to Clients Served by Others includes:

When counselors learn that their clients are in a professional relationship with other mental health professionals, they request release from clients to inform the other professionals and strive to establish positive and collaborative professional relationships (ACA, 2014, A.3).
When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately (APA, 2010, 3.09).

Social workers should respect confidential information shared by colleagues in the course of their professional relationships and transactions. Social workers should ensure that such colleagues understand social workers' obligations to respect confidentiality and any exceptions related to it (NASW, 2008, 2.02).

Decision Options - Therapist O understands that he must apply the solicitation standard to each of the three involved individuals and make a separate determination for each. David is engaged in individual therapy which Therapist O believes will continue to benefit David and which complies with the standards and his areas of expertise. Jim needs professional assistance, as David does, but Therapist O assesses that Jim is vulnerable due to his feeling desperate about his circumstances, and Therapist O is aware that providing therapy to Jim would occur within the context of Jim's vulnerability. Therapist O resolves to see Jim but solely within the accepted exception of collateral participation. Therapist O is concerned about Tim and senses that without help, or at least information, his situation will worsen. The therapist, however, believes that a multiple role conflict would exist by working with Tim on his issues under the classification of collateral participation within David's therapy. Therefore, Therapist O may decide to work pro bono with Tim to share information about available public sector resources and to offer direct services aimed at stabilizing him so he can resolve his living circumstances.

All things considered, the collateral sessions facilitate David's understanding of the current and future limitations of his brothers offering care for their father. Therapist O sees the value of having established goals and purpose for participation of family members in David's therapy (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Record Keeping

Record keeping is a process by which practitioners demonstrate their professional purpose, values, and roles. The documentation of one's professional activities will include pertinent factors such as work setting, population served, nature of the activity, expected use of the records, jurisdiction, and client wishes. Proper record keeping helps practitioners to: respect client rights, responsibly execute their professional roles, and comply with specific documentation needs and requirements.

Record keeping standards utilize core concepts from the general ethical principles. The principle of Fidelity and Responsibility promotes the need for trust and creating records regarding clients' personal and private information. The Integrity principle expresses the importance of honesty and truthfulness in generating accurate record keeping and transparent fee arrangements. The principle of Justice upholds fairness and equal quality in how practitioners treat the records of information and in the determination of fees. Record-keeping decisions commonly address the questions of: What is the purpose of creating this record? How is the record keeping facilitating informed decision-making? and What values are served by the record?

Decision making on the type of information to include in record-keeping may consider: a) the probability that the record will be used by third parties for decision-making purposes; b) continuity of care, and urgent care needs of specific populations, for instance, older individuals and the developmentally disabled; c) likelihood of litigation with high-risk clients; and d) continuity of care to those who are geographically moving.

The record keeping standard requires practitioners to "facilitate provision of services later by them or by other professionals." A clinical record describes the essential features of a case such that the case is understood over time and among multiple professionals. Information to be included in a record may answer the questions of: a) What does the practitioner want the reader to know about the purpose, course, and outcome of treatment? b) How can the practitioner differentially describe clinical information, such as an assessment versus therapy treatment, or a custody case versus educational placement? c) How can practitioners include developmental factors that depict current information about a person that might be interpreted differently or suggest different treatment options at a future time?

Clinical record keeping has the obligation to protect client welfare and to clearly describe treatment, referral, and disposition of the case.

The standard on record keeping relative to scientific work is distinct from other documentation as it may center on the quality of data treatment for peer review purposes, replication, and content and financial accountability. Due to exploitation and abuse by some in the past, research universities, funding agencies, publishers, and government entities have adopted requirements for conducting research that specify the management of informed consent, manipulation of experimental variables, data collection and analysis, reported findings, and other variables.

When documenting scientific findings and judgment, researchers often consider the response of peer reviewers, other scientists engaged in the same research, members of the public who may make decisions based on the conclusions, readers of scientific journals who may pose research questions based on the findings, and funding agencies that are concerned with ethical and legal treatment of subjects and others in the study, financial concerns, accurate documentation of all information, and validity of the findings. Generally, institutional review board approval is required.

Practitioners who are conducting research are advised to evaluate several factors in record keeping and documentation, such as criteria of the authorizing agencies, including institutional review board requirements, treatment of subjects, sufficient study description, and compatibility of documentation across government, university, and institutional entities.

The record keeping standard obligates practitioners to "meet institutional requirements." When conducting professional activities for an organization, one will be aware of informed-consent conditions, knowing and indicating who

the client is and who is receiving the services, acknowledgment of who controls the records during service provision and later in transfer or access to records, limits of confidentiality, administrative roles, and other procedural factors applicable to management and corporate systems. Institutional requirements may relate to hospitals, Veterans Affairs institutions, and educational settings in which the practitioner's role is not clinician, instead, as consultant, mediator, human resource specialist, or administrator of services. Practitioners may need to inquire of any unique record-keeping policies that the institution or organization requires.

There is overlap in some activities between organizational and clinical roles, thus, role diffusion can arise if professional tasks are not clarified through documentation.

Further, practitioners must "ensure accuracy of billing and payments." Record keeping and documentation for billing and payment may include transactions with private insurance or managed care companies, government entities such as Medicare or Medicaid, individual client billing, organizational billing, and forms that document services rendered, date of service, treatment, diagnosis, and other requested information. Client misunderstanding of services and billing issues can be avoided by clear records that explain the key elements of rendered services.

The record keeping standard also requires practitioners to "ensure compliance with law," including federal and state. Additionally, working in forensic settings requires awareness of jurisdictional implications, court proceedings, and regulations that affect one's practice. In such settings, practitioners' records may have several purposes, their clinical records, evaluations, consultations and all actions may be reviewed by others, and other individuals may have a specific interest in the practitioners' findings. Forensic records often have a level of specificity, focus, and treatment of content that may differ from clinical records, and practitioners should understand the protocols and procedures within court jurisdictions. The standards below apply to record keeping:

Counselors create, safeguard, and maintain documentation necessary for rendering professional services. Regardless of the medium, counselors include sufficient and timely documentation to facilitate the delivery and continuity of services. Counselors take reasonable steps to ensure that documentation accurately reflects client progress and services provided. If amendments are made to records and documentation, counselors take steps to properly note the amendments according to agency or institutional policies (ACA, 2014, A.1.b.).

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law (APA, 2010, 6.01).

Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided (NASW, 2008, 3.04.a.).

Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future (NASW, 2008, 3.04.b.).

Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services (NASW, 2008, 3.04.c.).

Marriage and family therapists maintain accurate and adequate clinical and financial records in accordance with applicable law (AAMFT, 2015, 3.5).

Case 8: Record Keeping

Case Scenario - Therapist P works in a large interdisciplinary organization which receives referrals for the general practice as well as for individual professionals. Therapist P maintains a practice within the organization and also has the administrative role of assigning the general referrals to individual therapists. The referrals are disseminated in a fair and organized way. One day, Therapist P received two referrals from other therapists in the community but each had record-keeping problems that could impede the provision of clinical services by the clinicians in Therapist P's organization. The treating therapists need to transfer the clients for reasonable reasons, but the records of each case jeopardizes continuity of care.

Case 1 is a referral of an 87-year-old man and his record indicates considerable mental status testing, individual, and family therapy. The client was hospitalized several times for his diabetes and there is a brief statement of a psychiatric evaluation while he was hospitalized. The client's family members called Therapist P asking which therapist their father will work with. They are eager to ask the therapist why their father is being seen and the expected treatment. Therapist P observes that the records do not indicate a diagnosis, course of treatment plan, results of the hospital visit, any informed consent, power of attorney, or guardianship documents. The fees for service are well-documented, and it appears that the client wrote personal checks for all services.

Case 2 represents a 26-year-old man who applied with his local police department to become a police officer. The psychologist who conducts evaluations of police department applicants asked the man for access to any physical or psychological health records. One report reflects that when the applicant was 15 years-old, his parents were concerned about his behavior problems, such as being oppositional, loitering after school, and two occurrences of knocking over mailboxes with his friends. At the time, he was evaluated by a therapist who detailed these issues and predicted this misbehavior would escalate with age. The psychologist working for the police department read this report and rejected the applicant due to instability as evidenced in the prior psychological report. The applicant is requesting an updated evaluation from Therapist P's organization to clear his record.

Ethical Concern - The record keeping standard requires therapists to include information within the psychological record that is essential to transfer that case to a different professional with ease of continuity and that would commonly apply, given circumstances of the case. Some types of information, specifically identification, purpose and course of treatment or service, fees, and disposition of the case would generally be provided. Such specific information

is relevant because an organizational, assessment, and custody case would each require some differences in content regarding specificity, duration, jurisdictional authority, and other matters.

Therapist P understands that the Case 1 record is missing vital information needed for the appropriate disposition and transfer of the case, and the record in Case 2 possesses information that probably misrepresents the applicant's current status. Therapist P ponders the application of the record-keeping standard in each case, and despite neither she nor her colleagues having been involved in the insufficient record keeping, she contemplates her and her practice's roles in working with these clients.

Case 1 lacks a clear record of the purpose for testing, individual, and family therapy, and hospitalization. The record contains only indirect references to the client's memory problems but omits a diagnosis. Further, there is inadequacy or absence of informed consent for the family's access to client records and for authorization of mental status testing.

Regarding Case 2, Therapist P is concerned about the record-keeping standard, and considers that she might not have released the report because it could misrepresent the client. The test data are probably outdated and should not be implicated in decision making, and rather than simply releasing the report, she would have explained the results and limitations of their usage.

Decision-Making Considerations - In each case, Therapist P will need to evaluate the purpose of the record, the content and detail required for continuity of care, and how the information should be used and in what context. Therapist P would need to deliberate over contacting the therapist who saw the applicant as a teenager and the psychologist working with the police department relative to the problems in each record.

Therapist P is uncomfortable that the record in Case 1 does not offer continuity of care, potential confidentiality limitations, and proper informed consent. She senses that the client may have memory and other associated issues and has received treatment as if he had legal caretakers despite the absence of a legal transaction. Therapist P thinks that this client is vulnerable to exploitation because he has been writing checks to pay for treatment and the client's interest may not have been upheld since the therapist was conscientious about fee, but not treatment records.

The report for Case 2 may have fulfilled the purpose of testing at that time, however, it lacked clarification in the statement that treatment was recommended and that no treatment could lead to exacerbation of symptoms. The report did not express specific recommendations or elaborate upon the evaluator's assessment that "behaviors could escalate." Therapist P surmises that even if the report is correct, it does not assist provision of services at this time. Therapist P will consider the inadequacy of the report to facilitate future use, and more pivotally, to continuity of care, because this case involved developmental changes and age-related behaviors that should have been kept in context.

Decision Options - Therapist P chooses to not accept Case 1 as a referral at this time until receiving information on the central factors of purpose of treatment and current diagnosis which will illuminate the course of treatment. She is disappointed by the dearth of information provided by the previous therapist. She is reminded of the necessity to keep accurate and thorough records to enable transfer of services. Therapist P understands that despite her organization having several therapists who specialize in working with older adults, a consultation with the client is needed to explain his confidentiality rights, confidentiality limits, informed consent, and to have the client disclose what he wants. Therapist P would want a client release of information to communicate with the previous therapist and police psychologist and to request testing data. Therapist P would need to execute an informed-consent authorization if the client desires his family to have access to information. She will also need to discuss these limits and the required course of action to the family.

Regarding Case 2, Therapist P will evaluate the need for any further testing and if testing is the best way to pursue the case. She acknowledges that outdated information was used to render a decision and resolution of this breach has several options. Therapist P contemplates a consultation with the police psychologist and the evaluating therapist. A recommendation to the evaluating therapist would suggest that he or she write a qualifying letter or statement (for any future prospective employer, inclusive of the current police department) explaining the clinical and ethical problems of using outdated information. A consultation with the police psychologist could elucidate developmental factors of adolescent behaviors, especially because the behavioral, academic, and social history of the applicant contraindicate the previous behavior problems. Therapist P (or the appointed therapist to conduct the consultation) would also inform the client of the needed transactions, obtain informed consent and a release for records, and advise the client as needed regarding developing circumstances.

Therapists recognize that their professional transactions promote the welfare and best interest of the client, which supports the general principle of Respect for People's Rights and Dignity. Therapist P infers that the police psychologist and evaluating therapist may have overlooked this key concept in their judgment in these cases (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

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TEST - ETHICS: CASES and COMMENTARY II

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1. **The public nature of the mental health field transports decision making from subjective, personal morality to**
   A) the client always dictating direction
   B) a broader public domain concern
   C) the therapist always dictating direction
   D) therapeutic process not being transferable across different clients

2. **Informed consent offers assurance that __________.**
   A) the trust required from the practitioner's clientele is justified
   B) therapist power is not abused
   C) therapist care is understood and agreed to
   D) All of the above

3. **The standard on In-Person Solicitation is meant to prohibit __________.**
   A) transference
   B) discrimination
   C) "ambulance chasing"
   D) ineffective record keeping

4. **The ban on solicitation of testimonials from all current therapy clients reflects that the nature of the therapeutic relationship between therapist and client creates a __________.**
   A) power differential
   B) dependence on the therapist for treatment of issues relevant to the client
   C) possible transference
   D) All of the above

5. **Proper record keeping helps practitioners to __________.**
   A) respect client rights
   B) responsibly execute their professional roles
   C) comply with specific documentation needs and requirements
   D) All of the above

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TRUE/FALSE: A = True and B = False

6. **Many of the standards within the Ethics Code allow for the concepts of "reasonable" and "appropriate" which grants a degree of professional judgment and deliberation.**
   A) True B) False

7. **If it becomes apparent that the practitioner may be called upon to perform potentially conflicting roles, the practitioner does not need to clarify, adjust, or withdraw from roles appropriately.**
   A) True B) False

8. **Practitioners should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible.**
   A) True B) False

9. **Upon agreeing to provide services to a person or entity at the request of a third party, practitioners clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party.**
   A) True B) False

10. **Informed consent is the end-result of therapist and client reaching an agreement to work together.**
    A) True B) False

11. **Informed consent recurs in order to clarify or renegotiate the therapeutic process.**
    A) True B) False

12. **Individuals who provide their informed consent to the practitioner do not need to have been given the chance to ask questions about the processes and procedures.**
    A) True B) False

13. **The informed consent standard requires informed consent to be obtained if the services are performed face to face, or by Internet, videoconference, or other forms of electronic communication.**
    A) True B) False

14. **When providing services to organizations, practitioners must specify which individuals are the clients and the type of relationship that will exist with all who are involved.**
    A) True B) False

15. **Practitioners are granted latitude regarding advertisements and public statements about their services and activities but the communications cannot be false, deceptive, or fraudulent.**
    A) True B) False

16. **The standards relative to advertising and public statements are designed to prevent the public from making uninformed decisions and choices.**
    A) True B) False

17. **When providing services to persons who cannot legally give consent, such as children and legally incompetent adults, practitioners do not need to protect the best interest of the client.**
    A) True B) False

18. **The standard on testimonials forbids solicitation of testimonials from former therapy clients if their life circumstances can cause vulnerability to undue influence.**
    A) True B) False

19. **A clinical record describes the essential features of a case such that the case is understood over time and among multiple professionals.**
    A) True B) False

20. **Clinical record keeping has the obligation to protect client welfare and to clearly describe treatment, referral, and disposition of the case.**
    A) True B) False

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