CHAPTER 1

ETHICS AND BOUNDARIES

(3 CE Hours)

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Learning objectives

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

Introduction

Ethics and mental health practice

Ethical issues are common in any profession. But mental health work, which relies heavily on relationship building and which can directly impact the health and welfare of its clients, poses even greater responsibilities and challenges.

Mental health practitioners must rely on internal guides of character and integrity and external guides such as laws and ethical codes of conduct. Consider these two examples:

- Mary, a mental health counselor, provided counseling services at a community mental health center. Most of her clients did not have insurance nor could afford to pay privately anywhere else. After several years of postgraduate full-time practice, Mary felt competent providing services for most issues.

  After three sessions with one of her clients, her client confessed that he wanted a sex-change operation and would need Mary's support through the process. Mary had taken few graduate level courses in human sexuality and had no other specialized training in this specialized area. If there was another clinician available who specialized in gender reassignment issues, her client could not afford it.

  Given her strong belief in client self-determination, the client's belief in her ability to assist, and her willingness to read the literature and consult the Internet on protocol, Mary agreed to revise their plan of treatment and proceed.

- Joaquin, a licensed clinical social worker, and his client, a young man with schizophrenia, have successfully worked together to achieve stability in symptom management and independent living. Joaquin and his client are close in age, have many interests in common and consequently have achieved a strong rapport and mutual trust. Now Joaquin is transferring to a supervisory position, which will effectively end his professional relationship with the client. His client wishes to continue their relationship as friends, and Joaquin is tempted to do so.

In these two examples, each mental health practitioner demonstrates both a compassion for and commitment to their respective clients. They are at a crossroads in their relationship with their clients. What they decide to do next must consider various issues that include what is in the best interest of the client and the client's right to self-determination.

The primary reason for action

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

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

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

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

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

Defining ethics

The word "ethics" is derived from both the Greek word "ethos," which means character, and the Latin word "mores," meaning customs. Ethics defines what is good for both society and the individual. Though closely related, law and ethics do not necessarily have a reciprocal relationship. While the origins of law can often be based upon ethical principles, law does not prohibit many unethical behaviors. Likewise, adherence to certain ethical principles may challenge a mental health practitioner's ability to uphold the law.

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

Implications for practice

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

The social work profession adopted the first code of ethics for the profession in 1947. In 1960, following the formation of the National Association of Social Work, another code of ethics was drafted, with multiple revisions in the following years. Ethics have been developed for other national mental health licensing associations and boards that include among others, The American Association for Marriage and Family Therapy, The American Counseling Association, and The American Mental Health Association.

The American Association for Marriage and Family Therapy "strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as professional expectations" that are enforced by its own Ethics Committee. The American Counseling Association "promotes ethical counseling practice in service to the public." The primary mission of the National Association for Social Workers is to "enhance human well-being and help meet the basic

human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty."

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

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

The law and mental health

Here is one scenario that illustrates how law can interface with mental health practice:

- A licensed mental health practitioner believes a foster teen's allegations of abuse toward her foster father merely represent countercoercive behavior related to her adjustment within a more stable, rule-enforced environment and chooses not to report it. He rationalized that this family had successfully helped many children before without incident.

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

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

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

Impact of law on practice

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

- Education.
- Experience.
- Passing score on an examination.

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

There are also laws that impose legal obligations to abide by practices that further serve to protect the consumer, such as federal and state statutes requiring mandatory child abuse reporting, practices that ensure client confidentiality, or competence to perform certain services. Unlike regulation under the law, adherence to regulations set forth by private credentialing bodies is voluntary. However, the regulations and codes of ethics are universally respected. Mental health professionals also practice in accordance to the professional standards of care established by private professional association organizations such as ACA, NASW, or AAMFT.

Establishing ethical codes of conduct

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

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

The study clustered those violations into 10 categories:

- Violating boundaries.
- Poor practice.
- Competence.
- Record keeping.
- Honesty.
- Confidentiality.
- Informed consent.
- Collegial actions.
- Reimbursement.
- Conflicts of interest.

Of the 267 individuals found to have violated ethical standards, 26 percent were found to have violated only one ethics category, while 74 percent had violated more than one. Most of the cases (55 percent) involved boundary violations, such as those involving sexual relationships and dual relationships. Given the frequency that these violations occur, (and remember, this study only examined reported violations) we will be exploring these two violation types in more depth later. The findings reflected a variety of inappropriate behaviors that blurred the helping process and exploited clients including:

- The use of physical contact in treatment.
- The pursuit of sexual activity with clients, either during or immediately after treatment.
- Social relationships.
- Business relationships.
- Bartering.

Unintended actions

Some mental health professionals may argue that an action is ethical as long as you are not intending harm and/or are not knowingly violating an ethical standard or law. Or, what about those unique situations that don't readily lend themselves to a reference in law or codes of conduct? What defines prudent practice? Grappling with questions about what is unethical and what isn't ethical is a situation faced by any person in the helping professions.

Pope and Vasquez (1998) discuss the tendency to rationalize that an action is acceptable, as it relates to the practice of psychotherapy and counseling:

> This rationalization encompasses two principles:
> 1. Specific ignorance.
> 2. Specific literalization.

Specific ignorance

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

Literalization

The principle of literalization states that if we cannot find a specific mention of a particular incident anywhere in legal, ethical, or

professional standards, it must be ethical. Assisting mental health practitioners in resolving ethical dilemmas that may arise in practice is just one of several purposes for establishing ethical codes of conduct.

Ethical standards of practice for mental health generally benefit both the practitioner and the public and include:

1. Identifying core values.
2. Establishing a set of specific ethical standards that should be used to guide mental health practice.
3. Identifying relevant considerations when professional obligations conflict or ethical uncertainties arise.
4. Providing ethical standards to which the general public can hold mental health professionals accountable.
5. Providing mental health ethical practice and standards orientation to practitioners new to the mental health field.
6. Articulating formal procedures to adjudicate ethics complaints filed against mental health practitioners.

Core values and ethical principles

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

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

Depending on a particular professional association's Code of Ethics, ethical professional practice can include:

- Helping people in need.
- Challenging social injustice.
- Respecting the inherent dignity and worth of the person.
- Recognizing the central importance of human relationships.
- Behaving in a trustworthy manner.
- Practicing within areas of competence and developing and enhancing professional expertise.

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

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

- To clients.
- To colleagues.
- To practice settings.
- As professionals.
- To a particular mental health profession focus.
- To the broader society.

This course will continue to look at issues around each of those areas.

Ethical responsibilities to clients

This illustration highlights the complexity of ethical responsibility to clients:

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

Commitment

Client interests are primary. The example above epitomizes the difficulties often faced by mental health practitioners when the principles of law, personal belief, professional codes of ethics, client need, and cultural and societal norms intersect and at times contradict each other. The professional is then faced with a conundrum that offers a multitude of potential decisions, actions, and consequences. We will discuss more about how the worker can best weigh all these considerations to make the most ethical decision later in this course.

Self-determination

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

Defining risk can be difficult – most mental health professionals cannot argue that suicide or homicide do not present a clear risk to the client or to others. Other client choices, such as staying in an abusive relationship or living in squalor or on the streets, may challenge a professional's personal values and sincere desire to protect, also known as "professional paternalism." (Reamer, 1998.) In the absence of clear and present harm, the client has a right to choose his or her own path and make his or her own decisions, whether we agree or disagree.

Suicide: right to choose versus duty to protect

Sometimes a mental health practitioner may be faced with a choice between a client's right to choose suicide and the duty to protect his or her life. The request by the emotionally stable and rational terminally ill client is a good example of a situation that is not as "cut and dried" as that involving a severely depressed young woman contemplating suicide.

Would one client deserve individual consideration and thus not be assessed for possible hospitalization over the other? Most workers choose this profession because it supports respect for the strengths and abilities of clients, and thus their ability to learn, make good decisions, and be self-sufficient. But aside from laws prohibiting assisted suicides, workers also rely on intuition and judgment in determining whether to take action to protect a client from harm. This scenario blurs the line between respect for the client's wishes and society's obligation to protect. It also raises the issue of client autonomy verses the professional obligation to prevent discrimination. Thus, it is essential that mental health practitioners establish clear procedures that ensure impartial assessment while valuing client autonomy and individual treatment.

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

- Careful evaluation, such as the client's ability to make rational choices based on the mental state and social situation.
- A good therapeutic alliance.
- Consultation.

Informed consent

Informed consent services should only be provided when valid informed

consent can be obtained. Therefore, clients must know the exceptions to self-determination before consenting to treatment or other services. Mental health professionals working in child welfare or forensic practice settings are faced with additional challenges. In their article about informed consent in court-ordered practice, Regehr and Antle (1997) state:

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

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

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

Competence (or professional and ethical competence)

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

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

- Personal impairments.
- Lack of adequate knowledge or preparation.
- Lack of needed supervision.

Conflicts of interest

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

- Professional discretion.
- Impartial judgment.

The issue of informed consent should include both prescribing the need to inform clients of potential or actual conflicts, and taking reasonable steps to resolve the conflict in a way that protects the client's needs and interests.

Dual or multiple relationships

Dual or multiple relationships occur when mental health professionals relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.

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

Further, workers should not engage in dual or multiple relationships with clients or former clients where there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries.

Recognizing that there are many contexts within which mental health work is practiced, dual relationships are not always entirely banned by different professional association ethical codes. The word "should" in sections where dual or multiple roles are outlined within various codes of ethics, implies there is room for exceptions. However, what they are usually distinguishing is that dual relationships are not permitted when there is risk of exploitation or harm. In not banning all dual relationships, each worker bears the responsibility for both determining, and if needed, proving that the relationship was not harmful to the client.

Boundary violations

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

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

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

- Current clients.
- Former clients.
- Colleagues.
- Supervisees and students.

With that in mind, the following would be examples of inappropriate boundary violations, and thus unethical, in that they involved a dual relationship that is exploitive, manipulative, deceptive, or coercive in nature.

- Buying property from a disaster client at far below its market level.
- Falsely testifying to support fraudulent actions of clients.
- Imposing religious beliefs on a client.
- Suggesting that a hospice client make you executor of his/her will.
- Referring a client to your brother-in-law, the stockbroker.
- Friendship with the spouse of a client you are treating for marital issues.

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

1. Intimate relationships – These relationships include physical contact, sexual relations, and gestures such as gift giving, friendship, and affectionate communication.
2. Pursuit of personal benefit – The various forms this may take include monetary gain, receiving goods and services, useful information.
3. Emotional and dependency needs – The continuum of boundary violations ranges from subtle to glaring and arise from social workers' need to satisfy their emotional needs.
4. Altruistically motivated gestures – These arise out of a mental health practitioner's desire to be helpful.
5. Responses to unanticipated circumstances – Unplanned situations over which the social worker has little to no control.

Intimate relationships

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

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

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

There are very respectful, sound and appropriate reasons for encouraging clients to share what they know and to listen to their strengths. Benefiting from information the client has (e.g., stock tips and leads on jobs) is another matter. It is important to remember that this can apply both ways, i.e., the mental health professional needs to avoid offering assistance in areas outside his or her role.

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

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

- An accepted practice among community professionals.
- Essential to service provision.
- Negotiated without coercion.
- Entered into at the client's initiative.
- Done with the client's informed consent.

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

Another area fraught with peril is when workers engage in behavior arising from their own emotional needs. Most mental health practitioners are more familiar with examples of intentional and even more egregious examples, such as the practitioner who uses undo influence to "convert" the client or takes sides in a custody case in order to foster a relationship with one of the spouses. Many times the boundaries are crossed unintentionally, as in a practitioner who becomes overly involved in a case with which she personally identifies. Or the worker may be experiencing life issues that make him or her more vulnerable to the attention of a client.

Mental health professionals have a responsibility to maintain competence in both the professional and emotional arenas. Regardless of the circumstances, the worker's first responsibility is always to the client.

There are also times that the intent of the professional is truly out of a desire to be helpful, such as buying merchandise from a client whose business is struggling or inviting a divorce recovery group client to a community function in order to help her broaden her social network. While some types of situations may not be considered unethical or illegal, the worker needs to carefully review his or her motivation and the potential consequences of each decision. Some helpful questions to ask are:

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

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

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

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

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

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

1. Protection of the therapeutic process – In the context of current clinical practice, "even minor boundary trespasses can create unwarranted expectations." Transference and countertransference issues are present and cannot be underestimated. According to Freud and King (2002), "The mystique of the tightly boundaried, hierarchical therapeutic relationship heightens transference phenomena."
2. Client protection from exploitation – A clinician may be tempted to meet personal sexual, financial, or social needs with persons who may be particularly vulnerable to exploitation. Ethical guidelines serve to protect clients from exploitation.
3. Protection from potential legal liability – Workers are concerned about legal liability, and "careful adherence to the boundary specifications may protect clinicians from malpractice suits."

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

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

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

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

Ethical mental health practice limits sexual relationships with clients,

former clients, and others close to the client, physical contact where there is risk of harm to the client, sexual harassment, and the use of derogatory language in written and verbal communication to or about clients.

Sexual harassment

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

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature, when:

- Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment.
- Submission to, or rejection of, such conduct by an individual is used as the basis for employment decisions affecting such individual.
- Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

In mental health practice, sexual harassment can take many forms including offensive or derogatory comments, sexually oriented jokes, requests or demands for sexual favors, leering, visual displays depicting sexual imagery, innuendos, pinching, fondling, impeding someone's egress, etc. Workers should not sexually harass supervisees, students, trainees or colleagues.

Sexual misconduct

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

- The fiduciary trust between clinician and patient.
- Exploitation of transference feelings.
- The right of the patient to expect clinical needs to be the overriding priority.
- Exploitation of the patient's purported inability to resist the therapist's influence.
- The alleged "power differential" between any patient and his or her clinician.

Anyone working in mental health practice has experienced different relationships with clients. Sometimes it is nearly impossible not to form respect and even affection for clients. However, practitioners must work diligently to avoid problems, i.e., either crossing the boundaries of the professional relationship or even appearing to do so. In addition to other previously discussed actions designed to prevent harm to the client, workers can proactively address this issue by doing the following;

- Limit practice to those populations that do not cause your own needs to surface.
- Seek clinical supervision to effectively deal with personal feelings.
- Document surroundings and who was present during sessions and visits.
- Avoid seeing the client at late hours or in locations that are atypical for routine practice.

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

Professional boundaries self-assessment

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

	Yes	No
Have you ever spent time with a client "off duty"?	❑	❑
Have you ever kept a secret with a client?	❑	❑
Have you ever adjusted your dress for a client?	❑	❑
Has a client ever changed a style of dress for you?	❑	❑
Have you ever received a gift from a client?	❑	❑
Have you shared personal information with a client?	❑	❑
Have you ever bent the rules for a client?	❑	❑
Have you ever given a client a gift?	❑	❑
Have you ever visited a client after case termination?	❑	❑
Have you ever called a client when "off duty"?	❑	❑
Have you ever felt sexually attracted to a client?	❑	❑
Have you ever reported only the positive or only the negative aspects of a client?	❑	❑
Have you ever felt that colleagues/family members are jealous of your client relationship?	❑	❑
Do you think you could ever become overinvolved with a client?	❑	❑
Have you ever felt possessive about a client?	❑	❑

Clients who lack decision-making capacity

The practitioner's responsibility is to safeguard the rights and interests of clients who lack decision-making capacity.

Payment of services

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

Ethics in practice settings

Administration

Mental health administrators should advocate within and outside their agencies for adequate resources, open and fair allocation procedures, and a work environment that is not only consistent with, but encourages compliance with ethical standards of practice.

Billing

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

Client transfer

Mental health practitioners should consider the needs and best interests of clients being served by other professionals or agencies before agreeing to provide services, and discuss with the client the appropriateness of consulting with the previous service provider. Informed consent is an important aspect of this issue, in that a practitioner must discuss all implications, including possible benefits and risks, of entering into a relationship with a new provider.

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

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

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

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

Recordkeeping
State statutes, contracts with state agencies, accreditation bodies and other relevant stakeholders prescribe the minimum number of years records should be kept. For example, HIPAA has a requirement of six years for electronic records. The Council on Accreditation requires records be kept a minimum of seven years. The NASW Insurance Trust actually strongly recommends retaining clinical records indefinitely.

Again, professionals who are primary custodians of client records should refer to additional legal requirements, such as those established by state licensing boards, regarding care for client records in the event they retire and/or close their business or practice.

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

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

Key provisions of the standards include:

- Access to medical records – Patients may ask to see and get a copy of their health records and have corrections added to their health information.
- Notice of privacy practices – Patients must be given a notice that tells them how a covered entity may use and share their health information and how they can exercise their rights.
- Limits on use of personal medical information – The privacy rule sets limits on how health plans and covered providers may use individually identifiable health information. Generally, health information cannot be given to the patient's employer or shared for any other purpose unless the patient signs an authorization form.
- Prohibition of marketing – Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before disclosing their patient information for marketing.
- Stronger state laws – As stated earlier, confidentiality protections are cumulative; any state law providing additional protections would continue to apply. However, should state law require a certain disclosure – such as reporting an infectious disease outbreak – the federal privacy regulations would not pre-empt the state law.
- Confidential communications – Patients have the right to expect covered entities to take reasonable steps to ensure communications with them are confidential. For example, a patient may want to be called on a work phone rather than home telephone.
- Complaints – Patients may file a formal complaint regarding privacy practices directly to the provider, health plan, or to the HHS Office for Civil Rights. Consumers can find out more information about filing a complaint at http://www.hhs.gov/ocr/hipaa or by calling 866-627-7748.

It is very important to know that professionals who work in the mental health field are responsible for following and enforcing the HIPAA Privacy Rule. There can be severe civil and criminal penalties if procedures are not followed, and depending on the situation, an individual employee may be held responsible for not protecting a client's privacy. For civil violations of the standards, the Office for Civil Rights (OCR) may impose monetary penalties up to $100 per violation, up to $25,000 per year, for each requirement or prohibition violated.

PL 104-191 prescribed criminal penalties for certain actions, such as knowingly obtaining protected health information in violation of the law. Criminal penalties are significantly higher, ranging from $50,000 and one year in prison, and up to $250,000 and 10 years in prison if the offenses are committed with the intent to sell, transfer, or use PHI for commercial advantage, personal gain, or malicious harm.

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

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

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

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

- Ensure that protected health information is kept out of sight. This could mean keeping it in separate, locked files, covering or turning over any material on your desk, or setting your computer to "go blank" after a minute or two in case you walk away.
- If you must discuss protected health information in a public area, such as a waiting room, hospital hallway, or courtroom, make sure you speak quietly so others cannot overhear your conversation. If this cannot be assured, move to another area or schedule another time to discuss the information.
- Use e-mail carefully. Make sure you send the information only to the

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

Note that there is another law that provides additional protections for clients receiving alcohol and drug treatment. Information is available at the Substance Abuse and Mental Health Services Agency website at www.samhsa.gov.

Supervision and consultation

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

1. Administration.
2. Support.
3. Education. (Kadushin, 1992).

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

To provide competent supervision, supervisors, particularly those in clinical settings, should remember the following:
- They need to possess the necessary knowledge and skill, and do so only within their area of competence.
- They must set clear, appropriate, and culturally sensitive boundaries that would include confidentiality, sexual appropriateness and others outlined earlier in this training.
- They should not engage in dual or multiple relationships with supervisees when there is risk of exploitation or potential harm.
- They should fairly and respectfully evaluate supervisee performance.
- They should avoid accepting supervisees when there has been a prior or an existing relationship that might compromise the supervisor's objectivity.
- They should take measures to assure that the supervisee's work is professional.
- They should not provide therapy to current students or supervisees.

Supervisors should consult their particular professional association guidelines regarding supervision, human resource policy, and other applicable resources. Effective and ethical supervisory practices not only benefit the supervisees and their clients but the supervisor as well. Supervisors can manage their vicarious liability in several ways through:
- Clearly defined policies and expectations.
- Awareness of high-risk areas.
- Provision of appropriate training and supervision.
- Understanding supervisee strengths and weaknesses as practitioners.
- Developing an adequate feedback system.
- Supervisors knowing their own responsibilities.

Commitment to employers

Several standards that address issues around loyalty and ethical responsibilities in one's capacity as an employee are formally or informally discussed in professional association ethical guidelines. Generally, mental health practitioners should:
- Adhere to commitments made to employers.
- Work to improve employing agencies' policies, procedures and effectiveness of service delivery.
- Take reasonable steps to educate employers about mental health workers' ethical obligations.
- Ensure that the employing organization's practices do not interfere with one's ability to practice consistent with one's mental health association professional ethical guidelines.
- Act to prevent and eliminate discrimination.
- Accept employment, or refer others to only organizations that exercise fair personnel practices.
- Be diligent stewards of agency resources.

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

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

This issue has been discussed with regard to the practice of social work when Reamer (1998), in his review of the NASW Code of Ethics, discussed the challenge a social worker may have in deciding whether or not to continue honoring a commitment to the employer:

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

He believes that it is possible to provide clear guidelines about when it is acceptable to break one's commitment to an employer. He poses several questions that must be explored before taking action:
- Is the cause a just one? Is the issue so unjust that civil disobedience is necessary?
- Is the civil disobedience the last resort?
- Does the act of civil disobedience have a reasonable expectation of success?
- Do the benefits likely to result clearly outweigh negative outcomes, such as intraorganizational discord and erosion of staff respect for authority?
- If warranted, does civil disobedience entail the least required to rectify the targeted injustice?

Labor-management disputes

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

Professional competence

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

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

- Refrain from private conduct that interferes with one's ability to practice professionally.
- Do not allow personal problems (e.g., emotional, legal, substance abuse) to impact one's ability to practice professionally, nor jeopardize the best interests of clients.
- Seek appropriate professional assistance for personal problems or conflicts that may impair work performance or critical judgment.
- Take responsible actions when personal problems interfere with professional judgment and performance.

Burnout and compassion fatigue

An area receiving increasing attention is that of burnout and compassion fatigue. The consequences of burnout and compassion fatigue (or any other form of professional impairment) include the risk of malpractice action. Results from the effects of day-to-day annoyances, overburdened workloads, crisis, and other stressors in the work place, burnout and compassion fatigue can be serious and considered similar in many ways to acute stress and post-traumatic stress disorder.

Burnout

Burnout is a "breakdown of psychological defenses that workers use to adapt and cope with intense job-related stressors and syndrome in which a worker feels emotionally exhausted or fatigued, withdrawn emotionally from clients, and where there is a perception of diminishment of achievements or accomplishments." Burnout occurs when gradual exposure to job strain leads to an erosion of idealism with little hope of resolving a situation. In other words, when mental health practitioners experience burnout:

- Their coping skills are weakened.
- They are emotionally and physically drained.
- They feel that what they do does not matter anymore.
- They feel a loss of control.
- They are overwhelmed.

Compassion fatigue

A newer definition of worker fatigue was introduced late in the last century by social researchers who studied workers who helped trauma survivors. This type of worker fatigue became known as compassion fatigue or secondary traumatic stress (STS.) Mental health practitioners acquire compassion fatigue or STS as a result of helping or wanting to help a suffering person in crisis. As a result, they often feel worthless and their thinking can become irrational. For example, they may begin to irrationally believe that they could have prevented someone from dying from a drug overdose.

Burnout is gradually acquired over time and recovery can be somewhat gradual. Compassion fatigue surfaces rapidly and diminishes more quickly. Both conditions can share symptoms such as emotional exhaustion, sleep disturbance, or irritability.

Dealing with burnout and compassion fatigue

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

In addition, ongoing supervision and regular supportive contact with other practitioners to prevent isolation is recommended. Houston-Vega, Nuehring, and Daguio (1997), recommend the following measures to help prevent burnout or compassion fatigue:

- Listen to the concerns of colleagues, family, and friends.
- Conduct periodic self-assessments.
- Take needed "mental health days" and use stress-reduction techniques.
- Arrange for reassignment at work, take leave, and seek appropriate professional help as needed.

Related personal and professional integrity issues

Mental health practitioners must also address issues related to personal and professional integrity. They are:

- Dishonesty, fraud, and deception.
- Misrepresentation.
- Solicitations.
- Acknowledging credit.

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

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

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

1. Clearly distinguish between private statements and actions, and those as representative of an organization, employer, etc.
2. Accurately present the official and authorized positions of the organization they are representing and/or speaking on behalf of.
3. Ensure accurate information about, and correct any inaccuracies regarding professional qualifications/credentials, services offered and outcomes/results.

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

1. Engage in uninvited solicitation.
2. Solicit testimonial endorsements from current clients or other potentially vulnerable persons.

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

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

Ethical responsibilities to colleagues

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

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

In addition, they demonstrate further ethical responsibility by:

- Respecting and fairly representing the qualifications, views and obligations of colleagues.
- Respecting shared, confidential information.
- Promoting interdisciplinary collaboration.
- Not taking advantage of disputes between colleagues and employers or exploiting clients in disputes with colleagues.
- Seeking advice and counsel of colleagues who have demonstrated

knowledge, expertise and competence so as to benefit the interests of clients.
- Referring clients, without payment for such, to qualified professionals and transferring responsibilities in an orderly fashion.
- Consulting and assisting impaired and/or incompetent colleagues; and addressing impairments through proper channels when they are unable to practice effectively (e.g., reporting to professional associations or licensing and regulatory bodies).
- Discouraging unethical conduct of colleagues; being knowledgeable about established procedures, and taking action as necessary through appropriate formal channels.
- Defending and assisting colleagues who are unjustly charged with unethical conduct.

Ethical responsibilities to the mental health profession

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

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

More about informed consent

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

1. Consent must be given voluntarily by a person of legal age.
2. The individual must be competent to refuse or to consent to treatment.
3. The client must be given thorough, accurate information about the service so she or he may weigh the benefits and risks of treatment.

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

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

Ethics for specialized practice areas

Responsible mental health practice can be found in a variety of settings and address multiple issues. As the world changes, practitioners are increasingly challenged to broaden their knowledge and adopt practices that meet the unique needs of their service populations and settings. Currently, most mental health associations provide additional guides or standards of practice that address areas including: substance abuse, health care, marriage and family issues, couples work, clinical social work, child welfare, palliative/end of life care, work with adolescents, and long-term care. They also publish standards that address issues such as technology.

It is helpful to review the relevant issue of technology and the impact on mental health practice:

Technology

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

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

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

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

For example, a copy of the standards as developed by NASW and ASWB is available for both review and print at: http://www.socialworkers.org/practice/default.asp and is summarized as follows. Social workers shall:

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

- Adhere to NASW standards for continuing professional education and applicable licensing laws regarding continuing education.

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

- Serve millions of people who would otherwise not participate (e.g., people with certain conditions, such as agoraphobia, persons living in remote locations, or those concerned about the stigma of counseling).
- Decrease inhibitions clients may have about fully disclosing relevant information.
- Increase the thoughtfulness and clarity of communication as an unintended byproduct of written communication.
- Produce a permanent record that can be easily referred to and forwarded to clients or colleagues for review and consultation purposes.
- Substantially reduce overhead costs, thus reducing costs for the consumer.

As discussed earlier in this training, one of the major areas still under debate as a result of this new technology is that of jurisdiction. Here are some thought-provoking considerations.

- When the client lives in a different state, it is difficult to avoid violating licensure laws because it is still unclear as to which state's laws would be applicable.
- Is the origin or location of counseling in the client's community, the therapist's, or is it somewhere in cyberspace?
- What defines location, if a busy executive is involved in an online session while flying from Tucson to Bangkok?

This is clearly an ambiguous area that will undoubtedly continue to be debated.

Kanani and Regehr (2003) have summarized some of the other concerns raised by others regarding the use of e-therapy:

- E-therapy does not allow practitioners to observe and interpret facial expressions and body language.
- The Internet poses serious risk to security, and thus, to confidentiality.
- Inappropriate counseling may occur due to therapist ignorance about location-specific factors related to the client (e.g., living conditions, culture).
- Clients cannot be sure as to the credentials, experience, or even identity of the person they are trusting to provide services.
- Clients may not have any legal recourse for malpractice, given unresolved questions about jurisdiction and standards of care.

Limiting risk in the practice of e-therapy
Matthew Robb recommends these points for those practicing e-therapy:

Full disclosure – This relates to informed consent and the need to fully disclose the possible benefits and risks of distance counseling, including informing the client that this is a new area of practice, which has not had the benefit of long-term study.

Comprehensive assessment – Provide clients with detailed and complete assessment tools and encourage full disclosure by client.

Confidentiality and disclosure of safeguards – Take all precautions to safeguard the confidentiality of information and avoid misdirected e-mails, eavesdropping, hacking, etc. Alert the client to these potential risks as well.

Emergency contact – Obtain information for an emergency contact and together develop a clear emergency plan.

Consult your association's code of ethics – Review standards regarding informed consent, confidentiality, conflict of interest, misrepresentation, etc.

Consult state licensing provisions – Research both the statutory regulations of your board, as well as those in the client's home state.

Consult a malpractice/risk management attorney – Consider asking a legal specialist to review website materials to determine compliance with standards of care and potential malpractice issues.

Provide communication tips – If communicating solely by text-based messaging, provide client with clear tips regarding communication.

Conclusion
Ethical dilemmas are varied, common and complex. Ethical decision-making can be difficult, as well as time-consuming, while sometimes, mental health practitioners are still left with a little ambivalence and uncertainty following their decision. Typically, there will be more than one person involved with the ethical decision-making process. It is always important to keep in mind the power of supervision and consultation regarding any mental health practice. With an ethical dilemma, this cannot be overstated.

This information is not intended to provide all of the details of the HIPAA Privacy Rule, or of any other laws or guidelines. This presentation also does not constitute legal advice. If there is any discrepancy between the provisions of the HIPAA Privacy Rule, other laws or regulations, and the material in this presentation, the terms of the laws, rules, professional guidelines and regulations will govern in all cases. This information is not intended to describe all of the national mental health associations' guidelines, but to ensure that learners are guided by their particular association's code of ethics and state licensing regulations in order to make the most appropriate ethical decisions.

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

(Final examination questions on next page)

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ETHICS AND BOUNDARIES

Final Examination Questions

Choose True or False for questions 1 through 10 and mark your answers online at **www.elitecme.com**.

1. Ethics defines what is good for the individual while law defines what is good for society.

   True False

2. The principle of specific ignorance states that even if there is a law prohibiting an action, what you do is not illegal as long as you are unaware of the law.

   True False

3. Most ethics codes describe specific ethical standards in just one specific area of professional functions.

   True False

4. Informed consent services can be provided regardless of whether valid informed consent can be obtained.

   True False

5. Boundary issues are limited to current clients.

   True False

6. As a mental health professional you are not ethically responsible for reporting sexual misconduct by a colleague.

   True False

7. The HIPAA law does allow the sharing of protected health information even as long as the mental health worker takes reasonable safeguards with the information.

   True False

8. Burnout occurs when gradual exposure to job strain leads to an erosion of idealism with little hope of resolving a situation.

   True False

9. When a client lives in a different state, it is difficult to avoid violating licensure laws because it is still unclear as to which state's law would be applicable.

   True False

10. Full disclosure relates to informed consent and the need to fully disclose the possible benefits and risks of distance counseling, including informing the client that e-therapy is a new area of practice.

    True False