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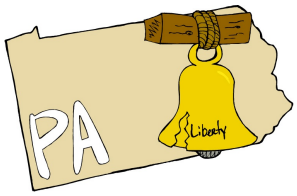
# Ethics in the Helping Professions




by
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# I. General Principles

"I can read the Code, why do I have to read this section on general principles?" you may ask. Unfortunately, the codes, rules, and regulations that govern our profession may be in conflict with one another. For example, the chemical dependency confidentiality rules bump heads with obligations to disclose information to third and fourth party payors. Confidentiality rules differ from chemical dependency to mental health, which makes dual diagnosis treatment all the more interesting. Further, we must weigh the importance of confidentiality with our duty to warn.

No ethical code can cover all situations. There are too many factors to consider for any one set of rules. Most professionals will encounter ethical dilemmas involving client welfare, rigorous honesty, professionalism, the interests of the community, financial issues, pressure from outside agencies, and the best interests of their employer. Many of these factors cannot be measured objectively, or change over time, or hold different values for different people.

What is the ethical clinician to do? What follows are general guidelines for making clinical decisions. While they are not cut-and-dry decision trees, they do provide direction.

## *The client's welfare comes first*

All ethical decisions should rest on the principle that the client's welfare comes first. Our interests, the interests of our employers, and the interests of the client's family must take a backseat to the interests of the client. Sadly, what is best for a client may not be clear to her. Your client's judgement may be clouded by substance abuse, mental illness, another professional's hidden agenda for that client, or a manipulative family member.

What is best for your client may not be clear to you. Your judgement may be impaired by your conscious and unconscious biases, lack of information, faulty information, lack of time, and pressures from other agencies. Therefore, clinicians must help clients explore what is in their best interest. We also need to anticipate the potential for harm when considering a course of action that affects our clients (Group for the Advancement of Psychiatry, 1984). We need to gather information, and evaluate how outside pressures affected our decision making processes.

## *Gather information*

Don't make decisions in the dark. Gather information. Look at what you know and how you know it. Ask yourself if you and your client have enough information. Is the information objective? Do the sources of information have their own biases? Gather as much information as you can, from as many sources as you can, and evaluate each source (Montrose & Daley, 1995).

Know what laws, policies, and regulations affect your client. For example, if your client is dealing with CYF, SSI, a PO, the IRS, or any other alphabet soup entity, you may need to contact that agency to discuss their rules. Giving your client advice without knowing the rules is unethical.

## *Discuss ethical concerns*

Don't make decisions in the darkness of secrecy. If you need to hide what you are doing from colleagues and clients, you are probably doing something unethical. Consider colleagues' opinions. Get feedback, and document, document, document.

It may help to picture yourself on the witness stand, defending your actions. How would you justify not discussing your concerns with your colleagues? On what information did you base your actions? How much effort did you put into gathering information? What conflicts of interest, either perceived or real, exist? What is the worst picture someone could paint of your actions?

## *Use the most restrictive interpretation of the most restrictive code*

When in doubt, use the most restrictive interpretation of an ethical code. Do the same when you are governed by two or more codes. For example, some agencies employ nurses, psychologists, addiction counselors, social workers, and EAPs. All of them are accredited by governing bodies with written codes of ethics. They are also bound by employers' policies, BDAP regulations, and agreements with referral sources. They do well to follow the most restrictive code or agreement. This prevents them from being in conflict with an accrediting body or agency. It also keeps treatment facilities from searching for the least restrictive code and using it to justify shady practices.

## *Avoid dual relationships with clients*

The most restrictive ethical codes define a *client* as anyone in treatment in your agency, whether or not you have any contact with that person. A dual relationship is any relationship in addition to that of treating agency and client. If your client is also your mechanic, you have a dual relationship.

Why no dual relationships? First, no matter how beneficial to the client a dual relationship may seem, the real or perceived potential for abuse exists. In any dual relationship the treatment center is in a position to take advantage of the client. We assume the client is in need of some service, and therefore is more vulnerable than the agency or professional.

Second, agencies and professionals may have a hard time separating one aspect of their relationship with the client from another. Suppose you have a client put in cement steps at your facility while still in treatment there. If the workmanship is shoddy, will you ask him for a refund? What if his clinician reports that he is hanging onto his recovery by a thread? Will the agency confront him about the poor workmanship? If his clinician trips over the uneven steps and gets hurt, will the client be treated differently? These questions and others underscore the ways dual relationships interfere in clinical matters.

Finally, the client, her family, or the community may assume you will treat a client differently depending on the nature of your dual relationship with her. Suppose a client files your tax return. If you get audited by the IRS, will you treat the client the same way you treated her before?

Bartering arrangements with clients are dual relationships because whatever the client trades becomes part and parcel of the relationship. If a client agrees to cut the grass, he is now your maintenance man. If he agrees to fix your pipes, he is your plumber as well as your client. Such dual relationships can't help but complicate treatment, for several reasons.

Bartering arrangements bring subjective judgements into the relationship. Money is the only ethically neutral form of payment. Money is standardized: a $20 bill is $20 to you and $20 to your client.

Suppose a client owes your agency $1500. Your facility has a patio roof you estimate will cost $750 to repair. You offer to eliminate the client's debt in exchange for providing the repair. After all, how could there be an ethical issue when he seems to be getting the better end of this bargain?

A problem arises because the value of materials, labor, experience, and skill are not objective. What if the client, who happens to be a master craftsman with a touch of Obsessive Compulsive Disorder, estimates that he put $2000 in materials and labor into the job? He may feel cheated and resentful.

Imagine instead that he has grandiose delusions about his roofing skills. What you see as substandard work, he may see as imaginative carpentry. You could find yourself with a leaky roof, a resentful client, and the prospect of having to go to court to get your roof fixed. In a society as litiginous as ours, you could conceivably be sued because he believes you cheated him, which he blames for his subsequent relapse. The bottom line is that bartering relationships are never ethically neutral, and never a good idea.

You must go to great lengths to avoid romantic and/or sexual relationships with clients. Remember, a client is anyone being treated by your agency, whether or not you are likely to have contact with him. The reason ethical codes define client so broadly is to curtail dual relationships, especially those that involve sex.

Suppose your office is in Erie. You go to Philadelphia to visit friends. While there you meet someone special at an AA meeting. Later you discover your newly significant other is a patient at your agency's Philadelphia office. You inform your paramour's therapist of your relationship and ask that no information regarding your loved one come across your desk. Are you on sound ground ethically?

Nope. The PCB code prohibits you from romantic relationships with your agency's clients. A client is anyone treated by your agency. You represent the same agency as the client's therapist. You may have access to the client's medical records, especially if those records are computerized. Your new found love may expect you to pull strings with her therapist. In short, you dating anyone treated by your agency either has, or is perceived to have, clinical implications. Don't date the people your agency treats.

Suppose you really like this new relationship, so you decide to leave your agency and go into private practice. You want to take your CAC or other credential with you. Are you on sound ground ethically now? Absolutely not.

Ethical codes apply mostly to the individual rather than the agency. Whether or not you work for a particular agency is beside the point. The supposition is that clients are vulnerable or they wouldn't be seeking treatment. Any relationship with them is assumed to be an exploitive one. Professionals dating clients are presumed to be taking advantage of the client. Changing jobs does not change the relationship between you and the client.

## *Please don't embarrass the profession*

Most ethical codes discuss behavior outside of work. The governing boards of the helping professions don't want you to embarrass the profession with felony and misdemeanor charges that involve sex, drugs, violence, fraud, or theft.

Research has shown that people who believe in treatment before they enter treatment tend to do better than those with low expectations. When we embarrass our professions, we lower the credibility of everyone in that profession. If our criminal behavior ruins someone's belief in our ability to help them, not being helped by treatment can become a self-fulfilling prophecy.

## *Protect clients' privacy*

Most of us know we are supposed to protect the privacy of our clients. We need to go to great lengths not to accidently violate someone's privacy. For example, in public we need to let clients acknowledge us before we say anything to them. We need to limit access to our facilities because everyone delivering a package, fixing the wiring, serving a summons, or visiting a loved one, may see who is in treatment. We need

to make sure that when we use real people for examples in books and presentations, that we disguise their identity. We need to not leave papers or charts on our desks or in our cars.

There are times when danger to the client and others *is* a reason to violate a client's privacy. We need to know the laws that apply to disclosing a client's information, starting with whether we can reveal a certain client is in treatment.

### *Be honest about your credentials and capabilities*

In a nutshell, get your credentials honestly and represent them honestly. When you have doubts about your qualifications, make sure the people you treat know about your concerns. Imagine a client comes to you for depression. In the course of treatment you discover he suffers from Post-Traumatic Stress Disorder. If you are not an expert on PTSD, you need to tell the client. Let the client make an informed decision about whether or not to continue treatment with you.

We have an obligation as professionals not to misrepresent our qualifications by what we say or don't say. Suppose I had a Ph.D. in English Literature. I decide to present a training on medications and addiction, and to refer to myself as "Dr. Montrose" in brochures and during the presentation. Too many people might think I am a medical doctor. I have a responsibility to correct this mistaken assumption. I cannot ethically say that I never misrepresented myself because I knew people might make the wrong assumption. The responsibility for correcting this assumption is mine.

Professionals should not help other professionals misrepresent their qualifications either. In fact, most ethical codes require professionals to report colleagues who misrepresent their training, education, and qualifications. One of our ethical duties is to cooperate with the PCB.

Know the Pennsylvania Certification Board's *Code of Ethics*.[1] There is no excuse for not knowing the code that governs your profession. The next section consists of the Code itself, and commentary on why each section of the Code benefits our clients, our employers, and ourselves.

## II. Rules of Conduct

The following Rules of Conduct, adopted by the PCB, set forth the minimum standards of conduct which all certified professionals are expected to honor. Failure to comply with an obligation or prohibition set forth in the rules may result in discipline by the PCB.

[1]https://www.pacertboard.org/ethics

Discussion sections accompany some of the rules. These discussions are intended to interpret, explain, or illustrate the meaning of the rules, but the rules themselves remain the authoritative standards of the conduct for which disciplinary action may be imposed.

## *Unlawful Conduct*

Rule 1.1: Once certified, a professional shall not be cited, arrested, or convicted for any summary offense, misdemeanor or felony relating to the individual's ability to provide substance abuse and other behavioral health services or that reflects conduct unbecoming a professional as determined by PCB.

*Discussion*: A certificate of conviction shall be deemed conclusive evidence of an individual's guilt of the felony or misdemeanor for which he or she has been charged. If the citation, arrest, or conviction relates to the individual's ability to provide substance abuse and other behavioral health services or reflects conduct unbecoming a certified professional, as determined by PCB, this shall be deemed a violation of this Rule. Some of the specific examples within this section include but are not limited to crimes involving violence, use or sale of any controlled or psychoactive substance, driving while intoxicated/impaired, fraud, theft, and sexual misconduct. PCB may choose to allow pending charges against the certified professional to be settled through the judicial system before rendering their decision on an ethics complaint.

*There are several reasons these rules are in place. First, remember that anything we do to embarrass our profession hurts our credibility. When our credibility suffers, so too does our ability to help our clients. People who don't trust us aren't as likely to benefit from treatment as those who believe in us.*

*Second, one of the most powerful clinical tools we have is setting a good example. We do not have to be paragons of virtue, but we need to show our clients that life is much simpler when we pay our taxes, don't use violence to meet our needs, and lead lives of everyday integrity. Living an upright life gives us moral footing upon which to address our clients "addictive behavior." How can we talk about a life of "rigorous honesty," if they see us on the evening news being arrested for insurance fraud?*

*Finally, our clients come for help because they are suffering. They are vulnerable. We need to protect them from the unscrupulous members of our profession. We do no want rapists, thieves, or drug dealers molding the lives of newly recovering addicts.*

## *Romantic/Sexual Misconduct*

Rule 2.1: A certified professional shall, under no circumstances, engage in romantic/sexual activities or romantic/sexual contact with clients, whether such contact is consensual or forced. This prohibition applies to both in person and electronic interactions or relationships.

Rule 2.2: A certified professionalshall not engage in romantic/sexual activities or romantic/sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. This prohibition applies to both in person and electronic interactions or relationships.

*Discussion*: Romantic/sexual activities or romantic/sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the certified professional and client to maintain appropriate professional boundaries. Certified professionals, not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship, assume the full burden of setting clear, appropriate, and culturally responsive boundaries. Romantic activities are oftentimes non-sexual in nature and may include emotional attraction toward another person such as love, intimacy, compassion, appreciation and affinity.

Rule 2.3: A certified professional shall not engage in romantic/sexual activities or romantic/sexual contact with former clients because of the potential harm to the client. This prohibition applies to both in person and electronic interactions or relationships.

*Discussion*: If certified professionals engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is certified professional's, not their clients, who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

Rule 2.4: A certified professional shall not provide clinical services to individuals with whom they have had a prior romantic/sexual relationship. This prohibition applies to both in person and electronic interactions or relationships.

*Discussion*: Providing clinical services to a former romantic/sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the certified professional and individual to maintain appropriate professional boundaries.

*There are several salient points. This section bans "sexual activity," but says nothing about dinner and a movie. Why not spend an enjoyable evening with a client you find attractive? A sober evening that doesn't culminate in sex could show your lonely client that there's more to life than prostitution and cocaine, you reason.*

*The problem is that taking a client to dinner is a date, and dating someone you are treating constitutes a dual relationship. Dating someone you used to treat is also a dual relationship. So is dating close relatives of a former client.*

*Also problematic is the appearance of impropriety. Whether or not you are sleeping with your client, or a member of his family, or his close friend, etc. it appears that you are. (One man's innocent date is another man's prelude to videotaped pagan love rituals.) The appearance of impropriety chips away at the credibility of the whole profession.*

*In the strictest sense, sex cannot be consensual in relationships of unequal power. How free is a client to say* no *to your sexual advances when she is dependent on you for a favorable report to her employer, licensing body, or probation officer? And how capable is she of making a wise decision about sexual partners as she faces the aftermath of years of addiction? Twelve Step programs wisely advise that newcomers not get involved in new relationships during the first year of recovery. The PCB just as wisely protects clients from getting into sexual relationships with treatment professionals.*

*Recently the PCB changed the five year prohibition against sexual relationships with clients to a lifetime ban. This ban is consistent with the codes of ethics of many related professions, including the code for social workers. Why forever ban sexual relationships with clients? Because clients often remain clients in their attitudes and behaviors long after they leave treatment. Their perception of authority in our relationships with them may never change, and hence they may never be in a position of equality.*

*Knowledge is power. We have knowledge of our clients that stays with us long after they leave treatment. This knowledge puts them at a disadvantage.*

*If there was no prohibition against relationships with clients, intake meetings could degenerate into matchmaking sessions: "He abuses heroin and Percocet, likes long walks in the park, has Hepatitis C, and is looking for a woman who understands the criminal justice system..." Hopefully you have difficulty imagining intakes ever getting that bad, but case assignments could conceivably hinge on romantic issues were it not for the PCB and other licensing bodies' rules against dating clients.*

*Treating former sexual partners can raise the appearance of favoritism, or of persecution, depending on how the relationship ended. Ex-lovers may have information that could undermine our abilities to provide services. We may have information they do no want shared with the rest of the treatment team. In a nutshell, bringing an "ex" into treatment constitutes a dual relationship, one that can be damaging to the clinician, the client, and the agency.*

*Having sex with the people in the lives of your clients can also be problematic. Again, others may assume you will behave more favorably toward their loved one if they sleep with you. Whether or not this was your intention, this may be what families believe and the community perceives*.

## *Fraud-related Conduct*

Rule 3.1: A certified professional shall not: 1) present or cause to be presented a false or fraudulent claim, or any proof in support of such claim, to be paid under any contract or certificate of insurance; 2) prepare, make, or subscribe to a false or fraudulent account, certificate, affidavit, proof of loss, or other document or writing, with knowledge that the same may be presented or used in support of a claim for payment under a policy of insurance; or 3) present or cause to be presented a false or fraudulent claim or benefit application, or any false or fraudulent proof in support of such a claim or benefit application, or false or fraudulent information, which would affect a future claim or benefit application, or be paid under any employee benefit program; 4)seek to have an employee commit fraud or assist in an act of commission or omission to aid fraud related behavior.

*Discussion*: The term "fraudulent claim" includes but is not limited to charging a client or a third-party payor for a service not performed or submitting an account or charge for services that is false or misleading. It does not include charging for an unkept appointment when the original verbal or written contract for services allows for such a charge.

*It's wrong to cheat the insurance companies, counties, and other third party payors. It's wrong to cheat fourth-party payors. Not only is it wrong, it is also criminal. Criminal behavior hurts* our *credibility and can result in the loss of* your *certification. All the rationalizations regarding third and fourth party payors' behavior does not justify insurance fraud.*

Rule 3.2: An individual shall not use misrepresentation in the procurement of certification or recertification, or assist another in the preparation or procurement of certification or recertification through misrepresentation. The term misrepresentation includes but is not limited

to the misrepresentation of professional qualifications, education, certification, accreditation, affiliations, employment experience, the plagiarism of application and recertification materials, or the falsification of references.

Rule 3.3: An individual shall not use a title designation, credential or license, firm name, letterhead, publication, term, title, or document which states or implies an ability, relationship, or qualification that does not exist and to which they are not entitled.

*Our clients have a right to be treated by qualified professionals. Anything that interferes with their ability to make an informed choice in picking treatment is unethical. This includes claiming qualifications you cheated to get, claiming qualifications you don't really have, misleading clients about your qualifications, or using another name to hide past unethical behavior.*

Rule 3.4: A certified professional shall not sign or issue, in their professional capacity, a document or a statement that the professional knows or should have known to contain a false or misleading statement.

Rule 3.5: A certified professional shall not produce, publish, create, or participate in the creation of any false, fraudulent, deceptive, or misleading advertisement.

Rule 3.6: A certified professional who participates in the writing, editing, or publication of professional papers, media resources, brochures or books must act to preserve the integrity of the profession by acknowledging and documenting any materials and/or techniques or people (i.e. co-authors, researchers, etc.) used in creating their opinions/papers, books, etc.

*Discussion*: Any work that is copied prior to receipt of approval by the author is discouraged. Whenever and wherever possible, the certified professional should seek permission from the author/creator of such materials. The use of copyrighted materials without first receiving author approval is against the law and, therefore, in violation of this Rule.

## *Dual Relationships/Exploitation of Clients*

Rule 4.1: A certified professional shall not initiate, develop, and/or maintain dual/exploitative relationships with clients and/or family members of clients. This prohibition applies to both in person and electronic interactions or relationships.

*Discussion*: Ethical problems are often raised when those persons providing services blend their professional relationships with another kind of relationship. Dual relationships can take many forms and are inherent in the work of all helping professions regardless of their setting or client population. The nature of the professional-client relationship is such that the client remains vulnerable to the real or perceived influences of the professional. Dual relationships may make it difficult for the professional to maintain appropriate professional boundaries. It is the professional's responsibility to assume the full burden for setting clear, appropriate, and culturally responsive boundaries. Examples of dual or multiple relationships that are potentially exploitive through the violation of professional boundaries include but are not limited to: romantic/sexual relationships, bartering arrangements, business arrangements, counseling ones' own family members, friendship, and social networking with clients and/or family members of clients. Social networking shall be defined to include but not limited to blogs, podcasts, wikis, pictures, email, instant messaging, forums, chat rooms, Facebook, MySpace, Twitter, texting, etc. Unavoidable or potentially helpful dual relationships should be discussed with a supervisor and documented prior to the interaction when feasible.

Rule 4.2: A certified professional shall not misappropriate property from clients and/or family members of clients.

Rule 4.3: A certified professional shall not enter into or maintain a financial dual relationship that results in financial gain to the certified professional, client or a third party.

Rule 4.4: A certified professional shall not promote to a client for their personal gain any treatment, procedure, product, or service.

Rule 4.5: A certified professional shall not ask for nor accept gifts or favors from clients and/or family members of clients.

*Discussion*: When a certified professional "plays" or "preys" upon the client's gratitude for services or covertly or overtly implies or states that the client remains indebted and should "repay" him or her through gifts or other favors, violates this rule. The unique position of trust and responsibility with the client not only becomes jeopardized, but the certified professional has also engaged in unethical actions.

Rule 4.6: A certified professional shall not offer, give, or receive commissions, rebates, or any other forms of remuneration fora client referral.

*Discussion*: Not withstanding this provision, a certified professional may pay an independent advertising or marketing agent compensation for advertising or marketing services rendered on their behalf by such agent. Included in this would be compensation for referrals of clients identified through such services on a per client basis.

*In an ideal world, clinical decisions would be based purely on objective information and unbiased clinical judgement. In the real world, all manner of outside factors affect clinical judgement. Rules in this section were written to mitigate the impact of non-clinical factors.*

*Any money that exchanges hands other than agreed upon payment for services becomes a non-clinical factor influencing clinical decisions. Suppose you run a rehab. One halfway house pays you $50 for each referral. Another halfway house pays $150 for each referral. You may find reasons to believe that the folks kicking back $150 are much better clinically than those only paying you $50.*

*A counselor who accepts money above and beyond agreed on fees may be tempted to provide more and better services to the clients paying extra. An unscrupulous counselor could subtly pressure families into quasi-bidding wars. Only families who paid enough extra could count on quality services for their loved ones. "Gee, I'd like to give Joe that back-to-work letter, but I was busy helping Mike. You'd like his family. They are very generous."*

## *Professional Standards*

Rule 5.1: A certified professional shall not in any way participate in discrimination on the basis of race, ethnicity, gender, sexual orientation, age, religion, national origin, socio-economic status, political belief, psychiatric or psychological impairment, or physical disability.

*Discussion*: The certified professional who promotes, condones, or engages in discriminatory conduct towards a client, a client's family, or a client's significant other(s) during the course of the professional activities creates an atmosphere that constitutes conduct contrary to the principles of the profession.

Rule 5.2: A certified professional who fails to seek therapy for any psychoactive substance abuse or dependence, psychiatric or psychological impairment, emotional distress, or for any other physical health related adversity that interferes with their professional functioning shall be in violation of this rule. Where any such conditions exist and impede their ability to function competently, a certified professional must request inactive status of their PCB credential for medical reasons for as long as necessary.

Rule 5.3: A certified professional shall meet and comply with all terms, conditions, or limitations of a certification or license.

Rule 5.4: A certified professional shall not perform services outside of their area of training, expertise, competence, or scope of practice.

*Discussion*: A certified professional must continually enrich his or her professional knowledge and must competently comprehend the domains of the credential. They shall not perform any client services in a manner that falls below the minimum standards of competence for the substance abuse and other behavioral health profession. It is recognized that honest disagreements may exist between professionals as to the best form of service for a given client. Competency does not mean perfection; nor is incompetence normally established by the showing of an isolated instance in which performance has been inadequate. However, when a professional demonstrates multiple inadequacies in performance, or when their behavior portrays a gross neglect of a client's rights and condition, a finding of incompetence will be warranted and disciplinary action imposed. A certified professional should not use a modality or a technique if they do not have supervision/consultation, education, training, or skills to perform in a competent or qualified manner.

Rule 5.5: A certified professionalshall not reveal confidential information obtained as the result of a professional relationship,without the prior written consent from the recipient of services, except as authorized or required by law.

Rule 5.6: The certified professionalshall not permit publication of photographs, disclosure of client names or records, or the nature of services being provided without securing all requisite releases from the client, or parents or legal guardians of the clients.

*Problems our clients face come with huge stigmas attached. Working in this field, we sometimes forget how negatively the general public can react to someone who is addicted to heroin, for example. We need to be vigilant not to break our clients' confidentiality.*

*Most of us know enough not to tell strangers on the bus about all the interesting people we have treated for addiction. We may overlook the not so obvious ways to violate confidentiality. For example, if your agency has a sign-in sheet, does more than one name appear on each sheet of paper? Do you or your colleagues discuss clients in hallways or elevators? Are clinical areas in plain view to people not in treatment? Is the computer you use to write clinical notes not password protected? Do you ever take notes home with you? Do you ever discuss clinical issues on a cell phone? We need to be able to answer "no" to all of these questions, and many more like them, if we are to say we protect our clients' privacy.*

Rule 5.7: The certified professional shall not discontinue professional services to a client nor shall they abandon the client without facilitating an appropriate closure of professional services for the client.

*Discussion*: This rule generally applies to those professionals in private practice or who have the capacity to directly bill the client or the insurer for services rendered. In an agency setting, the contract for services exists between the client and the agency. Therefore, it becomes the responsibility of the agency to assure continuation of services to the client in circumstances wherein the certified professional is not available to provide for the continuity of care. In the case of a certified professional who has direct contractive responsibilities, this person shall not discontinue professional services to a client unless 1) services have been completed; 2) the client requests the discontinuation; 3) alternative or replacement services are arranged, or the client is given reasonable opportunity to arrange alternative or replacement services.

Rule 5.8: A certified professional shall seek consultation or make appropriate referral when the person's problem is beyond their area of training, expertise, competence, or scope of practice.

*Discussion*: Certified professionals should strive to achieve and maintain the highest level of professional competence. In order to provide the highest standard of service for clients, they must maintain the commitment

to assess their own personal strengths, limitations, biases, and effectiveness. When a certified professional recognizes that a client's needs exceed their education, training, and capabilities, they must pursue advice and counsel from colleagues and supervisors. When a client'sissues are outside the professional's level of functioning or scope of service, they must refer the client to another professional who will provide the appropriate service.

*Suppose you work in a rural area at the only combination MH/MR/D&A treatment center in a tri-county area. If you have a client with an eating disorder, and eating disorders are not your area of expertise, you may not have anywhere to send her for treatment within fifty miles of her home. In that case you need to do three things. First, you need to be very clear with your client regarding your general counseling skills and your lack of specific knowledge about eating disorders. Second, you have to make sure treatment plans reflect that the client understands your dilemma, and agrees to be treated by you, fully aware that you are operating outside your area of expertise. Finally, you need to seek consultation.*

## *Safety & Welfare*

Rule 6.1: When a condition of clear and imminent danger exists that a client may inflict serious bodily harm on another person or persons, a certified professionalshall, consistent with federal and state confidentiality laws, take reasonable steps to warn any likely victims of the client's potential behavior.

*Discussion*: If during the course of treating the client, a certified professional becomes aware that a client intends or is likely to commit some act which may result in serious bodily harm to another person or persons and there is a clear and imminent danger of such harm occurring, the certified professional has a duty to take reasonable steps to warn such persons. In doing so, the certified professional should be aware that state and federal regulations set forth rules concerning the confidentiality of certified professional-client or person seeking certification-client communications and client records and identifying information. In cases where the threat is of the commission of a crime on agency premises or against agency personnel, the rules may allow disclosure of the circumstances of the threatened crime and identity of the consumer directly to law enforcement officers. In some instances, however, in order to warn the likely victims of the client's actions it may be necessary for the certified professional or the agency to make an emergency application to a court for an order permitting disclosure of information concerning the client or communications from the client before such information can be disclosed.

Rule 6.2: When a condition of clear and imminent danger exists that a client may inflict serious bodily self-harm, the certified professional shall, consistent with federal and state confidentiality laws, take reasonable steps to protect the client.

*Discussion*: If during the course of treating a client, certified professional becomes aware that a client intends or is likely to inflict serious bodily harm to himself or herself and that there is a clear and imminent danger of such harm occurring, the certified professional has a duty to take reasonable steps to protect the client. The certified professional should be aware that state and federal regulationsset forth rules concerning confidentiality. Under those rules, it may be permissible in some cases to communicate information about an individual if done in a manner that does not disclose the individual's status as a client in treatment. In other cases, however, in order to protect the client, it may be necessary for the certified professional or their agency to make an emergency application to a court for an order permitting disclosure of information concerning the client or communication from the client before such information can be disclosed.

Rule 6.3: All certified professionals are mandated child abuse reporters.

*Discussion*: Certified professionals are encouraged to be familiar with all applicable state child abuse reporting laws.

## *Record Keeping*

Rule 7.1: A certified professionalshall not falsify, amend, or knowingly make incorrect entries or fail to make timely essential entries into the client record.

*Common sense suggests, and research confirms, that memories tend to deteriorate fairly quickly. Writing clinical notes and reports as quickly as possible improves the quality of these notes. Like it or not, notes and other clinical documents are part of the services we bill for. We owe it to the people paying us to produce the highest quality clinical record we are capable of producing in any given day.*

*How much better would our charts be if we all had time to write our notes immediately after a group or individual session? Unfortunately, clinical issues can interfere with record keeping. When a suicidal client is on the phone, putting her on hold while you finish your group notes is not the ethical thing to do.*

*The ethical counselor tries to get notes done as quickly as possible, given the realities of his work day. The unethical counselor defines "timely essential entries" as those entries he has to make as the reviewers walk through the door.*

## *Assisting Unqualified/Unlicensed Practice*

Rule 8.1: A certified professional shall not refer a client to a person that he/she knows or should have known is not qualified by training, experience, certification, or license to perform the delegated professional responsibility.

## *Discipline in Other Jurisdictions*

Rule 9.1: A certified professional holding a certification, license, or other authorization to practice issued by any certification authority or any state, province, territory, tribe, or federal government whose certification or license has been suspended, revoked, placed on probation, or other restriction or discipline shall promptly alert PCB of such disciplinary action.

## *Cooperation with the Board*

Rule 10.1: A certified professional shall cooperate in any investigation conducted pursuant to this Code of Ethical Conduct and shall not interfere with an investigation or a disciplinary proceeding or attempt to prevent a disciplinary proceeding or other legal action from being filed, prosecuted, or completed. Interference attempts may include but are not limited to: the willful misrepresentation of facts before the disciplining authority or its authorized representative; the use of threats or harassment against, or an inducement to, any client or witness in an effort to prevent them from providing evidence in a disciplinary proceeding or any other legal action; the use of threats or harassment against, or an inducement to, any person in an effort to prevent or attempt to prevent a disciplinary proceeding or other legal action from being filed, prosecuted or completed; refusing to accept and/or respond to a letter of complaint, allowing a credential to lapse while an ethics complaint is pending, or attempting to resign a credential while an ethics complaint is pending. Violation of this rule under these circumstances will result in the immediate and indefinite suspension of the certified professional's credential until the ethical complaint is resolved.

Rule 10.2: A certified professional shall not make a false statement to the PCB or any other disciplinary authority; promptly alert colleagues informally to potentially unethical behavior; report violations of professional conduct of other certified professionals to the appropriate licensing/disciplinary authority when he/she knows or should have known that another certified professional has violated ethical standards and has failed to take corrective action after informal intervention.

Rule 10.3: A certified professional with firsthand knowledge of the actions of a respondent or a complainant shall cooperate with the PCB investigation or disciplinary proceeding. Failure or an unwillingness to cooperate in the PCB investigation or disciplinary proceeding shall be grounds for disciplinary action.

Rule 10.4: A certified professional shall not file a complaint or provide information to the PCB which he/she knows or should have known is false or misleading.

Rule 10.5: In submitting information to PCB, a certified professional shall comply with any requirements pertaining to the disclosure of client information established by the federal or state government.

*The PCB police are not going to tap your phone to see if you are using stock tips from clients for your personal gain. The PCB relies on certified professionals to police their own ranks, cooperating with investigations and reporting ethical violations. Without our cooperation the PCB cannot enforce the ethical standards of our profession. Our certifications become less valuable, and our clients have less reason to believe in us. Hopefully we cooperate willingly.*

## III. When Good Counselors Go Bad . . .

The vast majority of people in the helping professions are ethical. But, just as addicts rationalize drug abuse, too many professionals rationalize unethical behavior. Others are pressured to bend the rules, and still others build up a tolerance for the unethical. We will look at each one in turn.

## *Rationalization*

Self-deception isn't limited to addicts. Too many of us think we have good reasons for unethical behavior. One common rationalization is believing that a romance with you can only help a client. The following passage from *Casebook in Psychiatric Ethics* (1984) illustrates some of the other common rationalizations for starting a romantic relationship with a client.

> He wondered if it would be wrong to suggest to her that the two of them see each other socially on occasion. Both of them were single, and neither were involved with anyone else at the time. She seemed mature and not at all fragile – not like the women patients with whom he was aware some male doctors became involved.
>
> He thought, "I probably shouldn't do it. On the other hand, . . . If we had met in a social setting, I'm sure we would have had a great relationship from the start. Why should the two of us be penalized because we had the ironic bad luck to meet under these circumstances? I'm a doctor, but more basically I'm a man; she's a patient, but more basically she's a woman. She doesn't really have any serious psychiatric illness at all, and if we did hit it off she could probably just drop out of therapy or see someone else after a while if she needed to." (*Casebook in Psychiatric Ethics*, p. 56)

Even though we agree to follow certain rules just by accepting a position with a mental health/drug and alcohol facility, some of us later decide the rules are too strict, poorly written, out of touch with reality, or not necessary for someone of our experience and clinical acumen.

For example, there are professionals who question the mental health commitment laws. In a nutshell, these laws say that only people who represent a clear and present danger to themselves can be treated involuntarily. This leaves a lot of room for mentally ill people to do things that aren't in their best interests. (Family members of the mentally ill have referred to this as "dying with your rights on.") The temptation to exaggerate a client's symptoms in order to obtain an involuntary commitment to a psychiatric facility is strong. After all, the family thinks he needs treatment. You think he needs treatment. You ask yourself: what do the legislators who wrote the law know anyway? This rationalization can lead the clinician down the road from using a negative spin in describing the client's symptoms, to outright lying about how he is presenting.

The temptation to exaggerate a client's symptoms can be very strong when you think doing so is in the client's best interest. Imagine your depressed client stops taking his antidepressant because of its sexual side effects. He begins his downhill slide by giving away many of his possessions. You know this is a sign he is slipping into a suicidal depression, but he is smart enough not to report any suicidal thoughts to you. The most he will say is "I don't value my life very much." When you talk the County Delegate about having him committed you might be tempted to claim he indicated suicidal intent, even though he really didn't.

Some of us employ the "haves" and "worsers/n'yets" to justify our unethical behavior, just as our clients employ these tactics to rationalize their abuse of chemicals. The *haves* are things we have that we hold

up as proof we don't have a problem. For example, a client with a good job will say "I can't be an addict – I *have* a really good job." The worsers/n'yets are the terrible things other clinicians have done that are worse than any of our own ethical violations. The n'yets are those unethical things we have not yet done (Montrose, 2001).

We may see our experiences and credentials as something we *have* that exempts us from portions of the Code of Ethics. We may believe that who we think we are is more important than any rule or regulation. We rationalize unethical behavior by saying to ourselves:

- ★ "I have twenty years of sobriety. I know what is best better than any old Code."
- ★ "I have a masters degree and a CAC Diplomate. The Code was written for paraprofessionals."
- ★ "I have been doing this for twenty years. Only rookies need to worry about those Codes."
- ★ "I shot more dope than any other three junkies combined. I have first hand experience the people who wrote that code could only dream of having. I know how people get clean."

Our egos can lead us to misunderstandings about our place in the universe. (We start to believe we are at the center, and everything else revolves around us.) This manifest itself in the attitude *what worked for me will work for them.* For example, a common unethical practice is for a professional counselor without a medical degree to tell a client she would not need medication if she would work the Twelve Step programs, pray harder, take certain vitamins, eat a certain way, or meditate.

Some professionals look to the unethical behavior of colleagues to justify their own transgressions. They can always find somebody who has done something worse.

- ★ "I accept expensive gifts from clients, but I never sleep with them."
- ★ "I've billed for people who didn't show up, but not for people who weren't under my care."
- ★ "I sleep with the agency's clients, but never anyone from my branch office."

In their list of common rationalizations Pope & Vasquez (1998) cite two that qualify as *worsers/n'yets.* The first is the believing that if I follow most of the rules, most of the time, its OK to be unethical other times. "It could be worse, I could break all of the rules all of the time." This is equivalent to client's rationalization that if I abstain from most drugs, most of the time, I'm OK. "Its OK to smoke weed because I no longer snort cocaine." (I cheat on the wife, but I'm good to the kids.) Being *mostly ethical* is not the same as being *ethical*.

The second rationalization Pope & Vasquez (1998) mention is believing it's not unethical to break the rules, just this once. This mirrors a client's contention that eating one Oxycontin is not a slip, or that maybe it's a slip, but it's certainly not a relapse, and even if it's a relapse, it's not a reason to call the Probation Officer. Accepting cash from a client who just moved up on the waiting list is unethical, even once.

## *Tolerance*

Too many of us build up a tolerance for unethical behavior. Just as most addicts don't shoot heroin into their necks the first time they get high, most professionals don't start off sleeping with clients. They drift into unethical behavior one ethical compromise at a time.

Suppose you are the Clinical Director and your facility's charts will be audited next week. On Wednesday of this week you start adding initials to people's signatures where they forgot to list their credentials. On Thursday you start forging signatures for people who didn't sign their progress notes. By Friday you realize your staff is not going to be able to finish documenting all of the group sessions, so you write generic notes for groups clients attended. On Saturday you discover your therapists haven't been documenting all of their individual sessions. Working backwards from attendance sheets, you write individual notes for sessions that took place, but were never documented. Early Sunday morning you discover not enough individual sessions took place. How much easier is it on Sunday than it would have been the previous Wednesday to cross yet another line and start writing notes for phantom individual sessions?

## *Pressure*

Often the reason people drift into unethical behavior is outside pressure. This pressure can come from colleagues or clients' families. Referral sources and other agencies can apply pressure. The pressure to secure funding and make money can be overwhelming for non-profits and for-profits alike.

How tempted are we to exaggerate our abilities, results, and the community's needs in order to convince the powers-that-be to send some money our way? When that money will keep our friends and colleagues working, the pressure can be overwhelming. If we see ourselves as providing a vital service to the community, we can feel justified in bending the truth to obtain the money needed to keep our agency funded.

In the real world making money is a prime concern for non-profit and for profit agencies. Until recently, there was a hospital in Pittsburgh with an excellent clinical reputation, strong community ties, and a mission to help the poor. Their reimbursement rates fell and they went under. Anyone working in this field who took no notice of their demise needs to pull his or her head out of the sand. The pressure to make money can be a life and death struggle for the largest of agencies.

In any treatment facility administrative issues can come into conflict with ethical and clinical issues. For example, if a client's insurance runs out, the Business Office may argue that there are people on the waiting list just as deserving and needy, who *can* pay for treatment. They may argue that if the facility goes under, nobody gets treatment, free or otherwise.

Many of us have to placate outside agencies. If an outside agency is responsible for 70% of our referrals, they may have a lot to say about how we do treatment. They may be under their own pressures that we don't know about.

Suppose an agency that provides the bulk of your referrals opens a halfway house, but has trouble filling it. They may feel pressure from their funding sources to fill those beds. This may be part of the reason they pressure you to send your client to their halfway house rather than back into the community.

Political pressure can come from many sources. VIP clients are a great example. The son of a prominent politician may get more attention than a homeless man. This is especially true if the mother of the client is a legislator who can bring funding, prestige, and slackened governmental oversight to an agency. A celebrity who does well in treatment may be a good advertisement for that agency, and therefore may get special treatment.

Peers may apply pressure. Imagine you are the intake coordinator for a small mental health agency. Two people ask for treatment at the same time. One will get the last opening available, and the other will be put on a waiting list. One is a soft-spoken, elderly man who is having trouble coping with the second anniversary of his wife's death. He is drinking a little more than he is comfortable with, and would like some help.

The other person seeking treatment is a twenty-two year old woman who is well known to the treatment team. In the past she has cursed the clerical staff, cut her wrists in the waiting room, made sexual advances to male staff members, and stolen a purse from an area off-limits to clients. She is addicted to alcohol and painkillers. Your peers are less than thrilled about this woman returning to treatment. Soon you will need them to cover for you while you are on vacation. You will feel pressured to admit the kindly old man, even though the young woman more urgently needs treatment.

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