

Laws and Ethics Course
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Course Objectives

After completing this training the professional healthcare provider will be able to:

1. Discuss current laws and ethics in practicing general counseling principles.
2. Apply ethical principles in practice with an awareness of the ethics associated with your specific profession.
3. Discuss the complexities of ethical dilemmas and apply a framework for dealing with these complexities.
4. Establish and maintain appropriate boundaries.
5. Maintain self-awareness and manage transference and counter-transference issues.
6. Apply the laws and ethics regarding reporting requirements, i.e. child abuse, elderly abuse, plan to harm self or others, Tarasoff etc.
7. Discuss HIPPPAA regulations and how to apply them in practice.

Study helps: When you scroll over the **yellow sticky notes** you will receive study helps.

Chapter 1 - Introduction

Taking a course on laws and ethics does not exactly create excitement or anticipation. As a Social Worker you probably like working with people. If you wanted to work with laws and rules you would have been a lawyer. Is it enough to just know the basics (like Tarasoff) and move on? The answer to this is a definite, no. You have to know this information for at least two reasons: to protect your client (the consumer) and you (the healthcare professional). So, don't plug your nose and swallow like taking nasty medicine. Learn it, love it, embrace it, make it yours, take it home with you...uh....wait a minute...that's a boundary issue.

The trip through laws and ethics is a trip you must take so we'll keep it straight and to the point. There are many great links if you want to see more expanded information on different subjects.

Need to Know

Laws and ethics permeate all services licensed professionals offer. ***They give the consumer protection and a set of expectations in the services they receive.*** They concurrently provide a road map for the professional healthcare practitioner. Unfortunately, licensed professionals occasionally fail to abide by legal and ethical standards. This often results in creating emotional harm for the client and the loss or suspension of the professional's license, and even incarceration. This course is designed to make clear the legal and ethical responsibilities of the professional healthcare practitioner.

Chapter 2 – Codes of Ethics

Professional organizations, such as the **National Association of Social Workers (NASW)** and the **National Board of Certified Counseling (NBCC)** have developed and, from time to time, revised codes of ethics to provide standards and guidance to licensed professionals. Each code is worthwhile to look at and become familiar with for all healthcare practitioners. Because there are innumerable ways to violate appropriate practices, the codes are not meant to be an exhaustive list of rules, but rather values and principles that guide healthcare professionals in their providing of services. If these values, purposes and principles are followed, along with a heavy dose of common sense, clients will reap the benefit of effective services and the healthcare professions will grow stronger still. As stated in the NASW code of ethics Preamble "A code of ethics cannot guarantee ethical behavior....Rather a code of ethics sets forth values, ethical principles, and ethical standards to which professional aspire and by which their actions can be judged."

The following is the NASW Code of Ethics and can be found at this link:

Approved by the 1996 NASW Delegate Assembly and revised by the 2017 NASW Delegate Assembly

Preamble

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

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

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

This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience.

Purpose of the NASW Code of Ethics

Professional ethics are at the core of social work. The profession has an obligation to articulate its basic values, ethical principles, and ethical standards. The *NASW Code of Ethics* sets forth these values, principles, and standards to guide social workers' conduct. The *Code* is relevant to all social workers and social work students, regardless of their professional functions, the settings in which they work, or the populations they serve.

The *NASW Code of Ethics* serves six purposes:

1. **The Code identifies core values on which social work's mission is based.**
2. **The Code summarizes broad ethical principles that reflect the profession's core values and establishes a set of specific ethical standards that should be used to guide social work practice.**
3. **The Code is designed to help social workers identify relevant considerations when professional obligations conflict or ethical uncertainties arise.**
4. **The Code provides ethical standards to which the general public can hold the social work profession accountable.**
5. **The Code socializes practitioners new to the field to social work's mission, values, ethical principles, and ethical standards.**
6. **The Code articulates standards that the social work profession itself can use to assess whether social workers have engaged in unethical conduct. NASW has formal procedures to adjudicate ethics complaints filed against its members.* In subscribing to this Code, social workers are required to cooperate in its implementation, participate in NASW adjudication proceedings, and abide by any NASW disciplinary rulings or sanctions based on it.**

For information on NASW adjudication procedures, see *NASW Procedures for the Adjudication of Grievances

The *Code* offers a set of values, principles, and standards to guide decision making and conduct when ethical issues arise. It does not provide a set of rules that prescribe how social workers should act in all situations. Specific applications of the *Code* must take into account the context in which it is being considered and the possibility of conflicts among the *Code's* values, principles, and standards. Ethical responsibilities flow from all human relationships, from the personal and familial to the social and professional.

Further, the *NASW Code of Ethics* does not specify which values, principles, and standards are most important and ought to outweigh others in instances when they conflict. Reasonable differences of opinion can and do exist among social workers with respect to the ways in which values, ethical principles, and ethical standards should be rank ordered when they conflict. Ethical decision making in a given situation must apply the informed judgment of the individual social worker and should also consider how the issues would be judged in a peer review process where the ethical standards of the profession would be applied.

Ethical decision making is a process. There are many instances in social work where simple answers are not available to resolve complex ethical issues. Social workers should take into consideration all the values, principles, and standards in this *Code* that are relevant to any situation in which ethical judgment is warranted. Social workers' decisions and actions should be consistent with the spirit as well as the letter of this *Code*.

In addition to this *Code*, there are many other sources of information about ethical thinking that may be useful. Social workers should consider ethical theory and principles generally,

social work theory and research, laws, regulations, agency policies, and other relevant codes of ethics, recognizing that among codes of ethics social workers should consider the *NASW Code of Ethics* as their primary source. Social workers also should be aware of the impact on ethical decision making of their clients' and their own personal values and cultural and religious beliefs and practices. They should be aware of any conflicts between personal and professional values and deal with them responsibly. For additional guidance social workers should consult the relevant literature on professional ethics and ethical decision making and seek appropriate consultation when faced with ethical dilemmas. This may involve consultation with an agency-based or social work organization's ethics committee, a regulatory body, knowledgeable colleagues, supervisors, or legal counsel.

Instances may arise when social workers' ethical obligations conflict with agency policies or relevant laws or regulations. When such conflicts occur, social workers must make a responsible effort to resolve the conflict in a manner that is consistent with the values, principles, and standards expressed in this Code. If a reasonable resolution of the conflict does not appear possible, social workers should seek proper consultation before making a decision.

The *NASW Code of Ethics* is to be used by NASW and by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, professional liability insurance providers, courts of law, agency boards of directors, government agencies, and other professional groups) that choose to adopt it or use it as a frame of reference. Violation of standards in this *Code* does not automatically imply legal liability or violation of the law. Such determination can only be made in the context of legal and judicial proceedings. Alleged violations of the *Code* would be subject to a peer review process. Such processes are generally separate from legal or administrative procedures and insulated from legal review or proceedings to allow the profession to counsel and discipline its own members.

A code of ethics cannot guarantee ethical behavior. Moreover, a code of ethics cannot resolve all ethical issues or disputes or capture the richness and complexity involved in striving to make responsible choices within a moral community. Rather, a code of ethics sets forth values, ethical principles, and ethical standards to which professionals aspire and by which their actions can be judged. Social workers' ethical behavior should result from their personal commitment to engage in ethical practice. The *NASW Code of Ethics* reflects the commitment of all social workers to uphold the profession's values and to act ethically. Principles and standards must be applied by individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments.

Ethical Principles

The following broad ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These principles set forth ideals to which all social workers should aspire.

Value: Service

Ethical Principle: *Social workers' primary goal is to help people in need and to address social problems.*

Social workers elevate service to others above self-interest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems.

Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service).

Value: *Social Justice*

Ethical Principle: *Social workers challenge social injustice.*

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

Value: *Dignity and Worth of the Person*

Ethical Principle: *Social workers respect the inherent dignity and worth of the person.*

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

Value: *Importance of Human Relationships*

Ethical Principle: *Social workers recognize the central importance of human relationships.*

Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

Value: *Integrity*

Ethical Principle: *Social workers behave in a trustworthy manner.*

Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.

Value: *Competence*

Ethical Principle: *Social workers practice within their areas of competence and develop and enhance their professional expertise.*

Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

Ethical Standards

The following ethical standards are relevant to the professional activities of all social workers. These standards concern (1) social workers' ethical responsibilities to clients, (2) social workers' ethical responsibilities to colleagues, (3) social workers' ethical responsibilities in practice settings, (4) social workers' ethical responsibilities as professionals, (5) social workers' ethical responsibilities to the social work profession, and (6) social workers' ethical responsibilities to the broader society.

Some of the standards that follow are enforceable guidelines for professional conduct, and some are aspirational. The extent to which each standard is enforceable is a matter of professional judgment to be exercised by those responsible for reviewing alleged violations of ethical standards.

1. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO CLIENTS

1.01 Commitment to Clients

Social workers' primary responsibility is to promote the well-being of clients. In general, clients' interests are primary. **However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised.** (Examples include when a social

worker is required by law to report that a client has abused a child or has threatened to harm self or others.)

1.02 Self-Determination

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. **Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.**

1.03 Informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. **Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.**

(b) **In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.**

(c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent.

(d) **In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service.**

(e) **Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.**

(f) **Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party.**

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) **Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.**

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

1.05 Cultural Competence and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) **Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.**

1.06 Conflicts of Interest

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

(b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.

(c) **Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether**

professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

(d) When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest.

1.07 Privacy and Confidentiality

(a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the course of the relationship.

(f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by

others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements.

(g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling.

(h) Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure.

(i) Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants.

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media.

(l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.

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

(n) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure.

(o) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.

(p) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information.

(q) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure.

(r) Social workers should protect the confidentiality of deceased clients consistent with the preceding standards.

1.08 Access to Records

(a) Social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files.

(b) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.

1.09 Sexual Relationships

(a) Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced.

(b) Social workers should not engage in sexual activities or 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. Sexual activity or 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 social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual

partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

1.10 Physical Contact

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

1.11 Sexual Harassment

Social workers should not sexually harass clients. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

1.12 Derogatory Language

Social workers should not use derogatory language in their written or verbal communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients.

1.13 Payment for Services

(a) When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients' ability to pay.

(b) Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship.

(c) Social workers should not solicit a private fee or other remuneration for providing services to clients who are entitled to such available services through the social workers' employer or agency.

1.14 Clients Who Lack Decision-Making Capacity

When social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients.

1.15 Interruption of Services

Social workers should make reasonable efforts to ensure continuity of services in the event that services are interrupted by factors such as unavailability, relocation, illness, disability, or death.

1.16 Termination of Services

(a) Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests.

(b) Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary.

(c) Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.

(d) Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.

(e) Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences.

(f) Social workers who are leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options.

2. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO COLLEAGUES

2.01 Respect

(a) Social workers should treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues.

(b) Social workers should avoid unwarranted negative criticism of colleagues in communications with clients or with other professionals. Unwarranted negative criticism may include demeaning comments that refer to colleagues' level of competence or to individuals' attributes such as race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

(c) Social workers should cooperate with social work colleagues and with colleagues of other professions when such cooperation serves the well-being of clients.

2.02 Confidentiality

Social workers should respect confidential information shared by colleagues in the course of their professional relationships and transactions. Social workers should ensure that such colleagues understand social workers' obligation to respect confidentiality and any exceptions related to it.

2.03 Interdisciplinary Collaboration

(a) Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established.

(b) Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistent with client well-being.

2.04 Disputes Involving Colleagues

(a) Social workers should not take advantage of a dispute between a colleague and an employer to obtain a position or otherwise advance the social workers' own interests.

(b) Social workers should not exploit clients in disputes with colleagues or engage clients in any inappropriate discussion of conflicts between social workers and their colleagues.

2.05 Consultation

(a) Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients.

(b) Social workers should keep themselves informed about colleagues' areas of expertise and competencies. Social workers should seek consultation only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation.

(c) When consulting with colleagues about clients, social workers should disclose the least amount of information necessary to achieve the purposes of the consultation.

2.06 Referral for Services

(a) Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that additional service is required.

(b) Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers.

(c) Social workers are prohibited from giving or receiving payment for a referral when no professional service is provided by the referring social worker.

2.07 Sexual Relationships

(a) Social workers who function as supervisors or educators should not engage in sexual activities or contact with supervisees, students, trainees, or other colleagues over whom they exercise professional authority.

(b) Social workers should avoid engaging in sexual relationships with colleagues when there is potential for a conflict of interest. Social workers who become involved in, or anticipate becoming involved in, a sexual relationship with a colleague have a duty to transfer professional responsibilities, when necessary, to avoid a conflict of interest.

2.08 Sexual Harassment

Social workers should not sexually harass supervisees, students, trainees, or colleagues. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

2.09 Impairment of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.10 Incompetence of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's incompetence should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague is incompetent and has not taken adequate steps to address the incompetence should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.11 Unethical Conduct of Colleagues

(a) Social workers should take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues.

(b) Social workers should be knowledgeable about established policies and procedures for handling concerns about colleagues' unethical behavior. Social workers should be familiar with national, state, and local procedures for handling ethics complaints. These include policies and procedures created by NASW, licensing and regulatory bodies, employers, agencies, and other professional organizations.

(c) Social workers who believe that a colleague has acted unethically should seek resolution by discussing their concerns with the colleague when feasible and when such discussion is likely to be productive.

(d) When necessary, social workers who believe that a colleague has acted unethically should take action through appropriate formal channels (such as contacting a state licensing board or regulatory body, an NASW committee on inquiry, or other professional ethics committees).

(e) Social workers should defend and assist colleagues who are unjustly charged with unethical conduct.

3. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES IN PRACTICE SETTINGS

3.01 Supervision and Consultation

(a) Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.

(b) Social workers who provide supervision or consultation are responsible for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee.

(d) Social workers who provide supervision should evaluate supervisees' performance in a manner that is fair and respectful.

3.02 Education and Training

(a) Social workers who function as educators, field instructors for students, or trainers should provide instruction only within their areas of knowledge and competence and should provide instruction based on the most current information and knowledge available in the profession.

(b) **Social workers who function as educators or field instructors for students should evaluate students' performance in a manner that is fair and respectful.**

(c) **Social workers who function as educators or field instructors for students should take reasonable steps to ensure that clients are routinely informed when services are being provided by students.**

(d) **Social workers who function as educators or field instructors for students should not engage in any dual or multiple relationships with students in which there is a risk of exploitation or potential harm to the student. Social work educators and field instructors are responsible for setting clear, appropriate, and culturally sensitive boundaries.**

3.03 Performance Evaluation

Social workers who have responsibility for evaluating the performance of others should fulfill such responsibility in a fair and considerate manner and on the basis of clearly stated criteria.

3.04 Client Records

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

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

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

(d) Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts.

3.05 Billing

Social workers should establish and maintain billing practices that accurately reflect the nature and extent of services provided and that identify who provided the service in the practice setting.

3.06 Client Transfer

(a) When an individual who is receiving services from another agency or colleague contacts a social worker for services, the social worker should carefully consider the client's needs before agreeing to provide services. To minimize possible confusion and conflict, social workers should discuss with potential clients the nature of the clients' current relationship with other service providers and the implications, including possible benefits or risks, of entering into a relationship with a new service provider.

(b) If a new client has been served by another agency or colleague, social workers should discuss with the client whether consultation with the previous service provider is in the client's best interest.

3.07 Administration

(a) Social work administrators should advocate within and outside their agencies for adequate resources to meet clients' needs.

(b) Social workers should advocate for resource allocation procedures that are open and fair. When not all clients' needs can be met, an allocation procedure should be developed that is nondiscriminatory and based on appropriate and consistently applied principles.

(c) Social workers who are administrators should take reasonable steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision.

(d) Social work administrators should take reasonable steps to ensure that the working environment for which they are responsible is consistent with and encourages compliance with the *NASW Code of Ethics*. Social work administrators should take reasonable steps to eliminate any conditions in their organizations that violate, interfere with, or discourage compliance with the *Code*.

3.08 Continuing Education and Staff Development

Social work administrators and supervisors should take reasonable steps to provide or arrange for continuing education and staff development for all staff for whom they are responsible. Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics.

3.09 Commitments to Employers

(a) Social workers generally should adhere to commitments made to employers and employing organizations.

(b) Social workers should work to improve employing agencies' policies and procedures and the efficiency and effectiveness of their services.

(c) Social workers should take reasonable steps to ensure that employers are aware of social workers' ethical obligations as set forth in the *NASW Code of Ethics* and of the implications of those obligations for social work practice.

(d) Social workers should not allow an employing organization's policies, procedures, regulations, or administrative orders to interfere with their ethical practice of social work. Social workers should take reasonable steps to ensure that their employing organizations' practices are consistent with the *NASW Code of Ethics*.

(e) Social workers should act to prevent and eliminate discrimination in the employing organization's work assignments and in its employment policies and practices.

(f) Social workers should accept employment or arrange student field placements only in organizations that exercise fair personnel practices.

(g) Social workers should be diligent stewards of the resources of their employing organizations, wisely conserving funds where appropriate and never misappropriating funds or using them for unintended purposes.

3.10 Labor-Management Disputes

(a) Social workers may engage in organized action, including the formation of and participation in labor unions, to improve services to clients and working conditions.

(b) The actions of social workers who are involved in labor-management disputes, job actions, or labor strikes should be guided by the profession's values, ethical principles, and ethical standards. Reasonable differences of opinion exist among social workers concerning their primary obligation as professionals during an actual or threatened labor strike or job action. Social workers should carefully examine relevant issues and their possible impact on clients before deciding on a course of action.

4. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES AS PROFESSIONALS

4.01 Competence

(a) Social workers should accept responsibility or employment only on the basis of existing competence or the intention to acquire the necessary competence.

(b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.

(c) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.

4.02 Discrimination

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

4.03 Private Conduct

Social workers should not permit their private conduct to interfere with their ability to fulfill their professional responsibilities.

4.04 Dishonesty, Fraud, and Deception

Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception.

4.05 Impairment

(a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.

(b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.

4.06 Misrepresentation

(a) Social workers should make clear distinctions between statements made and actions engaged in as a private individual and as a representative of the social work profession, a professional social work organization, or the social worker's employing agency.

(b) Social workers who speak on behalf of professional social work organizations should accurately represent the official and authorized positions of the organizations.

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

4.07 Solicitations

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

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

4.08 Acknowledging Credit

(a) Social workers should take responsibility and credit, including authorship credit, only for work they have actually performed and to which they have contributed.

(b) Social workers should honestly acknowledge the work of and the contributions made by others.

5. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO THE SOCIAL WORK PROFESSION

5.01 Integrity of the Profession

(a) Social workers should work toward the maintenance and promotion of high standards of practice.

(b) **Social workers should uphold and advance the values, ethics, knowledge, and mission of the profession. Social workers should protect, enhance, and improve the integrity of the profession through appropriate study and research, active discussion, and responsible criticism of the profession.**

(c) **Social workers should contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the social work profession. These activities may include teaching, research, consultation, service, legislative testimony, presentations in the community, and participation in their professional organizations.**

(d) **Social workers should contribute to the knowledge base of social work and share with colleagues their knowledge related to practice, research, and ethics. Social workers should seek to contribute to the profession's literature and to share their knowledge at professional meetings and conferences.**

(e) **Social workers should act to prevent the unauthorized and unqualified practice of social work.**

5.02 Evaluation and Research

- (a) Social workers should monitor and evaluate policies, the implementation of programs, and practice interventions.
- (b) Social workers should promote and facilitate evaluation and research to contribute to the development of knowledge.
- (c) Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice.
- (d) Social workers engaged in evaluation or research should carefully consider possible consequences and should follow guidelines developed for the protection of evaluation and research participants. Appropriate institutional review boards should be consulted.
- (e) Social workers engaged in evaluation or research should obtain voluntary and written informed consent from participants, when appropriate, without any implied or actual deprivation or penalty for refusal to participate; without undue inducement to participate; and with due regard for participants' well-being, privacy, and dignity. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research.
- (f) When evaluation or research participants are incapable of giving informed consent, social workers should provide an appropriate explanation to the participants, obtain the participants' assent to the extent they are able, and obtain written consent from an appropriate proxy.
- (g) Social workers should never design or conduct evaluation or research that does not use consent procedures, such as certain forms of naturalistic observation and archival research, unless rigorous and responsible review of the research has found it to be justified because of its prospective scientific, educational, or applied value and unless equally effective alternative procedures that do not involve waiver of consent are not feasible.
- (h) Social workers should inform participants of their right to withdraw from evaluation and research at any time without penalty.
- (i) Social workers should take appropriate steps to ensure that participants in evaluation and research have access to appropriate supportive services.
- (j) Social workers engaged in evaluation or research should protect participants from unwarranted physical or mental distress, harm, danger, or deprivation.
- (k) Social workers engaged in the evaluation of services should discuss collected information only for professional purposes and only with people professionally concerned with this information.
- (l) Social workers engaged in evaluation or research should ensure the anonymity or confidentiality of participants and of the data obtained from them. Social workers should

inform participants of any limits of confidentiality, the measures that will be taken to ensure confidentiality, and when any records containing research data will be destroyed.

(m) Social workers who report evaluation and research results should protect participants' confidentiality by omitting identifying information unless proper consent has been obtained authorizing disclosure.

(n) Social workers should report evaluation and research findings accurately. They should not fabricate or falsify results and should take steps to correct any errors later found in published data using standard publication methods.

(o) Social workers engaged in evaluation or research should be alert to and avoid conflicts of interest and dual relationships with participants, should inform participants when a real or potential conflict of interest arises, and should take steps to resolve the issue in a manner that makes participants' interests primary.

(p) Social workers should educate themselves, their students, and their colleagues about responsible research practices.

6. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO THE BROADER SOCIETY

6.01 Social Welfare

Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments. Social workers should advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice.

6.02 Public Participation

Social workers should facilitate informed participation by the public in shaping social policies and institutions.

6.03 Public Emergencies

Social workers should provide appropriate professional services in public emergencies to the greatest extent possible.

6.04 Social and Political Action

(a) Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully. Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice.

(b) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups.

(c) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people.

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability. (NASW, 2020)

Below is the NBCC Code of Ethics which is found at this link:

<https://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf>

NATIONAL BOARD FOR CERTIFIED COUNSELORS (NBCC) CODE OF ETHICS

PREAMBLE

The National Board for Certified Counselors (NBCC) provides national certifications that recognize individuals who have voluntarily met standards for general and specialty areas of counseling practice. Counselors certified by NBCC may also identify with different professional associations and are often licensed by jurisdictions that promulgate standards of behavior. Regardless of any other affiliation, this Code of Ethics is applicable to all NBCC applicants and National Certified Counselors (NCCs).

This Code establishes the minimum ethical behaviors and provides an expectation of and assurance for the ethical practice for all who use the professional services of NCCs. Furthermore, it provides an enforceable set of directives and assures a resource for those served in the case of a perceived violation.

NCCs are required to adhere to all of the directives.

Sanctions of applicants and credential holders under this Code are issued by NBCC only if the provisions of the NBCC Code of Ethics are found to have been violated.



ALL DIRECTIVES

NCCs take appropriate action to prevent harm.

1. NCCs, recognizing the potential for harm, shall not share information that is obtained through the counseling process without specific written consent by the client or legal guardian except to prevent clear, imminent danger to the client or others or when required to do so by a court order.
2. NCCs shall respect client's privacy and shall solicit only information that contributes to the identified counseling goals.
3. NCCs generally shall not accept goods or services from clients in return for counseling services in recognition of the possible negative effects, including perceived exploitation. NCCs may accept goods, services or other nonmonetary compensation from clients only in cases where no referrals are possible or appropriate and if the arrangement is discussed with the client in advance, is an exchange of a reasonable equivalent value, does not place the counselor in an unfair advantage, is not harmful to the client or their treatment and is documented in the counseling services agreement.
4. NCCs shall not accept gifts from clients except in cases when it is culturally appropriate or therapeutically relevant because of the potential confusion that may arise. NCCs shall consider the value of the gift and the effect on the therapeutic relationship when contemplating acceptance. This consideration shall be documented in the client's record.
5. NCCs shall not engage in harmful multiple relationships with clients. In the event that a harmful multiple relationship develops in an unforeseen manner, the NCC shall discuss the potential effects with the client and shall take reasonable steps to resolve the situation, including the provision of referrals. This discussion shall be documented in the client's record.
6. NCCs shall discuss important considerations to avoid exploitation before entering into a non-counseling relationship with a former client. Important considerations to be discussed include amount of time since counseling service termination, duration of counseling, nature and circumstances of client's counseling, the likelihood that the client will want to resume

counseling at some time in the future; circumstances of service termination and possible negative effects or outcomes.

7. NCCs shall not engage in any form of sexual or romantic intimacy with clients or with former clients for two years from the date of counseling service termination.
8. NCCs shall not engage in sexual harassment, which is defined as a single act or multiple occurrences of verbal, nonverbal or physical actions that are known to be unwelcome or that are of the severity to be perceived as harassment by a reasonable person.
9. NCCs shall take proactive measures to avoid interruptions of counseling services due to illness, vacations or unforeseen circumstances. To prevent the harm that may occur if clients are unable to access professional assistance, such measures shall identify other professionals with whom the NCC has a working agreement or local emergency service agencies that can respond to clients in a mental health crisis.
10. NCCs shall create written procedures regarding the handling of client records in the event of their unexpected death or incapacitation. In recognition of the harm that may occur if clients are unable to access professional assistance in these cases, these procedures shall ensure that the confidentiality of client records is maintained and shall include the identification of individual(s) who are familiar with ethical and legal requirements regarding the counseling profession and who shall assist clients in locating other professional mental health providers as well as ensure the appropriate transfer of client records. These written procedures shall be provided to the client, and the NCC shall provide an opportunity for the client to discuss concerns regarding the process as it pertains to the transfer of his or her record.
11. NCCs who act as counselor educators, field placement or clinical supervisors shall not engage in sexual or romantic intimacy with current students or supervisees. They shall not engage in any form of sexual or romantic intimacy with former students or supervisees for two years from the date of last supervision contact.
12. NCCs who provide clinical supervision services shall keep accurate records of supervision goals and progress and consider all information gained in supervision as confidential except to prevent clear, imminent danger to the client or others or when legally required to do so by a court or government agency order. In cases in which the supervisor receives a court or governmental agency order requiring the production of supervision records, the

NCC shall make reasonable attempts to promptly notify the supervisee. In cases in which the supervisee is a student of a counselor education program, the supervisor shall release supervision records consistent with the terms of the arrangement with the counselor education program.

13. NCCs who provide clinical supervision services shall intervene in situations where supervisees are impaired or incompetent and thus place client(s) at risk.
14. NCCs who provide clinical supervision services shall not have multiple relationships with supervisees that may interfere with supervisors' professional judgment or exploit supervisees. Supervisors shall not supervise relatives.
15. NCCs who seek consultation (i.e., consultees) shall protect client's confidentiality and unnecessary invasion of privacy by providing only the information relevant to the consultation and in a manner that protects the client's identity.
16. NCCs shall not release the results of tests and assessments to individuals other than the client without prior written consent except as required to prevent clear, imminent danger to the client or others; by written agreement with the client; or when legally required to do so by a court order or governmental agency.
17. NCCs shall protect the welfare of research participants by taking reasonable precautions to prevent negative psychological or physical effects.
18. NCCs shall protect the identities of research participants by appropriately disguising data except when there is a detailed written authorization.
19. NCCs shall recognize the potential harm of informal uses of social media and other related technology with clients, former clients and their families and personal friends. After carefully considering all of the ethical implications, including confidentiality, privacy and multiple relationships, NCCs shall develop written practice procedures in regard to social media and digital technology, and these shall be incorporated with the information provided to clients before or during the initial session. At a minimum, these social media procedures shall specify that personal accounts will be separate and isolated from any used for professional counseling purposes including those used with prospective or current clients. These procedures shall also address "friending" and responding to material posted.
20. NCCs shall not use social media sources (e.g., updates, tweets, blogs, etc.) to provide confidential information regarding client cases that have not been consented to by the client. To facilitate the secure provision of information, NCCs shall inform clients prior to or

during the initial session about appropriate ways to communicate with them. Furthermore, NCCs shall advise clients about the potential risks of sending messages through digital technology and social media sources.

21. NCCs who use digital technology (e.g., social media) for professional purposes shall limit information posted to that which does not create multiple relationships or which may threaten client confidentiality.

NCCs provide only those services for which they have education and qualified experience.

22. NCCs shall perform only those professional services for which they are qualified by education and supervised experience.
23. NCCs shall seek professional assistance or withdraw from the practice of counseling if their mental or physical condition makes it unlikely that the counselor will be able to provide appropriate services.
24. NCCs shall seek supervision and consultation with other qualified professionals when unsure about client treatment or professional practice responsibilities.
25. NCCs shall use or interpret only the specific tests and assessments for which they have the required education and supervised experience.
26. NCCs shall demonstrate multicultural competence and shall not use techniques that discriminate against or show hostility towards individuals or groups based on gender, ethnicity, race, national origin, sexual orientation, disability, religion or any other legally prohibited basis. Techniques shall be based on established theory. NCCs shall discuss appropriate considerations and obtain written consent from the client(s) prior to the use of any experimental approach.

NCCs promote the welfare of clients, students, supervisees or the recipients of professional services provided.

27. NCCs shall discuss with prospective clients the appropriateness of counseling services offered and shall not offer services if there is reasonable cause to believe clients will not benefit.
28. NCCs who provide supervision services shall present supervisees with feedback according to a schedule with identified evaluation dates as well as on appropriate occasions throughout the process.
29. NCCs shall promote the welfare of supervisees by discussing ethical practices relating to supervision as well as the legal standards that regulate the practice of counseling.
30. NCCs who provide supervision services shall establish with their supervisees procedures for responding to crisis situations or expressing concerns regarding the supervision process. This information shall be provided in verbal and written formats.
31. NCCs who seek consultation (i.e., consultees) shall promote welfare by selecting appropriate professionals who can specifically respond to the identified issue with the client, supervisee or student.
32. NCCs who provide consultative services (i.e., consultants) shall establish a written plan with the professional seeking assistance. This plan shall include the identification of the primary client concern or issue, consultation goals, potential consequences of actions, evaluation and other future steps. The consultant shall document this information in their professional records. Brief collaborative conversations between an NCC and other professionals are not considered consultations as long as no identifying client information is provided.
33. NCCs shall limit the use of tests and assessments to those that are current, specifically necessary for the provision of quality services, and that have been carefully considered in terms of the instrument's validity, reliability, psychometric limitations and appropriateness for use in a given situation or with a particular client.
34. NCCs shall protect the confidentiality and security of tests or assessments, reports, data and any transmission of information in any form.
35. NCCs shall recognize results that are outside the norms for a given test and assessment, and shall document in the client's record how those results will be appropriately used in the counseling process.

36. NCCs who develop tests or assessments for measuring personal characteristics, development, diagnoses, goal attainment or other similar clinical uses shall provide test users with written information regarding the benefits and limitations of test instruments, including appropriate use, test results and interpretation.
37. NCCs who develop tests and assessments for measuring personal characteristics, development, diagnoses, goal attainment or other similar clinical uses shall identify other potential sources of appropriate information and shall emphasize to test users the importance of basing decisions on multiple sources rather than a single criterion.

NCCs communicate truthfully.

38. NCCs shall accurately represent their current qualifications and credentials in counseling or closely related disciplines. NCCs shall not use doctorate degrees with relation to professional counseling duties unless they are specific to counseling or mental health disciplines.
39. NCCs shall identify only earned degrees in counseling or closely related disciplines when it comes to all counseling work including publications. Listed degrees from programs in the United States must be from colleges and universities that were accredited at the time of graduation by one of the regional accrediting organizations recognized by the Council for Higher Education Accreditation (CHEA).
40. NCCs who have been awarded honorary degrees shall clearly distinguish these from earned degrees.
41. NCCs shall correct known misrepresentations of their qualifications and credentials by others and shall not allow such information to be used in a misleading way.
42. NCCs shall take credit only for work that they have performed, and when quoting the work of others, shall provide appropriate references.
43. NCCs shall provide accurate reports which are based on direct experiences with individual(s) or documentation from other professionals when providing opinions. NCCs shall limit opinions to areas within their expertise.
44. NCCs shall accurately note in the client's or supervisee's records all information necessary for the provision of quality services or as required by laws, regulations or institutional procedures.

45. NCCs who provide supervision services shall present accurate written information to supervisees regarding the NCC's credentials as well as information regarding the process of supervision. This information shall include any conditions of supervision, supervision goals, case management procedures, confidentiality and its limitations, appraisal methods and timing of evaluations.
46. NCCs who provide consultative services (i.e., consultants) shall use accurate information regarding their qualifications in relation to the identified concerns or situations.
47. NCCs who seek case consultation services from another professional shall document consultation in clients' records.
48. NCCs shall accurately report test and assessment results and limit conclusions to those based on evidence, taking into consideration any influences that may affect results such as health, motivation and multicultural factors. NCCs shall generally avoid making decisions based on a single test or assessment result.
49. NCCs shall note in the results and interpretation when tests and assessments are not administered under standard conditions or when unusual behavior or irregularities occur during the testing session.
50. NCCs shall not misrepresent a test or the results and shall provide accurate information in the event that he or she becomes aware of any false statements.
51. NCCs shall report to participants the subject and features of the study after research data is collected, as well as clarify any misconceptions about the research.
52. NCCs shall accurately report results of research, including limitations and variables that may have impacted the outcomes.
53. NCCs shall take reasonable steps to publicly correct errors in their published research if any are discovered.
54. NCCs shall include all electronic communications exchanged with clients and supervisees, including those through digital technology and social media methods, as a part of the record, even when strictly related to clerical issues such as change of contact information or scheduling appointments. All electronic therapeutic communication methods shall use encryption and password security.

NCCs recognize that their behavior reflects on the integrity of the profession as a whole, and thus, they avoid actions which can reasonably be expected to damage

trust.

55. NCCs shall retain client records for a minimum of five years unless state or federal laws require additional time. After the required retention period, NCCs shall dispose of records in a manner that protects client confidentiality.
56. NCCs shall act in a professional manner by protecting against unauthorized access to confidential information. This includes data contained in electronic formats. NCCs shall inform any subordinates who have physical or electronic access to information of the importance of maintaining privacy and confidentiality.
57. NCCs shall make all reasonable efforts to inform clients and former clients prior to the court-ordered release of confidential client information. In the event that the client seeks to prevent the release, the NCC shall request that a court withdraw any order to release confidential information due to the potential harm to the client or the counseling relationship. When ordered to disclose confidential client information by a court or governmental agency, NCCs shall release only the required information. Any release of information shall be appropriately documented in accordance with the practice setting.
58. NCCs shall not provide forensic evaluation services concerning current or past clients or client's family members. Also, NCCs shall not provide forensic evaluation services regarding their own family members, friends or professional associates.
59. NCCs who are retiring or departing from an established practice with other mental health professionals shall notify current and former clients as appropriate regarding their pending departure from the practice. Such notifications should include information about record availability and access, and contact information of appropriate referrals within the established practice.
60. NCCs who practice in multiple settings (e.g., agencies and private practice settings) shall not increase their private practices by referring clients from the setting of contact unless by specific prior arrangement with authorized individuals in the agency or group setting. In such situations, clients shall be instructed of their right to request to be referred to another professional in the original setting of contact.
61. NCCs shall not misuse their professional influence or meet their own needs at the expense of clients or their welfare. This shall include the promotion of products developed by the NCC.

62. NCCs shall not solicit testimonials from current clients or their families and close friends. Recognizing the possibility of future requests for services, NCCs shall not solicit testimonials from former clients within two years from the date of service termination.
63. NCCs shall not provide references if they have reasonable belief that the individual counselor is not qualified, is not able to provide competent professional services or presents a risk of harm to others.
64. NCCs who provide supervision services to supervisee's who have more than one supervisor (e.g., field placement and university) shall exchange contact information and communicate regularly about the shared supervisee's performance.
65. NCCs who develop tests or assessments for measuring personal characteristics, development, diagnoses, goal attainment or other similar clinical uses shall provide written evidence that technical features (e.g., reliability, validity) are consistent with the identified purposes.
66. NCCs shall limit use of information obtained through digital technology and social media sources (e.g., Facebook, LinkedIn, Twitter, etc.) in accordance with established practice procedures provided to clients at the initiation of services.

NCCs recognize the importance of and encourage active participation of clients, students or supervisees.

67. NCCs conducting counseling with more than one client at a time (e.g., group or family counseling) shall discuss with clients the nature, the rights and responsibilities as well as the possible additional limitations of confidentiality. NCCs shall also describe the steps that they will take in the event that having multiple clients in session creates issues between or concerning clients.
68. NCCs who learn that a client is receiving additional mental health services from other professionals shall discuss with the client the importance of developing clear agreements to avoid client confusion and conflict. Following this discussion, NCCs shall request the client's written consent to inform the other professional(s) of the counseling relationship and to collaborate on the provision of mental health services. This discussion and the client's response to the request shall be documented in the client's record.

69. NCCs shall inform clients of the purposes, goals, procedures, limitations, potential risks and benefits of services and techniques either prior to or during the initial session. NCCs also shall provide information about client's rights and responsibilities including billing arrangements, collection procedures in the event of nonpayment, confidentiality and its limitations, records and service termination policies as appropriate to the counseling setting. This professional information shall be provided to the client in verbal and written forms (i.e., the counseling services agreement). NCCs shall have a reasonable basis for believing that the information provided is understood. NCCs shall document any client concerns related to the information provided in the client's record.
70. NCCs shall respond to client requests for access to or copies of records within a practical timeframe. Additionally, NCCs shall provide an opportunity for the client to discuss the content of the record. If there is a reasonable basis to believe that providing such access will cause harm, the NCC shall discuss the request and possible effects; however, the information ultimately belongs to the client, and thus must be released. Records requests and any discussion regarding the provision shall be documented in the client's record.
71. NCCs who become aware of another mental health professional's unethical behavior shall first attempt to resolve issues through reasonable means except when state regulations require immediate reporting. In the event that it cannot be resolved, the NCC shall report the matter to all appropriate professional regulatory organizations and agencies.
72. NCCs shall obtain a client's consent prior to the provision of services. In private practice or other similar situations, this consent shall be documented in writing in a counseling services agreement. This counseling services agreement shall become a part of the client's record.
73. NCCs shall work collaboratively with clients in the creation of written plans of treatment that offer attainable goals and use appropriate techniques consistent with client's psychological and physical needs and abilities.
74. NCCs shall update the client's record throughout the counseling relationship when changes occur in the treatment plan, including those relating to goals, roles and techniques. The NCC shall obtain the client's written approval on such updates.
75. NCCs shall clearly designate in writing the primary client in the record. NCCs shall also identify in the record individuals who are receiving related professional services in connection with such client relationship. In the event of working with minors or individuals

- who are unable to give informed consent, NCCs shall discuss relevant considerations regarding the preferences of the individuals receiving services and legal guardian's rights and obligations. This information shall become a part of the client's record.
76. NCCs shall discuss service termination with clients when there is a reasonable belief that the clients are no longer benefiting from or are unlikely to benefit from future services. NCCs shall not abruptly terminate counseling services without good cause or significant justification, and in such cases, shall provide appropriate referrals.
77. NCCs shall provide referrals if the client cannot afford services, at the client's request or as appropriate at the conclusion of a professional counseling service relationship.
78. NCCs who act as university, field placement or clinical supervisors shall ensure that supervisees provide accurate information to clients about the supervisee's professional status (i.e., intern, licensed, etc.)
79. NCCs shall provide complete information regarding the format (electronic or otherwise), administration purpose, and the desired outcome, risks and limitations prior to the use of a test or assessment. NCCs shall have a reasonable basis for believing that the information provided is understood.
80. NCCs shall seek information, such as limitations, regarding a client which may affect the administration or interpretation of results prior to use of a test or assessment. If appropriate, the NCC may provide a referral to another professional who specializes in the evaluation of individuals with similar conditions. This discussion shall be documented in the client's record.
81. NCCs shall provide critical information to potential research subjects that will assist them in reaching a determination about participation. This information shall include the research's purpose, process, duration, potential consequences, and procedures as well as the participant's right to refuse or withdraw participation.
82. NCCs shall obtain prior consent from all research participants. This consent process shall contain relevant information with regard to the recording of voices or images of participants. In the event of conducting research with individuals who are unable to give informed consent, NCCs shall document considerations between the potential subject's desire to participate and the legal guardian's consent.
83. NCCs shall not employ deceptive techniques in research unless there are no alternatives and there is significant prospective scientific, educational or clinical value. In all cases,

NCCs shall review potential techniques and shall not use any that can be reasonably expected to cause harm, as well as provide an explanation to participants during the debriefing.

84. NCCs shall carefully consider ethical implications, including confidentiality and multiple relationships, prior to conducting research with students, supervisees or clients. NCCs shall not convey that participation is required or will otherwise negatively affect academic standing, supervision or counseling services.

NCCs are accountable in their actions and adhere to recognized professional standards and practices.

85. NCCs shall comply with all NBCC policies, procedures and agreements, including all disclosure requirements.

86. NCCs shall adhere to legal standards and state board regulations.

87. NCCs shall not engage in unlawful discrimination.

88. NCCs who make statements in a public manner shall state that their opinions represent their personal views and not another organization unless officially authorized to do otherwise.

89. NCCs providing public presentations by any means, shall ensure that statements are consistent with this Code of Ethics.

90. NCCs who act as university, field placement or clinical supervisors shall require that supervisees provide the supervising NCC's name, credentials and contact information to the supervisee's clients.

91. NCCs shall follow administration and interpretation protocols for tests and assessments, including the use of appropriate software if using electronic measures.

92. NCCs shall comply with identified security protocols when using published tests and assessments.

93. NCCs shall comply with intellectual property laws and other accepted publication guidelines.

94. NCCs shall comply with applicable guidelines when designing, conducting or reporting research, including those of an institutional review board.

95. NCCs shall credit the work of others who have contributed to research or publication either through joint authorship, acknowledgment or other appropriate means. (NBCC, 2016)

Chapter 3 – Laws and Regulations

Each state governing board sets rules and regulations pertaining to the practice of the corresponding professions. You can usually find these regulations for your state by doing a web search for the board and following the links to the state's regulations. In this course the regulations for the state of California are more particularly made mention, because of the large number of healthcare professionals in the state, and the progressive nature of the governing board. It is also arguable that many of the California regulations pertain to the general practice of healthcare professionals. In California, the Board of Behavioral Sciences (BBS) has established a very thorough set of rules and regulations relating to the practice of Social Workers, Marriage and Family Therapists and Licensed Professional Counselors. In addition, because nurses have extensive interaction with patients and must respond to their behaviors, it is worthwhile for them to be aware of the ethical standards and issues related to social workers and therapists. To see the code applicable to BBS licenses you can link to: <https://www.bbs.ca.gov/pdf/publications/lawsregs.pdf>

The following are some highlights from the laws and regulations mentioned:

A. Necessity of a License

Remember how happy you were when you received the notice that you had passed the exams and became a licensed clinician, or finally completed your master's degree and were able to obtain your registration number and certification? This was not just about that moment or even the thousands of hours of associate/internship work, or studying for the exams. It was the culmination of all your education from kindergarten, and that thought should still provide you a sense of accomplishment and elation. Now you can provide

services with confidence that your efforts will help others live a greater quality of life, and those who receive your services can have that same confidence in you.

As you know, consumers of healthcare services are protected by regulations that require individuals providing those services to be competent. This level of competence is acquired through formal education and supervised experience. Competence is then evaluated through an examination process. When the individual has received the education, the experiences, and shown a high level of competence (that's you!) then the state issues a license, and some agencies issue certifications, as a notice to the consumer that the individual is capable of providing such services. In California, one who presents him/herself as a licensed healthcare professional who has not meet these qualifications is guilty of a misdemeanor.

As Stated in the BBS Statutes and Regulations:

The Necessity of a License for a Social Worker:

4996

- (a) Only individuals who have received a license under this article may style themselves as "Licensed Clinical Social Workers." Every individual who styles himself or herself or who holds himself or herself out to be a licensed clinical social worker, or who uses any words or symbols indicating or tending to indicate that he or she is a licensed clinical social worker, without holding his or her license in good standing under this article, is guilty of a misdemeanor.

- (b) It is unlawful for any person to engage in the practice of clinical social work unless at the time of so doing such person holds a valid, unexpired, and unrevoked license under this article. (BBS, Laws and Statutes, 2020)

Similarly in the Statues regarding MFT's it states:

- (a) (1) Many California families and many individual Californians are experiencing difficulty and distress, and are in need of wise, competent, caring, compassionate, and effective counseling in order to enable them to improve and maintain healthy family relationships.

- (2) Healthy individuals and healthy families and healthy relationships are

inherently beneficial and crucial to a healthy society, and are our most precious and valuable natural resource. Licensed marriage and family therapists provide a crucial support for the well-being of the people and the State of California.

- (b) No person may engage in the practice of marriage and family therapy as defined by Section 4980.02, unless he or she holds a valid license as a marriage and family therapist, or unless he or she is specifically exempted from that requirement, nor may any person advertise himself or herself as performing the services of a marriage, family, child, domestic, or marital consultant, or in any way use these or any similar titles, including the letters “L.M.F.T.” “M.F.T,” or “M.F.C.C,” or other name, word initial, or symbol in connection with or following his or her name to imply that he or she performs these services without a license as provided by this chapter. Persons licensed under Article 4 (commencing with Section 4996) of Chapter 14 of Division 2, or under Chapter 6.6 (commencing with Section 2900) may engage in such practice or advertise that they practice marriage and family therapy but may not advertise that they hold the marriage and family therapist’s license. (BBS, Laws and Statutes, 2020)

The following are examples of Laws and Regulations (BBS, L&R Code) requiring individuals to possess a valid license from the state in California:

B. Application of Methods

The laws and regulations regarding healthcare professionals also address the application of methods for each license. This defines the purpose of the services and how the services are performed.

Licensed Clinicians

The application for social workers, as an example, covers a wide array of services and techniques that assist individuals, families and groups, both with their life satisfaction as individuals and relationships, but also in their community. Social Workers have awareness about the psychosocial environment in which a person’s experiences are played out, and in

addition to psychotherapy, can also help the person influence their environment to make circumstances and responses to them more satisfying.

“The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve **more adequate, satisfying, and productive social adjustments**. The application of social work principles and methods includes, but is not restricted to, counseling and **using applied psychotherapy** of a nonmedical nature with individuals, families, or groups; providing information and referral services; providing or arranging for the provision of social services; explaining or interpreting the psychosocial aspects in the situations of individuals, families, or groups; helping communities to organize, to provide, or to improve social or health services; or doing research related to social work.

Psychotherapy,...is the use of psychosocial methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions which affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes.” (BBS, L&S, 2020)

When a clinician feels it would benefit the client, it is important to refer them to a psychiatrist for an evaluation for medication. It is out of the scope of social workers, Therapists and Counselors to prescribe or tell a client that they should be on medication outside of what has been prescribed by a medical doctor.

C. Hiring and Supervision of Interns /Associates

A recent change in the regulations for California effective January 1, 2018 represents a title change:

The title “marriage and family therapist intern” or “marriage and family therapist registered intern” is hereby renamed “Associate Marriage and Family Therapist” or “Registered

Associate Marriage and Family Therapist,” respectively. Any reference in statute or regulation to a “marriage and family therapist intern” or “marriage and family therapist registered intern” shall be deemed a reference to an “associate marriage and family therapist” or “registered associate marriage and family therapist.” (§4980.09 BBS, L&S Code)

Additionally,

(a) Effective January 1, 2016, an applicant for licensure as a marriage and family therapist shall pass the following two examinations as prescribed by the board:

(1) A California law and ethics examination.

(2) A clinical examination.

(b) Upon registration with the board, a marriage and family therapist intern shall, within the first year of registration, take an examination on California law and ethics. (§4980.397 BBS L&S, 2020)

When hiring and/or supervising a Clinical Social Worker, MFT or Counseling Associate/Intern the employer must provide appropriate supervision. Clinical supervision has been defined as “Responsibility for, and control of, the quality of clinical social work services being provided.” This direct supervision must be performed with a qualified licensed professional, and must be performed each week with face to face contact of at least one hour of individual supervision or two hours of group supervision.

The supervisor and the associate/intern will need to develop a plan of supervision that describes the goals and objectives of supervision. The supervisory responsibility is a very active one as the supervisor helps the associate/intern reach the level of competence required for licensure. This is done through weekly direct supervision sessions, providing applicable, clinical experiences, and providing feedback and direction as laid out in the supervisory plan.

Each state has different pre-licensure requirements and it is important to be aware of those in the state you reside. Very often, the state will require some post graduate experience prior to becoming licensed. For example, in order to sit for the licensing examinations in California a Social worker must obtain at least 3200 supervised hours after obtaining their

master's degree. In addition, the supervisor must be qualified as such and may not supervise more than two unlicensed individuals. (BBS, L&S Code, 2020)

Supervising Associate Clinical Social Workers

A licensed mental health professional who provides supervision to an Associate Clinical Social Worker (ASW) who is pursuing LCSW licensure must meet certain minimum qualifications.

- Licensed Marriage and Family Therapist (LMFT)
 - Licensed Clinical Social Worker (LCSW)
 - Licensed Professional Clinical Counselor (LPCC)
 - Licensed Psychologist (Licensed by the [California Board of Psychology](#))
 - [Board-Certified](#) Psychiatrist (Licensed by the [Medical Board of California](#))
- Have been licensed in California or any other state for at least two (2) years out of the last five (5) years prior to the commencement of supervision.
 - Have practiced psychotherapy during at least two (2) years out of the last five (5) years prior to the commencement of supervision (or, if an LEP, has provided psychological counseling pursuant to Business and Professions Code (BPC) section 4989.14) OR
 - Provided direct supervision to ASWs, Associate Professional Clinical Counselors, Marriage and Family Therapist Trainees, or Associate Marriage and Family Therapists who perform psychotherapy during at least two (2) years out of the last five (5) years prior to the commencement of supervision. Supervision of psychotherapy performed by a student shall be accepted if substantially equivalent to the supervision required for registrants.
 - Sign and comply with the Supervisor Responsibility Statement

*LEPs may only supervise the provision of educationally related mental health services consistent with the LEP scope of practice described in BPC section 4989.14, up to a maximum of 1,200 hours.

Supervisor Training Requirements

LCSWs, LMFTs, LPCCs and LEPs must complete a minimum of 15 hours of supervision training prior to the commencement of supervision. No further training is required.

NOTE: Licensed Clinical Psychologists and Psychiatrists are exempt from this requirement

Supervising Associate Marriage and Family Therapists (AMFT) and Trainees

The following information pertains to supervising AMFTs and Trainees.

Mental health professionals authorized to supervise AMFTs, under California law, must maintain a current and valid license, for the following:

- Licensed Marriage and Family Therapist (LMFT)
 - Licensed Clinical Social Worker (LCSW)
 - Licensed Professional Clinical Counselor (LPCC)
 - Licensed Educational Psychologist (LEP)
 - Licensed Psychologist (Licensed by the [California Board of Psychology](#))
 - [Board-Certified](#) Psychiatrist (Licensed by the [Medical Board of California](#))
- Have been licensed in California or any other state for at least two (2) years out of the last five (5) years prior to the commencement of supervision.
 - Have practiced psychotherapy during at least two (2) years out of the last five (5) years prior to the commencement of supervision (or, if an LEP, has provided psychological counseling pursuant to Business and Professions Code (BPC) section 4989.14) OR
 - Provided direct supervision to MFT Trainees, AMFTs, Associate Professional Clinical Counselors, or Associate Clinical Social Workers who perform psychotherapy during at least two (2) years out of the last five (5) years prior to the commencement of supervision. Supervision of psychotherapy performed by a student shall be accepted if substantially equivalent to the supervision required for registrants.
 - Sign and comply with the Supervisor Responsibility Statement

*LEPs may only supervise the provision of educationally related mental health services consistent with the LEP scope of practice described in BPC section 4989.14, up to a maximum of 1,200 hours.

Requirements Applicable ONLY to Supervisors Licensed as an LPCC

An LPCC who supervises an MFT Trainee or an AMFT must provide the supervisee, prior to the commencement of supervision, with written confirmation from the Board verifying that he or she is qualified to assess and treat couples and families.

Supervisor Training Requirements

LMFTs, LCSWs, LPCCs and LEPs must complete a minimum of six (6) hours of supervision training within 60 days of commencement of supervision, and six (6) hours of supervision training each renewal period.

NOTE: Licensed Clinical Psychologists and Psychiatrists are exempt from this requirement.

For a more detailed report of supervisory requirements for California Social Workers, Counselors and MFT's you can go to the BBS website at this link:

<https://www.bbs.ca.gov/licensees/supervisor.html>

Evaluation of the Supervisee

In spite of the awareness that a big part of supervision is the supervisor's evaluation of the supervisee, it's apparently something that is often far from the favorite task of a supervisor. Some of the reasons for this include (Lichtenberg et al., 2007):

- Defining competencies in precise and measurable terms
- Reaching agreement within the profession about the key elements of each competence domain
- Establishing an armamentarium of tools for assessing all components of competence, including the knowledgebase, skills, and attitudes (and their integration)
- Determining appropriate, agreed-upon minimal levels of competence for individuals at different levels of professional development and when "competence problems" exist for individuals assuring the fidelity of competency assessments
- Establishing mechanisms for providing effective evaluative feedback and remediation

But Lichtenberg et al. (2007) believed that "the single biggest obstacle would be convincing those who are skeptical of the value of ... implementation of comprehensive competence assessments across the professional lifespan."

However, no matter what problems are related to it, supervisor evaluation of the supervisee is an established fact and must be faced. Interestingly, unless things have dramatically changed in the 21st century, supervisees frequently receive no evaluation until the last day of the required training, and then receive some negative feedback about which they had heard nary a word in the course of training. You can see why the lack of performance evaluation has been the most common ethical violation reported by supervisees in supervision (Ladany and Lehrman-Waterman, 1999).

For contrast with the above list from Lichtenberg et al. (2007), the primary reasons given in 1993 of why supervisors often *don't give* negative feedback were (Robiner, Fuhrman, and Ristvedt, 1993):

1. Definition and Measurement: Supervisors reported concern about the methodology, reliability, and validity of the scales or measures they use, or they're concerned that anecdotal feedback does not meet criteria for accurate assessment.
2. Legal Liability: Supervisors were concerned with legal and administrative issues-- legal liability if the supervisee would dispute the feedback (especially in light of the first concern, fearing the feedback may not be defensible).
3. Interpersonal Issues: Many supervisors feared that the evaluation might cause the supervisor to come under unwelcome scrutiny; they also feared that it might risk jeopardizing the supervisory alliance or interpersonal relationship established with the supervisee.

It's ironic that supervisees report that supervisors who give abundant constructive feedback and evaluation are their best supervisors (Falender, 2010). The Association of State and Provincial Psychology Boards (2003) suggested that summative evaluation be given to supervisees in written form four times during each training year.

Summative evaluations of supervisees would examine the outcome of their clinical work. It would include:

- Outcome evaluations that investigate whether the supervisee caused demonstrable effects on specifically defined target outcomes
- Impact evaluation is broader and assesses the overall or net effects--intended or unintended--of the supervisee as a whole
- Secondary analysis reexamining existing data to address new questions or methods not previously employed (Trochim, 2006)

A related type of evaluation is formative evaluation, which tries to improve or strengthen the person being evaluated. As it relates to supervisees, it examines their delivery of therapy or a social work program, the quality of this delivery, and assessment of the context. A formative evaluation includes:

- Praise or support
- Constructive feedback focused on suggestions or analysis

- Thinking about what other options might have been helpful
- Wondering about the rationale for particular interventions
- Thinking more about process than content, effect rather than content, or generally refocusing the therapy process
- Specific and directive for beginning level supervisees; more open-ended and thought provoking for more advanced supervisees

Current thinking is moving towards a 2-way feedback, where supervisees also evaluate supervisors. Supervisees might fear that summative feedback could influence their own evaluations negatively, and thus be cautious in giving summative feedback to supervisors. However if you, the supervisor, are truly open to feedback and accepting of it, it can be very helpful to both you and the supervisee. If, however, you respond with dismissive behaviors, resistance, or even anger, it will obviously not be a helpful process (Falender, 2010).

Options to aid effective competency-based evaluations:

- Track for outcomes in client progress; examples of a tool for this are Lambert's Outcome Questionnaire (OQ) and its child and adolescent equivalent (Y-OQ) and the other measurements that were discussed earlier in the course can be used, such as depression scales.
- A self-assessment to assess and extend one's areas of practice, or just to see how current the supervisee's knowledge and skills are. Belar et al. (2001) offer a template that a supervisor can use to devise pertinent self-assessments for his specific use.
- Use a multi-source feedback (also known as "360-degree feedback"). The individual being rated (supervisor should do on himself first, then the supervisee would follow suit) first rates himself, and then is rated by peers, administrators, clerical staff, clients, supervisors (who were first rated by the supervisee), and others in the setting. The coordinating supervisor integrates the results to make a comprehensive feedback.
- The supervisor(s) should be certain that the evaluation documents include every important performance area in the supervisee's setting. If something is overlooked in the evaluation documents, it should necessarily also be overlooked in the final evaluations.
- Use other evaluation measures such as alliance measures, supervision outcomes, and diversity/multicultural competence assessments.

If the supervisee does not meet performance standards, she can be given an action plan for improvement, or in most drastic situations, a longer period of time of required supervision. Supervisees who don't meet standards after the action plan approach are rare (Falender, 2010).

Red flags for performance problems include:

- **Delinquent paperwork**
- **Chronic lateness**
- **Client cancellations (by client or supervisee)**
- **Changes in interaction style or behavior**
- **Inconsistencies between notes and descriptions of cases in supervision**

Not meeting performance standards are reflected in professional functions in one or more of the following (Lamb, Anderson, Rapp, Rathnow, qne Sesan, 1986):

- Inability or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior
- Inability to acquire professional skills to reach acceptable level of competence
- Inability to control personal stress, psychological dysfunction, and/or excessive emotional reactions that may affect professional functioning
- Supervisees don't acknowledge, understand, or address the problem even when raised
- The problem is not just a reflection of a skill deficit rectifiable through academic or didactics
- The quality of intern service is consistently negatively impacted
- The problem is not restricted to one area of functioning
- Disproportionate amounts of attention by training personnel is required
- The intern's behavior does not change as a function of feedback, remediation efforts, and/or time

After you've determined that the supervisee is not meeting performance criteria, and you've given feedback directly to him, work with the supervisee to develop a plan (based on data you can find in regard to successful completion of the behaviors in the past and factors that facilitated those) for change or completion. Construct a time-line with intermediate check-in points that are fairly close together, and document the meeting in which all of this took place (Falender, 2010).

The initial check-in should be within a few days of the meeting; be sure to follow up to see if appropriate progress is being made. Even with appropriate progress, continue monitoring even past indications that the behavior has changed. If the problem behaviors don't decrease, take appropriate steps that might include:

- Consultation with the school (a step that could even have occurred earlier)
- Consultation with Human Resources or Personnel Department
- Consultation with Administrative personnel on site
- Increased supervision or different supervision modalities
- Introducing a co-therapist
- Reducing workload or, if necessary, removing clients from caseload as needed
- Suggesting outside supports such as therapy or whatever is indicated
- Leave of absence

Continue with these steps until the problem is solved or until you determine that the supervisee's position must be terminated (Falender, 2010). All steps must be carefully documented.

D. Social Worker Corporations

Licensed Clinical Social Worker Corporations in California must abide by **the Moscone-Knox Professional Corporation Act**. To see the full code link here:

http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?division=3.&part=4.&lawCode=CORP&title=1.

These corporations are authorized to render professional services pursuant to a license such as doctors, lawyers, registered nurses, social workers and marriage and family therapists. There are advantages and disadvantages to forming corporations including liability issues and tax issues. If you are interested in forming your own corporation or even doing private practice as an individual the following website can be helpful:

<http://nolo.com> A particularly useful book found at the website is *Working for Yourself* by Attorney Stephen Fishman. (There is no connection or relationship, financial or otherwise, between Mr. Fishman or Nolo Press and the author). It is also very important to speak to an experienced and knowledgeable tax professional.

Some other regulations pertaining to Social Work Corporations include that “the name of a licensed clinical social worker corporation and any name or names under which it may be rendering professional services shall contain the words "licensed clinical social worker" and wording or abbreviations denoting corporate existence.

A licensed clinical social worker corporation that conducts business under a fictitious business name shall not use any name which is false, misleading, or deceptive, and shall inform the patient, prior to the commencement of treatment, that the business is conducted by a licensed clinical social worker corporation.” (BBS, L&S, 2020)

E. Disciplinary Issues

In the State of California BSS members had expressed concerns over the ethical violations in a number of disciplinary cases. It was expressed that the laws and ethics had not been taught sufficiently and the constant changing of laws and regulations required a revolving requirement of training. Thus the requirement of six hour of training was put into effect on January 1, 2004. It is the only such required course for each license renewal period.

The following are some violations which can result in the suspension, revocation or denial of a license or registration:

The board may deny a license or a registration, or may suspend or revoke the license or registration of a licensee or registrant if the licensee or registrant has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter is a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to themselves any controlled substance or using any of the dangerous drugs specified in Section 4022 or any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application for a registration or license or revoke the license or registration of any person who uses or offers to use drugs in the course of performing clinical social work. This provision does not apply to any person also licensed as a physician and surgeon under Chapter 5 (commencing with Section 2000) or the Osteopathic Act who lawfully prescribes drugs to a patient under the person's care.

(d) Incompetence in the performance of clinical social work.

(e) An act or omission that falls sufficiently below the standard of conduct of the profession as to constitute an act of gross negligence.

(f) Violating, attempting to violate, or conspiring to violate this chapter or any regulation adopted by the board.

(g) Misrepresentation as to the type or status of a license or registration held by the licensee or registrant or otherwise misrepresenting or permitting misrepresentation of the licensee's or registrant's education, professional qualifications, or professional affiliations to any person or entity. For purposes of this subdivision, this misrepresentation includes, but is not limited to, misrepresentation of the person's qualifications as an adoption service provider pursuant to Section 8502 of the Family Code.

(h) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee or registrant, allowing any other person to use the licensee's or registrant's license or registration.

(i) Aiding or abetting, or employing, directly or indirectly, any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(j) Intentionally or recklessly causing physical or emotional harm to any client.

(k) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(l) Engaging in sexual relations with a client or with a former client within two years from the termination date of therapy with the client, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a clinical social worker.

(m) Performing, or holding oneself out as being able to perform, or offering to perform or permitting, any registered associate, trainee, or applicant for licensure under supervision to

perform any professional services beyond the scope of the license authorized by this chapter.

(n) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client that is obtained from tests or other means.

(o) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(p) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. This subdivision does not prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (o).

(q) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(r) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device. A licensee shall limit access to that test or device to persons with professional interest who are expected to safeguard its use.

(s) Any conduct in the supervision of any registered associate, trainee, or applicant for licensure by any licensee that violates this chapter or any rules or regulations adopted by the board.

(t) Performing or holding oneself out as being able to perform mental health services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(u) Permitting an applicant for licensure, trainee, or registrant under one's supervision or control to perform, or permitting the supervisee to hold themselves out as competent to perform, mental health services beyond the supervisee's level of education, training, or experience.

(v) The violation of any law governing the gaining or supervision of experience required by this chapter.

(w) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(x) Failure to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(y) Failure to comply with the elder and dependent adult abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(z) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(aa) Failure to comply with Section 2290.5.

(ab) (1) Engaging in an act described in Section 261, 286, 287, or 289 of, or former Section 288a of, the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(ac) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of the examination as described in Section 123.

(BBS, L&S Code, 2020)

Or in other words, there are a whole bunch of ways to get into trouble, so be aware and make good decisions.

Chapter 4 – Applying Ethical Principles in Practice

As already covered, having a working knowledge of current laws and ethics empowers you both in being a more effective healthcare practitioner, and in strengthening you against the possibility of litigation, criminal action, or action against your license and livelihood. Although reviewing laws and regulations can be tedious, the violation of such and the consequences

that come, are worse. Laws, ethics and regulations also give the consumer confidence of what they can expect from you and will therefore be more likely to seek your services.

The importance of ethics in society is clear. Take the example of going to a mechanic...an evil, unethical mechanic. My wife took her car to one such person. Her car was making an unflattering noise. The mechanic told her he would need to replace the catalytic converter for close to \$1000. She took the car to another mechanic and he fixed it for under \$100. He just needed to replace a small part. Another, more recent example, is the issues we have with a plumber. We had a small leak in our home. The first plumber wanted over \$1000 to repair the leak and all it entailed. We were referred to a different handyman who only charged \$65.

Now, you could argue that most auto mechanics and plumbers are ethical and try to do the best they can and stand behind their work. However, one bad mechanic's or plumber's reputation can tarnish the reputation of all of them. When you practice your profession, you are not only representing yourself, but all licensed professionals in your field. What will clients tell their friends and family about their experience in therapy? What happens when a bad story hits the news? People who really need help will be reluctant to do so because of what they have heard.

A. An Ethical Philosophy of Practice

It is wise for every professional to have a philosophy of practice made up of principles and values that help guide their services. The professional codes of ethics help define these principles and values. The following is also an example of such principles "gathered from a variety of sources and experiences" by Dean H. Hepworth and Jo Ann Larsen (1986).

1. People are capable of making their own choices and decisions. Although controlled to some extent by their environment, they are able to direct their lives more than they realize. They always have freedom and responsibility to exercise in shaping their own lives.

2. Helping persons have a responsibility to assist people to achieve maximal independence. Clients grow in strength as social workers promote independent action.
3. Helping persons have a responsibility to work toward changing the environmental influences that adversely impact upon clients.
4. Human behavior is purposive and goal directed, although the purpose and goals are often not readily discernible.
5. People are capable of learning new behaviors. Helping professionals have a responsibility to assist people to discover and employ their strengths and to affirm their capacity to grow and change.
6. Although problems of living may stem from past relationships and events, and although limited focus on the past may be beneficial in some instances, most difficulties can be resolved by focusing on present choices and by mobilizing extant and latent strengths and coping patterns.
7. Problems of living are often produced by inadequate knowledge and/or coping mechanisms. By gaining knowledge and learning new skills, people often not only resolve difficulties, but also achieve personal growth in the process.
8. Many problems of living are societal and systemic rather than personal or interpersonal. By learning to implement effective strategies, people can effect changes in various types of systems.
9. Adversity is an inherent part of the human condition, but human beings grow in strength through meeting adversities. Life's crises, therefore, represent opportunities for growth and mastery as well as sources of strain.
10. Human beings want and need to have self-esteem. To gain and maintain self-esteem, people need confirmation of their worth from significant others (spouse, parents, children, other relatives, and friends). Many interpersonal conflicts are indirect expressions of not feeling loved and esteemed.
11. Human growth occurs in the context of relationships with other human beings. Growth in helping relationships is fostered by the power of love, as manifested by acceptance, respect, concern, encouragement, and affirmation of clients' self-worth.
12. A prized aspect of human growth is becoming an open, authentic person. Open, authentic behavior by social workers fosters like behavior in clients.

13. Another prized aspect of human growth is becoming attuned to, concerned about, and responsive to the needs of loved ones and other people.
14. To live in the reality of the present moment is to exercise potentialities more fully.
15. Means to an end are equally important as the ends themselves. Any means of assisting clients to achieve goals should safeguard dignity, self-esteem, self-determination, and confidentiality.
16. Awareness of self is the first step to self-realization; astute and sensitive understanding by social workers facilitates self-understanding by clients. A genuine desire to understand is a gift of the self.
17. Peoples' right to their own values and belief systems are inviolate. Nevertheless, certain values and beliefs lead to dysfunctional and self-defeating behavior. When such is the case, social workers have a responsibility to assist clients to face these aspects of their difficulties.

(Pages 20-21)

B. The complexities in managing ethical dilemmas

“[Healthcare professionals] will inevitably encounter ethical dilemmas in their work. Ethical dilemmas can impact on [professionals] positively or negatively, at a number of levels, and in a range of ways” (McAuliffe, 2005). There are some rules that are clear cut. Most of these are written as laws or regulations. Other issues that confront the healthcare professional are written in ethical codes or rules of organizations. Sometimes the ethics of an organization and that of a profession may conflict.

McAuliffe points out that “identification of ethical dilemmas in practice situations is not always an easy task. While the social work literature provides many examples of definitions of the term ‘ethical dilemma’, a useful construct has been provided by Rothman (1998) to assist in determining the ethical components of a case, in order to decide whether an ethical *dilemma* actually exists. Rothman suggests applying a ‘dilemma formulation’ to a practice situation that will reduce the conflicting principles to “_____ v. _____.” An example might be an agency

policy mandating communication to parents of their daughter's desire to obtain an abortion versus maintaining confidentiality of the client.

As mentioned before, no code or laws can be written to cover every possible issue of ethics as it relates to the healthcare professional and their clients. For example: most of us, (hopefully all of us) would agree that it is not okay to steal—in fact, it is absolutely wrong to steal. But is it wrong in all circumstances?

For example: Many are familiar with the story of Jean Valjean in Victor Hugo's book, *Les Miserables*. Jean Valjean steals a loaf of bread, a crime for which he is sentenced to prison. Was stealing the loaf of bread wrong? It was against the law. Or was there a greater wrong in not stealing the loaf of bread. Jean Valjean stole the bread to feed his sister's starving children. He was not able to provide food for them any other way he had tried. What is the worse crime: to steal the bread, or allow the child to starve?

Regardless of your answer to such a dilemma, it is a good bet that a number of people would disagree with you. So there are times when there is not a clear cut path but differing opinions as to what is the right decision in a given set of circumstances.

Another ethical dilemma was presented on the television show 24: Terrorists who had already shot down Air Force One, critically injured the President of the United States, and caused nuclear power plants to melt down where thousands died, have now gotten hold of a nuclear warhead, and the government does not know their location. They do, however, have an individual in custody who does know, and who has information that will help the agents recover the warhead and capture the terrorists responsible. The expectation is that the warhead will be used as quickly as possible. The man they have in custody refuses to talk. Should he be tortured in violation of all such rules and regulations to the treatment of suspects?

Again, there are strong arguments and doubtless strong opinions for both sides of this question. The point of this course is not to debate the validity of the arguments, but to present some of the complexities as it applies to laws and ethics. These examples illustrate that

there can be more than one answer to a problem, thus a dilemma is created. A dilemma is a situation where there are two competing principles that must be considered against each other. Either may seem like the right thing to do, or it may be a case of agency policy verses ethics.

“Further clarification has been offered about the distinction between technical, legal and ethical issues, with the latter referring to those problematic situations that in some way relate to rights, responsibilities and obligations that have a moral and value-based foundation (Banks, 2012). As the debate about ethics and practice standards inhabits a contextual and often contested landscape within social work, it is acknowledged that what constitutes an ethical dilemma for one social worker, may not necessarily constitute an ethical dilemma for another social worker – even within the same workplace or in relation to the same practice situation. It is important then, to recognise that when a social worker becomes involved in what they consider to be a moral quandary, this can be an intensely personal experience that can cut deep to the heart of entrenched personal values.”

(McAuliffe, 2005)

Let us consider ethical dilemmas that are similar to those healthcare providers may have to address. Healthcare providers often have to make difficult decisions as to which ethic should take precedence in different situations. For example, a practitioner may recognize that a particular agency policy is detrimental to a client, but may not want to question it because it may threaten their position in that agency, or create conflict in relationships with coworkers. Another dilemma occurs when the client confides information that indicates they are a threat to the health or well being of another person. Intervening in such a situation means disclosing confidential information to others. (Hepworth and Larsen, 1986)

F.G. Reamer developed a general guideline to assist providers in making difficult decisions they typically encounter. According to Reamer, “one’s actual duty in instances where prima facie duties conflict should be based on a determination of which duty is most necessary

for the performance of action and represents the least threat to the well-being of individuals” (p. 583)

What was that again? Prima Facie means “as it seems at first sight.”

The principles Reamer uses also help the practitioner in determining priorities in that “it is based on a ranking of goods and resources according to the extent to which they are necessary for individual well-being and the extent to which their absence threatens the opportunities and abilities of individuals to fulfill their intentions” (p. 583). **Reamer clarifies that “goods and resources can be ranked, qualitatively ranging from, on one hand, those which are necessary for the performance of any and all human action (life, physical health, food, shelter, and basic mental equilibrium) to, on the other, goods and resources which may enhance an individual’s ability to fulfill his or her goal but are not, in the strict sense, necessary for human action (excessive wealth, recreational facilities, and artistic artifacts.)” (Pp.583-34).**

It is obvious, then, that choices vital to enabling relevant others (clients, colleagues and employers) to take essential actions take precedence over choices that are less essential.

Reamer gives a specific situation of how these principles can be applied:

“The duty to save a human life would take precedence over the duty to keep information shared by a client confidential...because the former is more necessary for the possibility of human action (that is, represents a greater threat to basic human well-being) than is the latter. Thus, if conflicts force practitioners to make hard choices, protecting individuals from threats to life itself...is more important than for, for example, keeping information confidential, telling the truth, keeping promises, and avoiding deception.” (p. 584).

Ethical dilemmas in treatment may appear in many different scenarios. As a practitioner, you have seen, and will continue to see, all sorts of people with all sorts of problems—some you had probably not even considered to be in the realm of possibilities. McAuliffe studied

ethical dilemmas that different social workers have to address and the effects of having to address them. A couple of possible dilemmas are illustrated here:

Case 1: A client dying of AIDS makes a confidential request that you supply him with information about euthanasia. Is it your ethical responsibility to provide information to the client? Would you provide that information to the client? You may have very strong values that run contrary to euthanasia. Many religiously oppose it. If you are in agreement that it is somebody's right, what if you live in a state where it is illegal? Or, if it is legal, but against agency policy to provide such information. Also, do you make a note in the medical chart of his request, or even report it to somebody else? Or if you oppose it, but you live in a state where it is legal, do you provide the information to him?

Case 2: A client of a disability service requested that Nell, the social worker, arrange respite care for her child, as she was no longer able to cope. No respite care was available due to lack of resources. Nell decided to covertly assist the mother to 'abandon' the child so that she could receive emergency respite. The ethical dilemma, as framed by Nell, was that she assisted the mother to deceive the government, placing the client in a potentially difficult situation, and putting her own job at risk in the process. Was this the right thing to do?...the ethical thing to do?

Having to face such ethical dilemmas regularly can bring a lot of pressure on the practitioner. There can be explicit links between work-related stress and moral indecision, and stress caused by moral indecision may manifest on the emotional, cognitive, behavioral and physical levels, and could affect front-line workers either personally and/or professionally.

Healthcare Practitioners need to be mindful of the risks inherent in dealing with ethical dilemmas in direct practice settings. As ethical dilemmas, by their very nature, involve a conflict of principles, social workers need to be clear about what principles are underpinning quality practice, and the professional responses that are expected by colleagues, managers, employers, and clients.

Social workers are strongly urged to consult others, to evaluate personal and professional value positions, to establish the legal, organizational and policy context, and have a sound working knowledge of ethical codes and standards of conduct (Loewenberg, Dolgoff and Harrington 2012)

C. Having a clinical self-awareness and counter-transference issues

Practitioners need to have awareness if the goals of the client are uncomfortable to the practitioner for reasons of differing value systems. It is doubtful that practitioners will ever have identical value systems to those of their clients, so it is important to maintain a self awareness regarding how your values may impact the different stages of treatment.

“Certainly it is reasonable to assume that therapists who are upwardly mobile, socially marginal, non religious, divorced, and politically liberal will see social and moral issues differently from more socially integrated and conventional persons, and they will communicate quite different judgments. Because therapists’ personalities and orientations are important aspects of therapy, and because psychotherapy is largely an influence process, the encounter inevitable involves the transmission of values. Therapists may wish to minimize personal biases, however, but they cannot help but transmit what they stand for. (Mechanic, 1989)

Indeed, we certainly all have values. It is doubtful that we would have become healthcare professionals if we did not have a very strong belief system based on some closely held values regarding helping people. We must be aware of the counter-transference issues of those who see things differently, behave differently, or express themselves differently than what we are comfortable with. We are all influenced by where we grew up, our socio-culture context, our experiences, and even by the agency cultures we work in and the school of training we attended. We may not be conscious of our own ideologies and orientations because they are so much a part of how we view the world. We must be careful with these

values that we hold so dear that we do not go against the client's wishes, because they conflict with our own, or be careful that we automatically have a greater knowledge than the clients about what is best for them. (Mechanic, 1989)

When treating a client, issues of counter-transference (personal feelings and thoughts we have towards a client) will often exist that, going unchecked, can have harmful effects on the therapeutic process. These feelings may come up most strongly when somebody we treat resembles a person from our past in looks, mannerisms, behaviors, or opinions. These feelings can either be of fondness, as the client reminds us of a person we have good feelings for, or they can go to the other extreme, creating feelings in us of severe anger or fear. Maintaining a healthy self-awareness regarding counter-transference issues and obtaining consultation when needed are appropriate ways to make sure these feelings do not infringe on the treatment.

The following scenario can help increase awareness of our value system. This exercise, which is most enjoyable and effective when done as a group catalyst or a staff training, highlights how different cultures and upbringings cause people to make different judgments about the same circumstances. The activity is accomplished by passing out the story to each participant, having them rank the characters in the story, and then discussing why they ranked them as they did. Feel free to do it yourself:

A Case Study, Author Unknown:

The Girl, the Old Man, and the Sailor...

On a beautiful and sunny day five people boarded a boat for an afternoon cruise: A girl, her Fiancé, her Fiancé's Best Friend, an Old Man, and a Sailor. A sudden storm blew in, sinking the boat. The five passengers were forced into two smaller boats to survive. In one boat was the Girl, the Old Man, and the Sailor. In the other boat was the girl's Fiancé, and his best friend.

The boats were separated in the swirl of the storm. The boat with the Girl, the Old Man and the Sailor ended up on one island and the boat with the Fiancé and his Best Friend on another island. The Girl was distraught being away from her Fiancé and kept searching the horizon looking for him. They knew there was another island nearby but the boat would need to be fixed to get to it. She went to the Sailor and asked him to fix the boat so she could be re-united with her Fiancé. The Sailor agreed to fix the boat but only on the condition the Girl sleep with him that night.

The Girl did not know what to do so she went to the Old Man for advice. The Old Man listened to her and then said, "I cannot tell you what you should do. Follow what your heart tells you." Confused and desperate she agreed to the Sailor's condition.

After the Sailor fixed the boat they sailed and reached the other Island. The Girl was very happy to see her Fiancé and rushed into his arms. He was very happy to see her and she then told him about sleeping with the Sailor to get there. The Fiancé became very angry and brushed her aside saying, "I never want to see you again. Crying profusely the Girl began walking down the beach. The Fiancé's Best Friend followed her and after about a quarter of a mile came to her and said, "I know you two have had a quarrel. I will try to work it out, but in the meantime I will take care of you."

PLEASE RANK THE FIVE PEOPLE IN ORDER THAT YOU LIKE THEM OR VALUE THEM THE MOST (1 IS HIGHEST AND 5 LOWEST)

The Girl _____

The Fiancé _____

The Old Man _____


The Sailor _____

The Best Friend _____

There are many issues and questions that can make a difference in how people rank the characters. For example, some like the Old Man the best. Others are very angry with him because he offered the Girl no assistance. Others think the Fiancé's best friend is taking the opportunity to move in on the Girl, but what if the Fiancé's best friend is a woman? Some find the Girl to be immoral and at fault, while others are touched at her sacrifice and very upset with her Fiancé for not understanding. The case illustrates how culture and upbringing can result in different views of the same scenario.

This example adds cultural diversity as an aspect to ethical dilemmas. It is the responsibility of the healthcare practitioners to be aware of these cultural differences.

D. Consulting with another professional when in doubt

 **When an ethical dilemma is complex, or occasionally when we are too close to a situation, we have difficulty seeing things clearly. It is a good idea to have an experienced professional with whom you can consult. A good consultant should be very helpful in the different ethical situations that may come up. Sometimes just being able to bounce ideas off another person can help you see the situation clearer. Consultation should not violate the agreed upon confidentiality of the client. It should be conducted in such a way that the identification of the client is not violated, or that there is a written waiver for such consultation as part of informed consent. Standards state that the practitioners should provide the least amount of information about the client possible to have a productive consultation. (NASW, Code of Ethics, 2.05c)**

Another reason to refer a client is if the presenting issues are different than your current competencies or, as addressed later, the presenting issues are contrary to your value system in such a way as to interfere with treatment.

E. Having good judgment and using common sense

There is a saying that common sense is not so common. Well, if it were, we probably would not need so many rules and regulations and codes. Be that as it may, without good judgment and common sense, the healthcare practitioner will probably find themselves in trouble. Remember that whatever your decision, you are responsible for that decision. When making a decision you should take into consideration the construct you have learned regarding the priorities in making decisions, also, the client's best interest and how you would justify it in front of a review hearing. You need to feel that you could justify the decision in application to ethical principles. You are expected to follow not only the letter of the codes that govern ethics, but also the intent and "spirit" of them.

F. Clients right to informed consent

In order to provide services to an individual in voluntary settings they must be clear about what to expect from the services so they might provide informed consent. *This information includes appointment cancellation policies, limits of confidentiality, expected number of sessions and length of sessions, and agreement on the goals of treatment and policy of termination. In addition, it is a violation if "Prior to the commencement of treatment, [you fail] to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed."* (BBS Laws, p. 27) Along with fees there should be a clear policy on what happens when the client fails to pay fees. You also must have written informed consent prior to video taping sessions of clients. (AAMFT, Code of Ethics, 1.12)


G. Guidelines for Selecting and Defining Goals

As mentioned, part of informed consent is having clear and measurable goals decided upon in a process with the client. These guidelines offer assistance in formulating goals:

Goals must relate to the desired end result sought by the clients. The healthcare practitioner brings into therapy their own set of values and belief system about how people should behave and what makes somebody happy. When listening to a client's problem the provider needs to be wary of imposing their own

desires of therapeutic outcomes on the client. The client needs to feel the set goals are those they have had input on, and that the accomplishment of such goals will enhance their life situations. Clients will only pursue those goals to which they are emotionally invested; therefore, practitioners who define goals unilaterally or attempt to impose goals on clients are unlikely to enlist their cooperation. The client should be the final authority in deciding the goals of treatment, although the practitioner should take an active role in the goal setting process.

Goals should be defined in explicit and measurable terms

In order to ensure the desired results, goals must specifically define the desired end result. The client and the practitioner should be clear on their responsibilities to help meet the goals and how things will be different as a result of obtaining the goals. When goals are too general it is difficult to create a path which leads there.  **The following provides examples of general vs. specifically stated goals including the tools or activities learned in therapy to accomplish the goals:**

1. Global: Gain increased control over emotions.

Specific: Reduce frequency and intensity of anger outbursts by discerning cues that elicit anger, using internal dialogue that quiets anger, and applying relaxation procedures that counter anger.

2. Global: Improve social relations.

Specific: Approach others and initiate and maintain conversations by employing listening skills and furthering responses.

3. Global: Enhance social environment.

Specific: Obtain living arrangements in a center for elderly persons that provide social activities.



4. Global: Enhance self-esteem.

Specific: Arrest habitual negative self-statements by engaging in self-dialogue about their destructive consequences: align performance expectations with realistic criteria; attend to strengths and positive qualities; express silent self-approval when merited.

5. Global: Improve quality of parenting.

Specific: Demonstrate competence and responsibility in assuring continuous child care, planning and preparing nutritional meals, and maintaining adequate sanitary and hygienic conditions.

6. Global: Increase social participation in a group context.

Specific: Resolve fears of “looking stupid,” initiate discussion of personal views, ask questions, and participate in group exploring and problem-solving activities.

7. Global: Improve marital communication.

Specific: Express needs and wants to each other, listen without interrupting and check out meaning attributions, increase frequency of positive messages, avoid competitive interactions, reduce critical and blaming messages.

8. Global: Relate more comfortably with opposite sex.

Specific: Explore and resolve fears of rejections, introduce self and intimate conversation, ask for date, engage in appropriate activities.

Goals must be feasible. Practitioners should avoid setting goals with the client that are overly ambitious or most likely unattainable. As much as you would like to see all of the clients problems solved, and see them living at the highest levels of functioning, this is not realistic. Clients usually come to therapy because their life, their current behaviors, feelings, relationships and attitudes are not satisfactory for them. Goals should look to reach a level where their functioning becomes satisfactory for them again. Some clients may expect too much of themselves and/or their abilities, or environment may limit their level of goal attainment. If a client has a goal that is too grandiose, it is better to

divide such a hopeful accomplishment into measurable smaller pieces. This way the client can make incremental improvements and gain satisfaction in accomplishments.

Goals should be commensurate with the knowledge and skill of the practitioner.

Just as a client's abilities can determine the level and types of goals that are set, so can the abilities of the practitioner. You should agree to work with clients only on those goals for which you have requisite knowledge and skill. As in the medical profession, where doctors specialize in a variety of skills and service populations, so practitioners of therapy have some specific skills that are most useful for particular problems. It is not something to feel inadequate about, but rather understand that it is very difficult, with the variety of problems that a person may present in therapy, that you will be an expert in treating all of them. You can, however, work with the client on the goals that are within your scope and abilities.

Whenever possible, goals should be stated in positive terms that emphasize growth.

Define a goal in ways that stress growth or highlight beneficial changes or gains that will occur in the life of the client as a result of attaining the goal. In formulating goal statements, stipulating negative behaviors that must be eliminated tends to draw attention to what clients must give up. Defining goals in terms of gains rather than losses tends to enhance motivation and to mitigate opposition to change inherent in goal statements.



The following are examples of negative versus positive stated goals:

1. Negative: To reduce the frequency of criticism among family members.
Positive: To increase the family members' awareness of each other's strengths and to increase the frequency of positive messages.
2. Negative: To eliminate pouting and cold wars between marital partners.
Positive: To deal with disagreements openly, promptly, and constructively.

3. Negative: To eliminate subgroups and non-participatory behavior by group members.

Positive: To unite efforts of group members in working collectively and to draw each member into participation.

4. Negative: To eliminate or reduce the frequency of drinking binges.

Positive: To achieve ever-increasing periods of sobriety, taking one day at a time.

5. Negative: To eliminate yelling at the children and resorting to physical punishment.

Positive: To consistently apply new ways of influencing and disciplining children, such as utilizing “time out” procedures, increasing positive feedback, and employing a problem-solving approach with them.

Avoid agreeing to goals about which you have major reservations. If clients posed goals about which you have strong reservations because of contradicting your own moral values or life philosophies it is generally better to refer the client to another therapist. It is important, with sensitivity to explain why you are referring the client elsewhere. Occasionally, you may also have reservations about clients’ goals that appear to be potentially harmful to the physical or mental well-being of themselves or others. Examples can include clients who want help exacting revenge on another person, or try in devious means to regain custody of children, or who want you to falsely testify for them in court. In cases like these you should explain why you have misgivings about such goals and express a willingness to work on other goals that would be more beneficial to the client and others.

(Hepworth and Larsen, 1986)

H. Record Keeping

Records should be kept according to professional standards and laws. It is a good idea to document services at the conclusion of a therapy session, if that is the service provided. The record needs to reflect the services provided and the progress of the client and should help maintain continuity in services. Records should not contain every story and detail of the client's personal life. "...documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services." (NASW, Ethics, 3.04d) It is also important to safeguard client records so that confidentiality is maintained. Records, both clinical and financial should be kept as long as state law requires. Records disposed of should be done in such a way that protects the confidentiality of the client.

Chapter 5 - Setting and Maintaining Boundaries

Violations of professional boundaries are one of the most common ways that the healthcare practitioner violates ethical and legal regulations. Boundaries can be weakened in any number of ways, from accepting or giving gifts to clients, to having sexual relationships with them. The therapeutic relationship is often an intense sharing of intimate information. The client, dissatisfied with his or her own relationships is vulnerable and may try to fill that void with you. There are many therapists who have lost their professional standing and many clients who have been emotionally damaged as a result of such relationships. It is important that the healthcare practitioner does not engage in behaviors that weaken boundaries, no matter how innocent they may appear.

We all have a desire to be accepted, and there is some level of desire in each of us to be well liked. This is normal and healthy; however, if our desire for acceptance is so great, we may create relationships that are damaging to both the client and the health care practitioner. You must always be aware that you are not there to get your own needs met.

C. *The following is a list of some behaviors that weaken boundaries:*

- Physical contact
- Inappropriate dress
- Horseplay
- Divulging too much personal information like your own marriage problems, dating life, use of alcohol, etc.
- Language
- Allowing clients to break client therapist agreement
- Selling or buying items to or from clients
- Seeing each other outside of counseling sessions /socially
- Dating
- Extending individual sessions longer than agreed upon
- Longer term therapy than necessary
- Flirting
- Dual relationship: Serving client you know outside of the therapeutic relationship.

B. Behaviors which strengthen therapeutic boundaries include:

- Maintain appropriate space
- Appropriate dress
- Professional consultation
- Keep time and number of session to agreed upon amount.
- Setting limits
- Consistency
- Role model appropriate behavior
- No personal favors
- Reinforce definition of relationship.

C. The use of appropriate boundaries to enhance therapeutic outcomes

People come to counseling for various reasons: usually as a result of some type of dissatisfaction with themselves, their lives and/or their relationships. It is important for them to have a safe environment to share thoughts feelings and emotions. Clients offer a high level of vulnerability in sharing with therapists intimate personal details of their lives. When the client can feel that there is positive regard and respect for their feelings, and this is maintained through appropriate boundaries, then the relationship becomes a significant part of the therapy itself. If those boundaries are broken, then the client enters an environment that only repeats, but at a more intense level, the issues that are the cause of them coming to therapy.

Levels of self-disclosure play a large part in the therapeutic relationship that can damage or help the relationship depending on the motivation, timing and content of the disclosure. When not sure about what to disclose, it is probably best to follow the rule: less is more. Therapy is not about the therapist. Talking too much about yourself can weaken boundaries and redefine the relationship as something more social than therapeutic.

When a client attempts to break down or bend the boundaries the therapist must be prepared to reinforce the relationship in a way that is clear, but not harsh. Experience and consultation are two tools that will help you maintain appropriate boundaries.

D. Risks of poor boundaries – How did that happen?

Violations of legal and ethical boundaries do not usually occur suddenly. There is usually a process by which boundaries gradually are weakened until the therapist is before a disciplinary review board and asking him or herself, “How did that happen?” Maintaining the highest standards of ethics will keep you and your clients safe from what can turn out to be rather tragic events.

E. Illustration of How Boundaries may be Weakened

Jeff is a handsome 25 year-old man who is going through a divorce. The separation was initiated by his wife who was seeing a previous boyfriend. He does not have any children and Jeff describes his marriage as having been seemingly happy for them both, and says he still loves his wife. He wants to develop a meaningful relationship with another woman, but is somewhat insecure about going through the dating scene again.

The divorce dealt a major blow to his confidence and his willingness to trust someone to be close. That is the dilemma he presents: On the one hand he is lonely and would like to have a marital relationship again, on the other, he is insecure about initiating such a relationship and fearful what might occur if he does.

The therapist, a Licensed Clinical Social Worker named Anne, is a 32 year-old happily married woman with two children. She has been practicing for five years with a focus on couples therapy and families. She has counseled many individuals in relationships including males and has not had a problem with boundaries or inappropriate behaviors.

Anne notices that Jeff is not bad looking. She expresses empathic concern for his heartbreak and troubles. She feels for Jeff's sadness and he is very distraught. At the end of the first session, she thinks giving him a hug would be the natural thing to do to offer comfort. It is what she would do with a child, or even a woman who seemed to need such comfort. She chooses not to because at the moment she decides it would be a weakening of the boundaries.

In a later session, however, she justifies to herself that it would be okay to give Jeff hugs to comfort him. She finds herself being more aware of her personal appearance on the days that Jeff is scheduled to be seen. They are developing a rapport and Jeff seems to be getting happier as he adjusts to the separation from his wife. In helping Jeff with his insecurity of initiating relationships, Anne roll plays as a date partner in phone and date conversations. Jeff thanks Anne for her assistance but states he is still very worried about how things will go on a date. He asks her if they could have a practice date---just out to dinner or lunch. She is hesitant, but agrees as Jeff expresses his need for the help.

The Poor Choices

Throughout this case there are turning points and decisions that Anne makes that either strengthen the therapeutic boundaries, or weaken them. In most decisions Anne is weakening them, in addition to passing over or disregarding the warning signs that she is on a slippery slope to losing her license, her career, and even worse, maybe her family. Anne is being faced with the same type of decisions that nearly every healthcare provider faces. Anne did not intend to begin a dual relationship. She had heretofore been very careful. In this case she gradually made those decisions that created that relationship.

First, Anne found Jeff to be handsome. Depending on Anne's internal response to this, it may or may not be a problem in itself; however, it would at least put up a red flag for her to be careful with her own thoughts, behaviors and emotions and to keep them in check. There are different rules of thought in regards to hugging clients, regardless of their age or gender. In this case, Anne did show some awareness by not hugging him at the first session, but then justified it later. Decisions such as these when justified through the foggy lens of human emotion often end up being poor decisions.

It is next noted that she is becoming more aware of wanting to look attractive to Jeff. Being aware of one's personal appearance would be a positive thing (and one more therapists should pay attention to!), but the fact that she was paying extra attention in regards to how she would look to Jeff was a sure sign that her boundaries and feelings were going beyond the therapeutic relationship. Anne's self-awareness as a therapist should have been a warning bell, but she ignored it. It is doubtful that she was not aware of what she was doing, but she was ignoring the potential consequences. With the proper response, she may have referred Jeff to another therapist, or at least at this point, if she had not from the beginning, sought consultation.

The roll playing could have been a positive therapeutic technique, except that Anne had weakened the boundaries to the point where the roll play wasn't just a roll play, and obviously the practice date was not going to be just practice. Anne has then created a dual relationship under the guise of therapy, and the path, if she continued on it, becomes obviously difficult.

Fortunately, Anne suddenly got a hold of herself, realized what she was doing and where it was leading. She sought consultation and, instead of the practice date, asked Jeff to see her in the office for an appointment. In that appointment, as discussed in her consultation session, she stated to Mark that it was out of the scope of their therapy for her to go on a “practice date” with him, and that she should not have set such an appointment to do so. They discussed the progress that he had made thus far in his counseling and suggested to him that if he still felt a need to see a therapist that she could refer him to another very qualified therapist.

To her credit, Anne eventually stopped the relationship from moving further in the direction it was. It was unfortunate that she let it go as far as it did, having potentially harmed the client, depending on his response to it. This vignette illustrates the need for the provider to have vigilant self-awareness in order to maintain appropriate boundaries. The harm that comes from the failure to do so can be severe.

Chapter 6 -- Reporting Requirements and Issues

Mandatory reporting laws have been put in place to protect the most vulnerable among us. Mandated reporters are often times the first line of defense. It is crucial mandated reporters do just that: report. Others who have been trained and have further legal responsibilities will come assess and investigate the possible abuse. The mandated reporter does not need to determine if there has been abuse, only to suspect abuse and then report it. Reports typically include an immediate phone call and then a written report within the next day or so. The following are reporting laws for the state of California:

A. Child Abuse & Neglect

Mandated Reporter Requirements

As a Helping Professional you are a mandated reporter. The specific requirements for reporting in each State may be slight different. In this section we will first, review the reporting requirements for California, then Second, review the penalties in each state for failing to report.

The most common types of abuse are physical, sexual, and neglect. Healthcare practitioners are required to know the symptoms of child abuse and are mandated to report any suspicion of such abuse by the California Penal Code.

The following is a list of **mandatory reporters** of child abuse in the state of California. (**Bold Font** added)

(a) As used in this article, "**mandated reporter**" is defined as any of the following:

- (1) A teacher.
- (2) An instructional aide.
- (3) A teacher's aide or teacher's assistant employed by any public or private school.
- (4) A classified employee of any public school.
- (5) An administrative officer or supervisor of child welfare and attendance, or a certificated pupil personnel employee of any public or private school.
- (6) An administrator of a public or private day camp.
- (7) An administrator or employee of a public or private youth center, youth recreation program, or youth organization.
- (8) An administrator or employee of a public or private organization whose duties require direct contact and supervision of children.
- (9) Any employee of a county office of education or the California Department of Education, whose duties bring the employee into

contact with children on a regular basis.

(10) A licensee, an administrator, or an employee of a licensed community care or child day care facility.

(11) A Head Start program teacher.

(12) A licensing worker or licensing evaluator employed by a licensing agency.

(13) A public assistance worker.

(14) An employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities.

(15) A **social worker**, probation officer, or parole officer.

(16) An employee of a school district police or security department.

(17) Any person who is an administrator or presenter of, or a counselor in, a child abuse prevention program in any public or private school.

(18) A district attorney investigator, inspector, or local child support agency caseworker unless the investigator, inspector, or caseworker is working with an attorney appointed to represent a minor.

(19) A peace officer,

(20) A firefighter, except for volunteer firefighters.

(21) A physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, **licensed nurse**, dental hygienist, optometrist, **marriage, family and child counselor, clinical social worker, or any other person who is currently licensed**

(22) Any emergency medical technician I or II, paramedic

(23) A psychological assistant registered

(24) **A marriage, family, and child therapist trainee,**

(25) An **unlicensed marriage, family, and child therapist intern**

(26) A state or county public health employee who treats a minor for venereal disease or any other condition.

(27) A coroner.

(28) A medical examiner, or any other person who performs

autopsies.

(29) A commercial film and photographic print processor,

(30) A child visitation monitor.

(31) An animal control officer or humane society officer

(32) A clergy member

(33) Any custodian of records of a clergy member,

(34) Any employee of any police department, county sheriff's department, county probation department, or county welfare department.

(35) An employee or volunteer of a Court Appointed Special Advocate program

(36) A custodial officer

(37) Any person providing services to a minor child under Section 12300 or 12300.1 of the Welfare and Institutions Code.

(b) Except as provided in paragraph (35) of subdivision (a), volunteers of public or private organizations whose duties require direct contact with and supervision of children are not mandated reporters but are encouraged to obtain training in the identification and reporting of child abuse and neglect and are further encouraged to report known or suspected instances of child abuse or neglect to an agency specified in Section 11165.9.

(c) Employers are strongly encouraged to provide their employees who are mandated reporters with training in the duties imposed by this article. This training shall include training in child abuse and neglect identification and training in child abuse and neglect reporting. Whether or not employers provide their employees with training in child abuse and neglect identification and reporting, the employers shall provide their employees who are mandated reporters with the statement required pursuant to subdivision (a) of Section 11166.5.

(d) School districts that do not train their employees specified in subdivision (a) in the duties of mandated reporters under the child abuse reporting laws shall report to the State Department of Education the reasons why this training is not provided.

(e) Unless otherwise specifically provided, the absence of training shall not excuse a mandated reporter from the duties imposed by this article.

(f) Public and private organizations are encouraged to provide their volunteers whose duties require direct contact with and supervision of children with training in the identification and reporting of child abuse and neglect.” (CA Penal Code, 11165.7.)

To whom should the report be made?

Make sure that you have access to child abuse hotlines. Regardless of the information you have, you must make a report if you have a reasonable suspicion of the abuse. Reports must be made to those designated by law to take such reports. These include the police, probation department if designated to receive such reports, or county welfare department.

The code reads as follows:

“Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff’s department, not including a school district police or security department, county probation department, if designated by the county to receive mandated reports, or the county welfare department. Any of those agencies shall accept a report of suspected child abuse or neglect whether offered by a mandated reporter or another person, or referred by another agency, even if the agency to whom the report is being made lacks subject matter or geographical jurisdiction to investigate the reported case, unless the agency can immediately electronically transfer the call to an agency with proper jurisdiction. When an agency takes a report about a case of suspected child abuse or neglect in which that agency lacks jurisdiction, the agency shall immediately refer the case by telephone, fax, or electronic transmission to an agency with proper jurisdiction. (CA Penal Code, 11165.9)”

What does a **reasonable suspicion** mean?

“A "reasonable suspicion" means that *it is objectively reasonable for a person to entertain a suspicion*, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect **child abuse** or neglect.” (CA Penal Code, 11166)

What is the **reporting timetable**?

What are the possible legal penalties for **failing to report**?

Suspected child abuse must be reported immediately by telephone and followed up by a written report within 36 hours. Failure to do so can result in a \$1000 fine and/or six months of incarceration or both for each instance.

Penalties for Failure to Report and False Reporting of Child Abuse and Neglect

This section is sourced from the Child Welfare Information Gateway. (2019). *Penalties for failure to report and false reporting of child abuse and neglect*. Washington, DC: U.S. Department of Health and Human Services, Children’s Bureau.

To find statute information for a particular State, copy and paste this link:

<https://www.childwelfare.gov/topics/systemwide/laws-policies/state/>

Many cases of child abuse and neglect are not reported, even when mandated by law. Therefore, nearly every State and U.S. territory imposes penalties, often in the form of a fine or imprisonment, on mandatory reporters who fail to report suspected child abuse or neglect as required by law.¹ In addition, to prevent malicious or intentional reporting of cases that are not founded, many States and the U.S. Virgin Islands impose penalties against any person who files a report known to be false.

A. Penalties for Failure to Report

Approximately 49 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands impose penalties on mandatory reporters who knowingly or willfully fail to make a report when they suspect that a child is being abused

or neglected.¹ In Florida, a mandatory reporter who fails to report as required by law can be charged with a felony. Failure to report is classified as a misdemeanor or a similar charge in 40 States and American Samoa, Guam, and the Virgin Islands.² Misdemeanors are upgraded to felonies for failure to report more serious situations in Arizona (for a serious offense such as child prostitution or incest) and Minnesota (for when a child has died because of the lack of medical care). In Connecticut, Illinois, Kentucky, and Guam, second or subsequent violations are classified as felonies.

Twenty States and the District of Columbia, Guam, the Northern Mariana Islands, and the Virgin Islands specify in the reporting laws the penalties for a failure to report.³ Upon conviction, a mandated reporter who fails to report can face jail terms ranging from 30 days to 5 years, fines ranging from \$300 to \$10,000, or both jail terms and fines. In seven States, harsher penalties may be imposed under certain circumstances.⁴ In seven States and American Samoa, in addition to any criminal penalties, the reporter may be civilly liable for any damages caused by the failure to report.⁵

Florida imposes a fine of up to \$1 million on any institution of higher learning, including any State university and nonpublic college, who fails to report or prevents any person from reporting an instance of abuse committed on the property of the institution or at an event sponsored

¹ The word “approximately” is used to stress the fact that the States frequently amend their laws. This information is current through February 2019. Wyoming currently does not have a statute that imposes penalties on mandatory reporters for failure to report.

² Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey (charged as a disorderly person), New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, and West Virginia.

³ Alabama, California, Connecticut, Delaware, Florida, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, New Mexico, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

⁴ In California and Massachusetts, harsher penalties are imposed when the failure to report results in the child’s death or serious bodily injury. Louisiana imposes harsher penalties when the reporter fails to report sexual abuse or serious bodily injury. Delaware and Virginia impose harsher penalties upon second or subsequent convictions for failure to report. Vermont imposes its fine for failure to report when the reporter willfully fails to report with the intent to conceal the abuse. West Virginia imposes harsher penalties for failure to report the sexual assault of a child.

⁵ Arkansas, Colorado, Iowa, Michigan, Montana, New York, and Rhode Island.

by the institution. In Maryland, an agency participating in a child abuse or neglect investigation that has reason to suspect that a health-care practitioner, police officer, or educator has failed to report as required must file a complaint with that professional's respective licensing authority. In Missouri, a film or photographic film processor, computer technician, or internet provider who fails to report child pornography commits a misdemeanor.

a. Obstructing Reports of Abuse or Neglect

Approximately 10 States impose penalties against any employer who discharges, suspends, disciplines, or engages in any action to prevent or prohibit an employee or volunteer from making a report of suspected child maltreatment as required by the reporting laws.⁶ In six States, an action to prevent a report is classified as a misdemeanor.⁷ In Connecticut, an employer who interferes with making a report will be charged with a felony and may be subject to a civil penalty of up to \$2,500. Three States specify the penalties for that action,⁸ and in four States the employer is civilly liable for damages for any harm caused to the mandatory reporter.⁹

In Pennsylvania, a person commits a felony if he or she uses force, violence, or threat; offers a bribe to prevent a report; or has a prior conviction for the same or a similar offense. In Puerto Rico, any person who deliberately prevents another person from making a report commits a misdemeanor.¹⁰ In the Northern Mariana Islands, any person who is convicted of interfering with the good-faith efforts of any person making or attempting to make a report shall be subject to imprisonment for up to 1 year, or a fine of \$1,000, or both.

B. Penalties for False Reporting

Approximately 29 States and Puerto Rico carry penalties in their civil child protection laws for any person who willfully or intentionally makes a false report of child abuse or

⁶ Alabama, Arkansas, Connecticut, Maryland, Minnesota, North Dakota, Oklahoma, Pennsylvania, Vermont, and Wyoming.

⁷ Alabama, Arkansas, Maryland, North Dakota, Pennsylvania, and Wyoming.

⁸ Maryland (\$10,000, 5 years in jail, or both), Minnesota (\$10,000), and Wyoming (\$750, 6 months in jail, or both).

⁹ Minnesota, North Dakota, Oklahoma, and Vermont.

¹⁰ Upon conviction, the person is subject to a fine of up to \$5,000 or imprisonment of up to 90 days.

neglect.¹¹ In New York, Ohio, Pennsylvania, and the Virgin Islands, making false reports of child maltreatment is made illegal in criminal sections of State code.

Nineteen States and the Virgin Islands classify false reporting as a misdemeanor or similar charge.¹² In Florida, Illinois, Tennessee, and Texas, false reporting is a felony; while in Arkansas, Indiana, Missouri, and Virginia, second or subsequent offenses are upgraded to felonies. In Michigan, false reporting can be either a misdemeanor or a felony, depending on the seriousness of the alleged abuse in the report. No criminal penalties are imposed in California, Maine, Minnesota, Montana, and Nebraska; however, the immunity from civil or criminal action that is provided to reporters of abuse or neglect is not extended to those who make a false report. In South Carolina, in addition to any criminal penalties, the Department of Social Services may bring civil action against the person to recover the costs of investigation and any proceedings related to the investigation.

Eleven States, Puerto Rico, and the Virgin Islands specify the penalties for making a false report.¹³ Upon conviction, the reporter can face jail terms ranging from 90 days to 5 years or fines ranging from \$500 to \$5,000. Florida imposes the most severe penalties: In addition to a court sentence of 5 years and \$5,000, the Department of Children and Family Services may fine the reporter up to \$10,000. In six States, the reporter may be civilly liable for any damages caused by the report.¹⁴

C. Citation

The previous chapter was from the Child Welfare Information Gateway. (2019). *Penalties for failure to report and false reporting of child abuse and neglect*.

¹¹ Arizona, Arkansas, California, Colorado, Connecticut, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, North Dakota, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, and Wyoming.

¹² Arizona, Arkansas, Colorado, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Missouri, New York, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, Virginia, Washington, and Wyoming. In Iowa, a person who makes more than three reports regarding the same child victim or the same alleged abuser that are determined to be false or without merit may be subject to criminal charges.

¹³ Connecticut, Florida, Louisiana, Massachusetts, Michigan, Oklahoma, Rhode Island, South Carolina, Texas, Washington, and Wyoming.

¹⁴ California, Colorado, Idaho, Indiana, Minnesota, and North Dakota.

Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

D. Summaries of State Law

Alabama

Current Through February 2019

Failure to Report

Citation: Ala. Code §§ 26-14-3(g); 26-14-13

Commencing on August 1, 2013, a public or private employer who discharges, suspends, disciplines, or penalizes an employee solely for reporting suspected child abuse or neglect pursuant to this section shall be guilty of a class C misdemeanor.

Any person who knowingly fails to make the report required by the reporting laws shall be guilty of a misdemeanor and shall be punished by a sentence of not more than 6 months imprisonment or a fine of not more than \$500.

False Reporting

This issue is not addressed in the statutes reviewed.

Alaska

Current Through February 2019

Failure to Report

Citation: Alaska Stat. § 47.17.068

A person who fails to comply with the laws requiring reports of child abuse or neglect or child pornography and who knew or should have known that the circumstances gave rise to the need for a report is guilty of a class A misdemeanor.

False Reporting

This issue is not addressed in the statutes reviewed.

American Samoa

Current Through February 2019

Failure to Report

Citation: Ann. Code § 45.2002(d)

Any person who willfully violates the provisions of § 45.2002(a) (requiring certain persons to report) commits a class A misdemeanor and is liable for damages proximately caused.

False Reporting

This issue is not addressed in the statutes reviewed.

Arizona

Current Through February 2019

Failure to Report

Citation: Rev. Stat. § 13-3620(O), (P)

A person who violates this section requiring the reporting of child abuse or neglect is guilty of a class 1 misdemeanor, except if the failure to report involves a reportable offense, in which case the person is guilty of a class 6 felony.

A 'reportable offense' means any of the following:

- Any offense listed in chapters 14 and 35.1 of this title or § 13-3506.01
- Surreptitious photographing, videotaping, filming, or digitally recording or viewing a minor pursuant to § 13-3019
- Child prostitution pursuant to § 13-3212
- Incest pursuant to § 13-3608
- Unlawful mutilation pursuant to § 13-1214

False Reporting

Citation: Rev. Stat. § 13-3620.01

A person acting with malice who knowingly and intentionally makes a false report of child abuse or neglect, or a person acting with malice who coerces another person to make a false report of child abuse or neglect, is guilty of a class 1 misdemeanor.

A person who knowingly and intentionally makes a false report that another person made a false report is guilty of a class 1 misdemeanor.

Arkansas

Current Through February 2019

Failure to Report

Citation: Ann. Code §§ 12-18-201; 12-18-202; 12-18-206; 12-18-204

A mandated reporter commits the offense of failure to notify by a mandated reporter in the first degree if he or she has reasonable cause to suspect that a child has been subjected to or has died as a result of child maltreatment or observes a child being subjected to conditions or circumstances that would reasonably result in child maltreatment, and he or she knowingly fails to notify the child abuse hotline of the child maltreatment or suspected child maltreatment.

Failure to notify by a mandated reporter in the first degree is a class A misdemeanor.

A mandated reporter commits the offense of failure to notify by a mandated reporter in the second degree if he or she has reasonable cause to suspect that a child has been subjected to or has died as a result of child maltreatment or observes a child being subjected to conditions or circumstances that would reasonably result in child maltreatment, and he or she recklessly fails to notify the child abuse hotline of the child maltreatment or suspected child maltreatment.

Failure to notify by a mandated reporter in the second degree is a class C misdemeanor.

A mandated reporter who purposely fails to report as required is civilly liable for damages proximately caused by that failure.

An employer or supervisor of an employee who is a mandated reporter commits the offense of unlawful restriction of child abuse reporting if he or she does the following:

- Prohibits a mandated reporter from making a report of child maltreatment or suspected child maltreatment
- Requires that a mandated reporter receive permission or notify a person before the mandated reporter makes a report
- Knowingly retaliates against a mandated reporter for reporting child maltreatment or suspected child maltreatment Unlawful restriction of child abuse reporting is a class A misdemeanor.

False Reporting

Citation: Ann. Code § 12-18-203

A person commits the offense of making a false report under this chapter if he or she purposely and knowingly makes a report containing a false allegation to the child abuse hotline.

A first offense of making a false report under this chapter is a class A misdemeanor. A subsequent offense of making a false report under this chapter is a class D felony.

California

Current Through February 2019

Failure to Report

Citation: Penal Code §§ 11166(c); 11166.01

Any mandated reporter who fails to report an incident of known or reasonably suspected child abuse or neglect is guilty of a misdemeanor punishable by up to 6 months in a county jail or by a fine of \$1,000, or both. If a mandated reporter intentionally conceals his or her failure to report an incident known by the mandated reporter to be abuse or severe neglect, the failure to report is a continuing offense until an agency specified in § 11165.9 discovers the offense.

Any supervisor or administrator who violates § 11166(1) (that prohibits impeding others from making a report), shall be punished by not more than 6 months in a county jail or by a fine of not more than \$1,000, or both.

Any mandated reporter who willfully fails to report abuse or neglect, or any person who impedes or inhibits a report of abuse or neglect, where that abuse or neglect results in death or great bodily injury, shall be punished by not more than 1 year in a county jail or by a fine of not more than \$5,000, or both.

False Reporting

Citation: Penal Code § 11172(a)

Any person reporting a known or suspected instance of child abuse or neglect shall not incur civil or criminal liability as a result of any report, unless it can be proven that a false report was made and the person knew that the report was false or was made with reckless disregard of the truth or falsity of the report.

Any person who makes a report of child abuse or neglect known to be false or with reckless disregard of the truth or falsity of the report is liable for any damages caused.

Colorado

Current Through February 2019

Failure to Report

Citation: Rev. Stat. § 19-3-304(4)

Any mandatory reporter who willfully fails to report as required by § 19-3-304(1) commits a class 3 misdemeanor and shall be punished as provided by law and shall be liable for damages proximately caused

False Reporting

Citation: Rev. Stat. § 19-3-304(3.5), (4)

No person, including a mandatory reporter, shall knowingly make a false report of abuse or neglect to a county department or local law enforcement agency.

Any person who violates this provision commits a class 3 misdemeanor and shall be punished as provided by law and shall be liable for damages proximately caused.

Connecticut

Current Through February 2019

Failure to Report

Citation: Gen. Stat. §§ 17a-101a; 17a-101e(a)

Any mandated reporter who fails to report as required by law or fails to make such report within the time period prescribed by law shall be guilty of a class A misdemeanor. That person, however, shall be guilty of a class E felony if any of the following is true:

- The failure to report is a subsequent violation.
- The failure to report was willful, intentional, or due to gross negligence.
- The person had actual knowledge that a child was abused or neglected.

Any person who intentionally and unreasonably interferes with or prevents the making of a report pursuant to this section, or attempts or conspires to do so, shall be guilty of a class D felony. The provisions of this subdivision shall not apply to any child under age 18 or any person who is being educated by the Technical Education and Career System or a local or regional board of education, other than as part of an adult education program.

Any person found guilty under the provisions of this section shall be required to participate in an educational and training program.

The attorney general may bring an action in superior court against an employer who discharges or in any manner discriminates or retaliates against any in employee who in good faith makes a report of child abuse or neglect. The court may assess a civil penalty of no more than \$2,500 and may order such other equitable relief as the court deems appropriate.

False Reporting

Citation: Gen. Stat. § 17a-101e(c)-(d)

Any person who is alleged to have knowingly made a false report of child abuse or neglect shall be referred to the office of the Chief State's Attorney for purposes of a criminal investigation.

Any person who knowingly makes a false report of child abuse or neglect shall be fined not more than \$2,000 or imprisoned for not more than 1 year, or both.

Delaware

Current Through February 2019

Failure to Report

Citation: Ann. Code Tit. 16, § 914

Any person who violates § 903 of this title requiring certain persons to report suspected child abuse or neglect shall be liable for a civil penalty not to exceed \$10,000 for the first violation and not to exceed \$50,000 for any subsequent violation.

In any action brought under this section, if the court finds a violation, the court may award costs and attorneys' fees.

False Reporting

This issue is not addressed in the statutes reviewed.

District of Columbia

Current Through February 2019

Failure to Report

Citation: Ann. Code § 4-1321.07

Any person required to make a report under the reporting laws who willfully fails to make such a report shall be fined no more than the amount set forth in § 22-3571.01 (\$1,000) or imprisoned for no more than 180 days, or both.

False Reporting

This issue is not addressed in the statutes reviewed.

Florida

Current Through February 2019

Failure to Report

Citation: Ann. Stat. § 39.205(1)-(4)

A person who is required to report known or suspected child abuse and who knowingly and willfully fails to do so, or who knowingly and willfully prevents another person from doing so, commits a felony of the third degree, which is punishable as provided in §§ 775.082, 775.083, or 775.084. Upon conviction, the person may be punished as follows:

- Imprisoned for a term not to exceed 5 years

- Fined \$5,000

Unless the court finds that the person is a victim of domestic violence or that other mitigating circumstances exist, a person age 18 or older who lives in the same house or living unit as a child who is known or suspected to be a victim of child abuse and knowingly and willfully fails to report the child abuse commits a felony of the third degree.

Any Florida College System institution; State university; or nonpublic college, university, or school whose administrators knowingly and willfully, upon receiving information from faculty, staff, or other institution employees, fail to report known or suspected child abuse, abandonment, or neglect committed on the property of the university, college, or school or during an event or function sponsored by the university, college, or school, or who knowingly and willfully prevents another person from doing so, shall be subject to fines of \$1 million for each such failure.

Any Florida College System institution; State university; or nonpublic college, university, or school whose law enforcement agency fails to report known or suspected child abuse, abandonment, or neglect committed on the property of the university, college, or school or during an event or function sponsored by the university, college, or school shall be subject to fines of \$1 million for each such failure.

False Reporting

Citation: Ann. Stat. §§ 39.205(9); 39.206(1)

A person who knowingly and willfully makes a false report of child abuse, abandonment, or neglect, or who advises another to make a false report, is guilty of a felony of the third degree. Upon conviction, the person may be punished as follows:

- Imprisoned for a term not to exceed 5 years
- Fined \$5,000

In addition to any other penalty authorized by this section or other law, the Department of Children and Family Services may impose a fine, not to exceed \$10,000 for each violation, upon a person who knowingly and willfully makes a false report of abuse, abandonment, or neglect of a child or a person who counsels another to make a false report.

Georgia

Current Through February 2019

Failure to Report

Citation: Ann. Code § 19-7-5(h)

Any person or official required by law to report a suspected case of child abuse who knowingly and willfully fails to do so shall be guilty of a misdemeanor.

False Reporting

This issue is not addressed in the statutes reviewed.

Guam

Current Through February 2019

Failure to Report

Citation: Ann. Code Tit. 19, § 13207

Any person required to report who fails to report an instance of child abuse that he or she knows to exist or reasonably should know to exist is guilty of a misdemeanor that is punishable by imprisonment for a term not to exceed 6 months or a fine of no more than

\$1,000, or both.

A second or subsequent conviction shall be a felony in the third degree.

False Reporting

This issue is not addressed in the statutes reviewed.

[Hawaii](#)

Current Through February 2019

Failure to Report

Citation: Rev. Stat. § 350-1.2

Any mandatory reporter who knowingly prevents another person from reporting, or who knowingly fails to provide information as required by the reporting laws, shall be guilty of a petty misdemeanor.

False Reporting

This issue is not addressed in the statutes reviewed.

[Idaho](#)

Current Through February 2019

Failure to Report

Citation: Ann. Code § 16-1605(4)

Failure to report as required by the reporting laws shall be a misdemeanor.

False Reporting

Citation: Ann. Code § 16-1607

Any person who makes a report or allegation of child abuse, abandonment, or neglect knowing the report is false, or who reports or alleges the same in bad faith or with malice, shall be liable to the party or parties against whom the report was made for the amount of actual damages sustained or statutory damages of \$2,500, whichever is greater, plus attorney's fees and costs of suit.

If the court finds that the defendant acted with malice or oppression, the court may award treble actual damages or treble statutory damages, whichever is greater.

Illinois

Current Through February 2019

Failure to Report

Citation: Comp. Stat. Ch. 325, §§ 5/4.02; 5/4

Any physician who willfully fails to report suspected child abuse or neglect shall be referred to the Illinois State Medical Disciplinary Board for action in accordance with the Medical Practice Act of 1987. Any dentist or dental hygienist who willfully fails to report suspected child abuse or neglect shall be referred to the Department of Professional Regulation for action in accordance with the Illinois Dental Practice Act.

Any mandatory reporter who willfully fails to report suspected child abuse or neglect shall be guilty of a Class A misdemeanor for a first violation and a class 4 felony for a second or subsequent violation.

Any person who knowingly and willfully violates any provision of this section is guilty of a class A misdemeanor for a first violation and a class 4 felony for a second or subsequent violation.

If the person acted as part of a plan or scheme with the object of preventing discovery of an abused or neglected child by lawful authorities for the purpose of protecting or insulating any person or entity from arrest or prosecution, the person is guilty of a class 4 felony for a first offense and a class 3 felony for a second or subsequent offense (regardless of whether the second or subsequent offense involves any of the same facts or persons as the first or other prior offense).

False Reporting

Citation: Comp. Stat. Ch. 325, § 5/4

Any person who knowingly transmits a false report to the department commits the offense of disorderly conduct under Ch. 720, § 5/26.1(a)(7). A violation of this provision is a class 4 felony.

Indiana

Current Through February 2019

Failure to Report

Citation: Ann. Code § 31-33-22-1

A person who knowingly fails to make a report required by § 31-33-5-1 commits a class B misdemeanor.

A person who, in his or her capacity as a staff member of a medical or other institution, school, facility, or agency is required to make a report to the individual in charge of the institution, school, facility, or agency, or his or her designated agent, as required by § 31-33-5-2 or 31-33-5-2.5, and who knowingly fails to make a report commits a class B misdemeanor. This penalty is imposed in addition to the penalty imposed above.

False Reporting

Citation: Ann. Code § 31-33-22-3(a)-(b)

A person who intentionally communicates to a law enforcement agency or the Department of Child Services a knowingly false report of child abuse or neglect commits a class A misdemeanor. The offense is a level 6 felony if the person has a previous unrelated conviction for making a knowingly false report of child abuse or neglect.

A person who intentionally communicates to a law enforcement agency or the department a report of child abuse or neglect knowing the report to be false is liable to the person accused of child abuse or neglect for actual damages. The finder of fact may award punitive damages and attorney's fees in an amount determined by the finder of fact against the person.

Iowa

Current Through February 2019

Failure to Report

Citation: Ann. Stat. § 232.75(1)-(2)

Any person, official, agency, or institution required to report a suspected case of child abuse who knowingly and willfully fails to do so is guilty of a simple misdemeanor.

Any person, official, agency, or institution required by § 232.69 to report a suspected case of child abuse who knowingly fails to do so, or who knowingly interferes with the making of such a report in violation of § 232.70, is civilly liable for the damages proximately caused by such failure or interference.

False Reporting

Citation: Ann. Stat. §§ 232.75(3); 232.71B

A person who reports or causes to be reported to the Department of Human Services false information regarding an alleged act of child abuse, knowing that the information is false or that the act did not occur, commits a simple misdemeanor.

If the department receives more than three reports that identify the same child as a victim of child abuse or the same person as the alleged abuser of a child, or which were made by the same person, and the department determined the reports to be entirely false or without merit, the department shall provide information concerning the reports to the county attorney for consideration of criminal charges under § 232.75(3).

Kansas

Current Through February 2019

Failure to Report

Citation: Ann. Stat. § 38-2223(e)

Willful and knowing failure to make a report required by this section is a class B misdemeanor. It is not a defense that another mandatory reporter made a report.

Intentionally preventing or interfering with the making of a report required by this section is a class B misdemeanor.

False Reporting

Citation: Ann. Stat. § 38-2223(e)

Any person who willfully and knowingly makes a false report pursuant to this section or makes a report that such person knows lacks factual foundation is guilty of a class B misdemeanor.

Kentucky

Current Through August 2015

Failure to Report

Citation: Rev. Stat. § 620.030(6)

Any person who intentionally violates the provisions of this section shall be guilty of one of the following:

- A class B misdemeanor for the first offense
- A class A misdemeanor for the second offense

- A class D felony for each subsequent offense

False Reporting

Citation: Rev. Stat. § 620.050(1)

Any person who knowingly makes a false report and does so with malice shall be guilty of a class A misdemeanor.

Louisiana

Current Through February 2019

Failure to Report

Citation: Children’s Code Art. 609; Rev. Stat. § 14:403

Violation of the duties imposed upon a mandatory reporter subjects the offender to criminal prosecution.

Any person who is required to report the abuse or neglect of a child and knowingly and willfully fails to do so shall be fined no more than \$500 or imprisoned for no more than 6 months, or both.

Any person who is required to report the sexual abuse of a child or the abuse or neglect of a child that results in the serious bodily injury, neurological impairment, or death of the child and knowingly and willfully fails to report shall be fined no more than \$3,000 or imprisoned with or without hard labor for no more than 3 years, or both. The term ‘serious bodily injury’ includes, but is not limited to, injury involving protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ, or mental faculty; substantial risk of death; or injury resulting from starvation or malnutrition.

Notwithstanding the provisions above, any person who is age 18 or older who witnesses the sexual abuse of a child and knowingly and willfully fails to report the sexual abuse to law enforcement or to the Department of Children and Family Services, as required by law, shall be fined no more than \$10,000 or imprisoned with or without hard labor for no more than 5 years, or both.

False Reporting

Citation: Children’s Code Art. 609; Rev. Stat. § 14:403(A)(3)

The filing of a report that is known to be false may subject the offender to criminal prosecution.

Any person who reports a child as abused or neglected or sexually abused to the department or to any law enforcement agency knowing that such information is false shall be fined no more than \$500 or imprisoned for no more than 6 months, or both.

Maine

Current Through February 2019

Failure to Report

Citation: Rev. Stat. Tit. 22, § 4009

A person who knowingly violates a provision of this chapter commits a civil violation for which a forfeiture of not more than \$500 may be adjudged.

False Reporting

Citation: Rev. Stat. Tit. 22, § 4014(1)

Immunity from any criminal or civil liability for the act of reporting or participating in the investigation or proceeding is not extended in instances when a false report is made and the person knows the report is false. Nothing in this section may be construed to bar criminal or civil action regarding perjury.

Maryland

Current Through February 2019

Failure to Report

Citation: Fam. Law §§ 5-705.2; 5-705.4

An individual may not intentionally prevent or interfere with the making of a report of suspected abuse or neglect as required by law. A person who violates this section is guilty of a misdemeanor and, on conviction, is subject to imprisonment not exceeding 5 years or a fine not exceeding \$10,000, or both.

If an agency participating in an investigation under § 5-706 has substantial grounds to believe that a person has knowingly failed to report suspected abuse or neglect as required by § 5-704, the agency shall do any of the following:

- File a complaint with the appropriate licensing board in accordance with the provisions of the Health Occupations Article if the person is a health practitioner
- File a complaint with the appropriate law enforcement agency if the person is a police officer
- File a complaint with the county board of education or the appropriate agency, institution, or licensed facility at which the person is employed if the person is an educator or a human service worker

False Reporting

This issue is not addressed in the statutes reviewed.

Massachusetts

Current Through February 2019

Failure to Report

Citation: Gen. Laws Ch. 119, § 51A

Any mandatory reporter who fails to report shall be punished by a fine of not more than \$1,000.

Any mandated reporter who has knowledge of child abuse or neglect that resulted in serious bodily injury to or death of a child and willfully fails to report the abuse or neglect shall be punished by a fine of up to \$5,000 or imprisonment for no more than 2 ½ years or by both, and, upon a guilty finding or a continuance without a finding, the court shall notify any appropriate professional licensing authority of the mandated reporter's violation of this paragraph.

False Reporting

Citation: Gen. Laws Ch. 119, § 51A

Whoever knowingly and willfully files a frivolous report of child abuse or neglect under this section shall be punished as follows:

- A fine of no more than \$2,000 for the first offense
- Imprisonment for no more than 6 months and a fine of no more than \$2,000 for the second offense
- Imprisonment for no more than 2 ½ years and a fine of no more than \$2,000 for the third and subsequent offenses

Michigan

Current Through February 2019

Failure to Report

Citation: Comp. Laws § 722.633(1), (2)

A mandatory reporter who fails to report as required is civilly liable for the damages proximately caused by the failure.

A mandatory reporter who knowingly fails to report as required is guilty of a misdemeanor punishable by one or both of the following:

- Imprisonment for not more than 93 days
- A fine of not more than \$500

False Reporting

Citation: Comp. Laws § 722.633(5)

Any person who intentionally makes a false report of child abuse or neglect knowing that the report is false is guilty of a crime as follows:

- If the child abuse or neglect would not constitute a crime but would constitute a misdemeanor if the report were true, the person is guilty of a misdemeanor punishable by imprisonment for not more than 93 days or a fine of not more than \$100, or both.
- If the child abuse or neglect reported would constitute a felony if the report were true, the person is guilty of a felony punishable by the lesser of the following:
 - » The penalty for the child abuse or neglect falsely reported
 - » Imprisonment for not more than 4 years or a fine of not more than \$2,000, or both

Minnesota

Current Through February 2019

Failure to Report

Citation: Ann. Stat. § 626.556, Subd. 4a; 6

An employer of any person required to make reports shall not retaliate against the person for reporting in good faith abuse or neglect pursuant to this section, or against a child with respect to whom a report is made, because of the report. The employer of any person required to report who retaliates against the person because of a report of abuse or neglect is liable to that person for actual damages and, in addition, a penalty up to \$10,000. There shall be a rebuttable presumption that any adverse action within 90 days of a report is retaliatory.

A mandatory reporter who knows or has reason to believe that a child is neglected or physically or sexually abused or has been neglected or physically or sexually abused within the preceding 3 years, and fails to report the abuse, is guilty of a misdemeanor.

A mandatory reporter who knows or has reason to believe that two or more children not related to the perpetrator have been physically or sexually abused by the same perpetrator within the preceding 10 years and fails to report is guilty of a gross misdemeanor.

A parent, guardian, or caregiver who knows or reasonably should know that the child's health is in serious danger and who fails to report:

- Is guilty of a gross misdemeanor if the child suffers substantial or great bodily harm because of the lack of medical care

- Is guilty of a felony if the child dies because of the lack of medical care and may be subject to one or both of the following:

- » Imprisonment for not more than 2 years

- » A fine of not more than \$4,000

The law providing that a parent, guardian, or caregiver may, in good faith, select and depend on spiritual means or prayer for treatment or care of a child does not exempt a parent, guardian, or caregiver from the duty to report under this provision.

False Reporting

Citation: Ann. Stat. § 626.556, Subd. 5

Any person who knowingly or recklessly makes a false report under the reporting laws shall be liable in a civil suit for any actual damages suffered by the person(s) so reported and for any punitive damages set by the court or jury, plus costs and reasonable attorney fees.

Mississippi

Current Through February 2019

Failure to Report

Citation: Ann. Code. § 43-21-353(7)

Anyone who willfully violates any provision of this section shall be, upon being found guilty, punished by a fine not to exceed \$5,000 or by imprisonment in jail not to exceed 1 year, or both.

False Reporting

This issue is not addressed in the statutes reviewed.

Missouri

Current Through February 2019

Failure to Report

Citation: Ann. Stat. §§ 210.165(1); 573.215

Any person violating any provision of the reporting laws is guilty of a class A misdemeanor.

A person commits the offense of failure to report child pornography if he or she, being a film and photographic print processor, computer provider, installer or repair person, or any internet service provider who has knowledge of or observes, within the scope of the person's professional capacity or employment, any film, photograph, videotape,

negative, slide, or computer-generated image or picture depicting a child under age 18 engaged in an act of sexual conduct fails to report such instance to any law enforcement agency immediately or as soon as practically possible.

The offense of failure to report child pornography is a class B misdemeanor.

Nothing in this section shall be construed to require a provider of electronic communication services or remote computing services to monitor any user, subscriber, or customer of the provider or the content of any communication of any user, subscriber, or customer of the provider.

False Reporting

Citation: Ann. Stat. § 210.165(2)-(3)

Any person who intentionally files a false report of child abuse or neglect shall be guilty of a class A misdemeanor.

Every person who has been previously convicted of making a false report to the Children's Division or its predecessor agency, the Division of Family Services, and who is subsequently convicted of making a false report is guilty of a class E felony and shall be punished as provided by law.

Montana

Current Through February 2019

Failure to Report

Citation: Ann. Code § 41-3-207

Any mandatory reporter who fails to report known or suspected child abuse or neglect or who prevents another person from reasonably doing so is civilly liable for the damages proximately caused by such failure or prevention. Any mandatory reporter who purposely or knowingly fails to report when required or purposely or knowingly prevents another person from doing so is guilty of a misdemeanor.

False Reporting

Citation: Ann. Code § 41-3-203(1)

Anyone reporting any incident of child abuse or neglect as required by law is immune from any liability, civil or criminal, that might otherwise be incurred or imposed unless the person was grossly negligent, acted in bad faith or with malicious purpose, or provided information knowing the information to be false.

Nebraska

Current Through February 2019

Failure to Report

Citation: Rev. Stat. § 28-717

Any person who willfully fails to make any report of child abuse or neglect required by § 28-711 shall be guilty of a class III misdemeanor.

False Reporting

Citation: Rev. Stat. § 28-716

Any person participating in an investigation, making a report of child abuse or neglect, or participating in a judicial proceeding resulting from a report shall be immune from any liability, civil or criminal, that might otherwise be incurred or imposed, except for maliciously false statements.

Nevada

Current Through February 2019

Failure to Report

Citation: Rev. Stat. § 432B.240

Any person who knowingly and willfully violates the provisions of § 432B.220 is guilty of one of the following:

- For the first violation, a misdemeanor
- For each subsequent violation, a gross misdemeanor

False Reporting

This issue is not addressed in the statutes reviewed.

New Hampshire

Current Through February 2019

Failure to Report

Citation: Rev. Stat. § 169-C:39

Anyone who knowingly violates any provision of the reporting laws shall be guilty of a misdemeanor.

False Reporting

This issue is not addressed in the statutes reviewed.

New Jersey

Current Through February 2019

Failure to Report

Citation: Ann. Stat. § 9:6-8.14

Any person knowingly violating the reporting laws, including the failure to report an act of child abuse while having reasonable cause to believe that an act of child abuse has been committed, is a disorderly person.

False Reporting

This issue is not addressed in the statutes reviewed.

New Mexico

Current Through February 2019

Failure to Report

Citation: Ann. Stat. § 32A-4-3(F)

Any person who violates the provisions of this section pertaining to the duty to report is guilty of a misdemeanor and shall be sentenced pursuant to § 31-19-1.

Upon conviction, the person shall be imprisoned in the county jail for a definite term that is less than 1 year, be fined not more than \$1,000, or both, at the discretion of the judge.

False Reporting

This issue is not addressed in the statutes reviewed.

New York

Current Through February 2019

Failure to Report

Citation: Soc. Serv. Law § 420

Any mandatory reporter who willfully fails to report as required shall be guilty of a class A misdemeanor.

Any mandatory reporter who knowingly and willfully fails to report as required shall be civilly liable for the damages proximately caused by such failure.

False Reporting

Citation: Penal Law § 240.50(4)

A person is guilty of falsely reporting an incident in the third degree when, knowing the information reported, conveyed, or circulated to be false or baseless, he or she reports, by word or action, an alleged occurrence or condition of child abuse or maltreatment that did not in fact occur or exist to the following:

- The statewide central register of child abuse and maltreatment
- Any person required to report cases of suspected child abuse or maltreatment, knowing that the person is required to report such cases, and with the intent that such an alleged occurrence be reported to the statewide central register

Falsely reporting an incident in the third degree is a class A misdemeanor.

North Carolina

Current Through February 2019

Failure to Report

Citation: Gen. Stat. § 7B-301

Any person or institution who knowingly or wantonly fails to report the case of a juvenile as required, or who knowingly or wantonly prevents another person from making a report as required, is guilty of a class 1 misdemeanor.

A director of social services who receives a report of sexual abuse of a juvenile in a child care facility and who knowingly fails to notify the State Bureau of Investigation of the report as required is guilty of a class 1 misdemeanor.

False Reporting

This issue is not addressed in the statutes reviewed.

North Dakota

Current Through February 2019

Failure to Report

Citation: Cent. Code §§ 50-25.1-13; 50-25.1-09.1

Any person required by this chapter to report or to supply information concerning a case of known or suspected child abuse, neglect, or death resulting from abuse or neglect who willfully fails to do so is guilty of a class B misdemeanor.

An employer who retaliates against an employee solely because the employee in good faith reported having reasonable cause to suspect that a child was abused or neglected, died as a result of abuse or neglect, or because the employee is a child with respect to whom a report was made, is guilty of a class B misdemeanor. It is a defense to any charge brought under this section that the presumption of good faith, described in § 50-25.1-09, has been rebutted.

The employer of a person required or permitted to report pursuant to § 50-25.1-03 who retaliates against the person because of a report of abuse or neglect, or a report of a death resulting from child abuse or neglect, is liable to that person in a civil action for all damages, including exemplary damages, costs of the litigation, and reasonable attorney's fees.

False Reporting

Citation: Cent. Code § 50-25.1-13

Any person who willfully makes a false report or provides false information that causes a report to be made is guilty of a class B misdemeanor, unless the false report is made to a law enforcement official, in which case the person who causes the report to be made is guilty of a class A misdemeanor.

A person who willfully makes a false report or willfully provides false information that causes a report to be made also is liable in a civil action for all damages suffered by the person reported, including exemplary damages.

Northern Mariana Islands

Current Through February 2019

Failure to Report

Citation: Commonwealth Code Tit. 6, §§ 5315; 5316

Knowing or willful failure of any person to make a report pursuant to § 5313 shall, upon conviction, be punished by one or both of the following:

- Imprisonment for up to 1 year
- A fine of not more than \$1,000

Knowing or willful interference by any person with the good-faith efforts of any person making or attempting to make a report under this chapter shall, upon conviction, be punished by imprisonment for up to 1 year or a fine of \$1,000, or both.

False Reporting

This issue is not addressed in the statutes reviewed.

Ohio

Current Through February 2019

Failure to Report

Citation: Rev. Code § 2151.99

Any person who fails to report suspected child abuse or neglect, as required by § 2151.421, is guilty of a misdemeanor of the fourth degree.

Any person required to report by § 2151.421(A)(4) (requiring reports by clergy) who fails to report when knowing that a child has been abused or neglected and knowing that the person who committed the abuse or neglect was a cleric or another person other than a volunteer designated by a church, religious society, or faith to act as a leader, official, or delegate on behalf of the church, religious society, or faith is guilty of a misdemeanor of the first degree if the person who has failed to report and the person who committed the abuse or neglect belong to the same church, religious society, or faith.

The person who fails to report is guilty of a misdemeanor of the first degree if the child suffers or faces the threat of suffering the physical or mental wound, injury, disability, or condition that would be the basis of the required report when the child is under the direct care or supervision of another person over whom the offender has supervisory control.

False Reporting

Citation: Rev. Code § 2921.14

No person shall knowingly make or cause another person to make a false report alleging that any person has committed an act or omission that resulted in a child being abused or neglected.

Whoever violates this section is guilty of making or causing a false report of child abuse or child neglect, a misdemeanor of the first degree.

Oklahoma

Current Through February 2019

Failure to Report

Citation: Ann. Stat. Tit. 10A, § 1-2-101(B)(4); (C)

Any employer, supervisor, or administrator who discharges, discriminates, or retaliates against the employee or other person shall be liable for damages, costs, and attorney fees.

Any person who knowingly and willfully fails to promptly report suspected child abuse or neglect or who interferes with the prompt reporting of suspected child abuse or

neglect may be reported to local law enforcement for criminal investigation and, upon conviction thereof, shall be guilty of a misdemeanor.

False Reporting

Citation: Ann. Stat. Tit. 10A, § 1-2-101(D)

Any person who knowingly and willfully makes a false report pursuant to the provisions of this section or a report that the person knows lacks factual foundation may be reported to local law enforcement for criminal investigation and, upon conviction thereof, shall be guilty of a misdemeanor.

If a court determines that an accusation of child abuse or neglect made during a child custody proceeding is false and the person making the accusation knew it to be false at the time the accusation was made, the court may impose a fine, not to exceed \$5,000 and reasonable attorney fees incurred in recovering the sanctions, against the person making the accusation. The remedy provided by this paragraph is in addition to the first paragraph above or to any other remedy provided by law.

Oregon

Current Through February 2019

Failure to Report

Citation: Rev. Stat. § 419B.010(3)

A person who violates the reporting laws commits a class A violation. Prosecution under this law shall be commenced at any time within 18 months after the commission of the offense.

False Reporting

Citation: Rev. Stat. § 419B.016

A person commits the offense of making a false report of child abuse if, with the intent to influence a custody, parenting time, visitation, or child support decision, the person:

- Makes a false report of child abuse to the Department of Human Services or a law enforcement agency, knowing that the report is false
- Makes a false report of child abuse to a public or private official knowing that the report is false and with the intent that the public or private official make a report of child abuse to the department or a law enforcement agency

Making a false report of child abuse is a class A violation.

Pennsylvania

Current Through February 2019

Failure to Report

Citation: Cons. Stat. Tit. 23, § 6319; Tit. 18, § 4958

A mandatory reporter who willfully fails to report as required commits a misdemeanor of the third degree for the first violation and a misdemeanor of the second degree for a second or subsequent violation.

A person commits an offense if:

- The person acts to obstruct, impede, impair, prevent, or interfere with making a child abuse report, conducting of an investigation, or prosecuting a child abuse case.
- The person intimidates or attempts to intimidate any reporter, victim, or witness to engage in any of the following actions:
 - » Refrain from making a report of suspected child abuse
 - » Refrain from providing or withholding information, documentation, testimony, or evidence to any person regarding a child abuse investigation or proceeding
 - » Give false or misleading information, documentation, testimony, or evidence regarding a child abuse investigation or proceeding
 - » Elude, evade, or ignore any request or legal process summoning the reporter, victim, or witness to appear to testify or supply evidence regarding a child abuse investigation or proceeding
 - » Fail to appear at or participate in a child abuse proceeding or meeting involving a child abuse investigation to which the reporter, victim, or witness has been legally summoned

A person commits an offense if the person harms another person by any unlawful act or engages in a course of conduct that threatens another person in retaliation for anything that the other person has lawfully done in the capacity of a reporter, witness, or victim of child abuse.

A violation of this section is a felony of the second degree if the person:

- Uses force, violence, deception, or threat upon the reporter, witness, or victim
- Offers pecuniary or other benefit to the reporter, witness, or victim
- Has a prior conviction for a violation of this section or a similar law

An offense not otherwise addressed above is a misdemeanor of the second degree.

False Reporting

Citation: Cons. Stat. Tit. 18, § 4906.1

A person commits a misdemeanor of the second degree if the person intentionally or knowingly makes a false report of child abuse under chapter 23 (relating to child protective services) or intentionally or knowingly induces a child to make a false claim of child abuse.

Puerto Rico

Current Through February 2019

Failure to Report

Citation: Ann. Laws Tit. 8, § 450a

Any person, official, or public or private institution with the obligation of furnishing information pursuant to the provisions of either

§ 444 or 446 and who voluntarily and deliberately fails to comply with that obligation, who fails to perform any other act required by this chapter, or deliberately prevents another person acting reasonably from doing so shall commit a misdemeanor and if convicted shall be sanctioned by a fine up to \$5000 or by imprisonment up to 90 days.

False Reporting

Citation: Ann. Laws Tit. 8, § 450a

Any person, official, or public or private institution with the obligation of furnishing information pursuant to the provisions of either

§ 444 or 446 who deliberately furnishes false information or advises another person to do so shall commit a misdemeanor and if convicted shall be sanctioned by a fine up to \$5000 or by imprisonment up to 90 days. Any information furnished that is found to be false and whose natural or probable consequence is deemed to have interfered in the legitimate exercise of custody, parental rights, and patria potestas shall be referred by the competent authority to the Department of Justice for evaluation and the subsequent corresponding prosecution.

Rhode Island

Current Through February 2019

Failure to Report

Citation: Gen. Laws § 40-11-6.1

Any mandatory reporter who knowingly fails to report as required or who knowingly prevents any person acting reasonably from doing so shall be guilty of a

misdemeanor and, upon conviction, shall be subject to a fine of not more than \$500 or imprisonment for not more than 1 year or both.

In addition, any mandatory reporter who knowingly fails to perform any act required by the reporting laws or who knowingly prevents another person from performing a required act shall be civilly liable for the damages proximately caused by that failure.

False Reporting

Citation: Gen. Laws § 40-11-3.2

Any person who knowingly and willingly makes or causes a false report of child abuse or neglect to be made to the Department of Children, Youth and Families shall be guilty of a misdemeanor and, upon conviction thereof, shall be fined not more than \$1,000 or imprisoned for not more than 1 year or both.

South Carolina

Current Through February 2019

Failure to Report

Citation: Ann. Code § 63-7-410

Any mandatory reporter or any person required to perform any other function under the reporting laws who knowingly fails to do so, or a person who threatens or attempts to intimidate a witness, is guilty of a misdemeanor and, upon conviction, must be fined not more than \$500 or be imprisoned for not more than 6 months, or both.

False Reporting

Citation: Ann. Code §§ 63-7-430; 63-7-440

If the family court determines that a person has made a report of suspected child abuse or neglect maliciously or in bad faith, or if a person has been found guilty of making a false report pursuant to § 63-7-440, the Department of Social Services may bring a civil

action to recover the costs of the department's investigation and proceedings associated with the investigation, including attorney's fees. The department also is entitled to recover costs and attorney's fees incurred in the civil action authorized by this section. The decision of whether to bring a civil action is in the sole discretion of the department.

If the family court determines that a person has made a false report of suspected child abuse or neglect maliciously or in bad faith or if a person has been found guilty of making a false report, a person who was subject of the false report has a civil cause of action against the person who made the false report and is entitled to recover from the person who made the false report such relief as may be

appropriate, including actual damages, punitive damages, a reasonable attorney's fee, and other litigation costs reasonably incurred.

It is unlawful to knowingly make a false report of abuse or neglect. A person who violates this section is guilty of a misdemeanor and, upon conviction, must be fined not more than \$5,000 or imprisoned for not more than 90 days, or both.

South Dakota

Current Through February 2019

Failure to Report

Citation: Ann. Stat. §§ 26-8A-3; 26-8A-4; 26-8A-6; 26-8A-7

Any mandatory reporter who knowingly and intentionally fails to make the required report is guilty of a class 1 misdemeanor. This provision includes the following:

- Reports that must be made to the coroner when the reporter suspects that a child has died as a result of abuse or neglect
- Reports that are required of hospital staff
- Reports that are required of staff of public or private schools

False Reporting

This issue is not addressed in the statutes reviewed.

Tennessee

Current Through February 2019

Failure to Report

Citation: Ann. Code § 37-1-412

Any person who knowingly fails to make a report required by § 37-1-403 commits a class A misdemeanor.

A person believed to have violated this section shall be brought before the court. If the defendant pleads not guilty, the juvenile court judge shall bind the defendant over to the grand jury. If the defendant pleads guilty, the juvenile court judge shall sentence the defendant under this section with a fine not to exceed \$2,500.

False Reporting

Citation: Ann. Code § 37-1-413

Any person who either verbally or by written or printed communication knowingly and maliciously reports or causes, encourages, aids, counsels, or procures another to report a false accusation of child sexual abuse, or false accusation that a child has

sustained any wound, injury, disability, or physical or mental condition caused by brutality, abuse, or neglect, commits a class E felony.

Texas

Current Through February 2019

Failure to Report

Citation: Fam. Code § 261.109

A person commits an offense if the person is required to make a report under § 261.101 and knowingly fails to make a report as required.

A person who is a professional as defined by § 261.101 commits an offense if the person is required to make a report and knowingly fails to make a report as provided in this chapter.

An offense by a person is a class A misdemeanor, except that the offense is a State jail felony if it is shown on the trial of the offense that the child was a person with an intellectual disability who resided in a State-supported living center, the medical assistance program for persons with intellectual disabilities component of the Rio Grande State Center, or a facility licensed under chapter 252, Health and Safety Code, and the actor knew that the child had suffered serious bodily injury as a result of the abuse or neglect.

An offense by a professional is a class A misdemeanor, except that the offense is a State jail felony if it is shown on the trial of the offense that the actor intended to conceal the abuse or neglect.

False Reporting

Citation: Fam. Code § 261.107

A person commits an offense if, with the intent to deceive, he or she knowingly makes a report of child abuse or neglect that is false. An offense under this subsection is either of the following:

- A State jail felony
- A felony of the third degree if the person has previously been convicted under this section. A person who is convicted of an offense under this section shall be subject to the following:
 - Be required to pay any reasonable attorney's fees incurred by the person who was falsely accused of abuse or neglect
 - Be liable to the State for a civil penalty of \$1,000

Utah

Current Through February 2019

Failure to Report

Citation: Ann. Code § 62A-4a-411

Any person, official, or institution required to report a case of suspected child abuse, child sexual abuse, neglect, fetal alcohol syndrome, or fetal drug dependency who willfully fails to do so is guilty of a class B misdemeanor.

Action for failure to report must be commenced within 4 years from the date of knowledge of the offense and the willful failure to report.

False Reporting

This issue is not addressed in the statutes reviewed.

Vermont

Current Through February 2019

Failure to Report

Citation: Ann. Stat. Tit. 33, § 4913(d)(2); (f)

An employer or supervisor shall not discharge; demote; transfer; reduce pay, benefits, or work privileges; prepare a negative work performance evaluation; or take any other action detrimental to any employee because that employee filed a good faith report in accordance with the provisions of this subchapter. Any person making a report under this subchapter shall have a civil cause of action for appropriate compensatory and punitive damages against any person who causes detrimental changes in the employment status of the reporting party by reason of his or her making a report.

A person who violates the law requiring mandated reporters to report suspected child abuse or neglect shall be fined no more than \$500.

A person who violates the reporting laws with the intent to conceal abuse or neglect of a child shall be imprisoned no more than 6 months or fined for no more than \$1,000, or both.

False Reporting

This issue is not addressed in the statutes reviewed.

Virgin Islands

Current Through February 2019

Failure to Report

Citation: Ann. Code Tit. 5, § 2539

Any person, official, or institution required by this subchapter to report a case of alleged child abuse, sexual abuse, or neglect or to perform any other act, who knowingly fails to do so, shall be guilty of a misdemeanor and shall be fined no more than \$500 or imprisoned for no more than 1 year, or both.

False Reporting

Citation: Ann. Code Tit. 14, §§ 2146(c); 2144(a)

A person is guilty of falsely reporting an incident in the second degree when, knowing the information reported, conveyed, or circulated to be false or baseless, he or she reports, by word or action, to the Department of Human Services or Department of Health an alleged occurrence of child abuse or maltreatment that did not, in fact, occur or exist. A person who is found guilty of reporting an incident in the second degree shall be fined \$5,000 and be imprisoned for no less than 5 years.

Virginia

Current Through February 2019

Failure to Report

Citation: Ann. Code § 63.2-1509(D)-(E)

Any person required to file a report pursuant to this section who fails to do so as soon as possible, but no longer than 24 hours after having reason to suspect a reportable offense of child abuse or neglect, shall be fined no more than \$500 for the first failure and, for any subsequent failures, no less than \$1,000. In cases evidencing acts of rape, sodomy, or object sexual penetration, as defined in § 18.2-61, et seq., a person who knowingly and intentionally fails to make the report required pursuant to this section shall be guilty of a class 1 misdemeanor.

No person shall be required to make a report pursuant to this section if the person has actual knowledge that the same matter has already been reported to the local department or the toll-free child abuse and neglect hotline of the Department of Social Services.

False Reporting

Citation: Ann. Code § 63.2-1513(A)

Any person age 14 or older who makes or causes to be made a report of child abuse or neglect that he or she knows to be false shall be guilty of a class 1 misdemeanor.

Any person age 14 or older who has been previously convicted under this subsection and who is subsequently convicted of making a false report of child abuse or neglect shall be guilty of a class 6 felony.

Washington

Current Through February 2019

Failure to Report

Citation: Rev. Code §§ 26.44.080; 9A.20.021

Every person who is required to make a report pursuant to the reporting laws and who knowingly fails to make such a report shall be guilty of a gross misdemeanor.

Every person convicted of a gross misdemeanor shall be punished by imprisonment in the county jail for up to 364 days or a fine of no more than \$5,000, or both.

This section applies to only those crimes committed on or after July 1, 1984. The fines in this section apply to adult offenders only.

False Reporting

Citation: Rev. Code §§ 26.44.060(4); 9A.20.021

A person who intentionally and in bad faith knowingly makes a false report of alleged abuse or neglect shall be guilty of a misdemeanor.

Every person convicted of a misdemeanor shall be punished by imprisonment in the county jail for no more than 90 days or a fine of no more than \$1,000, or both.

This section applies to only those crimes committed on or after July 1, 1984. The fines in this section apply to adult offenders only.

West Virginia

Current Through February 2019

Failure to Report

Citation: Ann. Code § 49-2-812

Any person, official, or institution required by this article to report a case involving a child known or suspected to be abused or neglected who knowingly fails to do so or knowingly prevents another person acting reasonably from doing so, is guilty of a misdemeanor and, upon conviction, shall be confined in jail not more than 90 days or fined not more than \$5,000, or both fined and confined.

Any person, official, or institution required by this article to report a case involving a child known or suspected to be sexually assaulted or sexually abused, or a student known or suspected to have been a victim of any nonconsensual sexual contact, sexual intercourse, or sexual intrusion on school premises, who knowingly fails to do so or knowingly prevents another person acting reasonably from doing so is guilty of a misdemeanor and, upon conviction thereof, shall be confined in jail not more than 6 months or fined not more than \$10,000, or both.

False Reporting

This issue is not addressed in the statutes reviewed.

Wisconsin

Current Through February 2019

Failure to Report

Citation: Ann. Stat. § 48.981(6)

Whoever intentionally violates the reporting laws by failure to report as required may be fined no more than \$1,000 or imprisoned for no more than 6 months, or both.

False Reporting

This issue is not addressed in the statutes reviewed.

Wyoming

Current Through February 2019

Failure to Report

Citation: Ann. Stat. § 14-3-205

Any employer, public or private, who discharges, suspends, disciplines, or penalizes an employee solely for making a report of neglect or abuse is guilty of a misdemeanor punishable by imprisonment for no more than 6 months or a fine of no more than \$750, or both.

False Reporting

Citation: Ann. Stat. § 14-3-205(d)

Any person who knowingly and intentionally makes a false report of child abuse or neglect, or who encourages or coerces another person to make a false report, is guilty of a misdemeanor that is punishable by imprisonment for no more than 6 months or a fine of no more than \$750, or both.

B. Elder Abuse

The National Center on Elder Abuse is a comprehensive resource for issues of Elder Abuse. Here is a link to their site: <http://www.elderabusecenter.org>

The following link provides information pertaining to the mandatory reporting statutes of elder abuse in the United States and U.S. Territories:

<http://www.stetson.edu/law/academics/elder/ecpp/media/Mandatory%20Reporting%20Statutes%20for%20Elder%20Abuse%202016.pdf>.

As an example, the following is an excerpt from the California Welfare and Institutions Code regarding mandated reporters and penalties:

CALIFORNIA WELFARE AND INSTITUTIONS CODE

SECTION 15630

Who is a mandate reporter of Elder Abuse?

Anybody who has assumed care for an elderly person is a mandated reporter:

“15630. (a) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member,

or employee of a county adult protective services agency or a local law enforcement agency, is a **mandated reporter**.

(b) (1) Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days, as follows:

(A) If the abuse has occurred in a long-term care facility, except a state mental health hospital or a state developmental center, the report shall be made to the local ombudsperson or the local law enforcement agency.”

What are the penalties for failure to report?

Penalties for failing to report become more severe if it is determined that, as a result of the failure to report, the elderly person is injured or killed:

“(h) Failure to report physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, is a misdemeanor, punishable by not more than **six months in the county jail, by a fine of not more than one thousand dollars (\$1,000), or by both that fine and imprisonment**. Any mandated reporter who willfully fails to report physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, where that abuse **results in death or great bodily injury**, shall be punished by not more than **one year in a county jail, by a fine of not more than five thousand dollars (\$5,000), or by both that fine and imprisonment**. If a mandated reporter intentionally conceals his or her failure to report an incident known by the mandated

reporter to be abuse or severe neglect under this section, the failure to report is a continuing offense until a law enforcement agency specified in paragraph (1) of subdivision (b) of Section 15630 of the Welfare and Institutions Code discovers the offense.” **(Bolding font added)**

C. Domestic Violence

The clients of healthcare practitioners may be victims of domestic/family violence. These may not be child abuse or Elder abuse, but between a husband and wife or another type of adult on adult violence. The safety of the client is the primary concern. It is important for the healthcare practitioners to discuss with the victim of domestic violence the resources available and to assist them to obtain those resources. This includes medical attention if needed, the involvement of law enforcement and shelters. There should also be an awareness of children in the home and their emotional health under such a situation, which can be abusive in itself.

There are many complex biopsychosocial issues surrounding abuse and violence. The purpose of this section has been to clarify the legal and ethical responsibilities of the licensed healthcare professional surrounding abuse.

D. Confidentiality vs. Need to Report: Tarasoff

“In 1976, the California Supreme Court ruled that psychotherapists have a duty to protect potential victims if their patients made threats or otherwise behaved as if they presented a “serious danger of violence to another.” In ruling on the case of [Tarasoff v. Regents of the University of California](#), the court determined that the need for therapists to protect the public was more important than protecting client-therapist confidentiality.

Guided by the court decision, the state of California later passed a law stating that all therapists have a duty to protect intended victims by either warning victims directly, notifying law enforcement directly, or taking whatever other steps to prevent harm might be needed. Despite the controversy over the circumstances for breaching confidentiality,

Tarasoff laws have been adopted across many U.S. states and have guided similar legislation in countries around the world.

The Tarasoff case is based on the 1969 murder of a university student named Tatiana Tarasoff. The perpetrator, Prosenjit Poddar, was an Indian graduate student at the University of California, Berkeley who had met Tarasoff at a folk dancing class on campus. While they went on several dates, they soon disagreed on the seriousness of their relationship and Poddar became obsessed with her. When Tatiana rebuffed him, Poddar began stalking her and underwent an emotional crisis for which he began psychological counseling at the university medical centre.

His therapist, Dr. Lawrence Moore, became concerned when his patient confessed his intention of killing Tarasoff (he never actually named her in the sessions, but identifying Tarasoff wasn't difficult). While the patient showed up for eight sessions, Moore then advised him that, if the death threats continued, then he would have no choice but to have Poddar hospitalized. After this ultimatum, Poddar stopped attending treatment and Moore was left with the question of what to do next.

After consulting with his psychiatrist supervisor, Dr. Harvey Powelson, they wrote a letter to campus police advising them of the death threats. Police then interviewed Poddar in an apartment that he shared with a roommate (who happened to be Tatiana Tarasoff's brother). When Poddar denied making any death threats and assured police that he would stay away from Tarasoff, he was released and Dr. Powelson ordered all therapy notes destroyed. Despite his promise, Prosenjit Poddar continued the stalking behaviour.

On October 27, 1969, Poddar confronted Tatiana Tarasoff at her home. When she attempted to flee, he pursued her and then stabbed her to death with the kitchen knife he had been carrying. After returning to her home, he called police. Despite attempting to plead guilty to manslaughter, Prosenjit Poddar went on trial for first-degree murder and was found guilty of second-degree murder instead. He served five years in prison until a lawyer successfully appealed the conviction. Though the state opted not to retry the case, Poddar was deported to India where he lives in relative anonymity (and has since married).

Shortly after Poddar's release, Tatiana Tarasoff's parents launched a civil suit against the therapists and the University of California, Berkeley. The suit stated that the defendants should have warned Tarasoff directly about the death threats which might have saved her life. Moore and Powelson defended their actions on the grounds of their duty to their patient over a private third party and the trial court agreed with them. After the plaintiffs appealed this decision, the California Supreme Court reviewed the case and finally handed down what would become a landmark decision in 1976.

In the decades following the Tarasoff decision, 33 U.S. states have passed Tarasoff laws while another 11 have left the issue up to the discretion of the therapist.” (Vitelli, Ph.D., Romeo, Revisiting Tarasoff: Should Therapists breach confidentiality over a patient's violent threat?, Psychology Today, July 28, 2014 Retrieved from <https://www.psychologytoday.com/us/blog/media-spotlight/201407/revisiting-tarasoff>

Chapter 7 -- HIPAA and other Confidentiality Guidelines

A. Exercises in Confidentiality

You have probably already had to deal with situations where you questioned the extent you should go in keeping certain information confidential, and how much information should you reveal. Remember that a client may reveal some information you are required to reveal and report to proper authorities, but that does not give one license to be excessive. Indeed, one may argue that a provider should not reveal a greater amount of information than is expedient to fulfill their responsibilities as a mandated reporter. The following exercises are provided for you to consider how to handle different confidentiality dilemmas that may come up in the course of practice. There are doubtless as many situations as there are clients, so you cannot predict every situation that may come up. These situations (Hepworth and Larsen,

1986) generally address many of the possible scenarios and thinking them through may be of real assistance down the road.

For each situation consider the following:

1. How can you best discharge your ethical responsibilities in the situation?
2. Do you experience conflicting pulls regarding possible courses of action?
3. In situations that involve legal ramifications, how would you handle it with the client in the event your planned action would be contrary to the client's request?

Situation 1. A male client confided in an individual marital therapy session several weeks ago that he is a practicing homosexual, although his wife does not know this. The client's wife, who you have also seen conjointly with him, calls you today, troubled over the lack of progress in solving marital problems, and asks you point-blank whether you think her husband could be homosexual.

Situation 2. A client with whom you have had several sessions in a family agency confides to you that he is wanted by legal authorities for repeatedly ignoring court orders to pay child support to his wives from two previous marriages. The client, who has eluded authorities by assuming a false name and changing addresses frequently, also indicates that he has been warned he will be incarcerated if he is apprehended. With respect to such situations, you were recently advised by legal counsel in a staff meeting that withholding information regarding fugitives from the law also makes you culpable.

Situation 3. You are forming a group for youth in a state correctional facility. You know from the past experience that youth sometimes make references in the group to previous offenses that they have committed without being apprehended. You also know that they may talk about plans to run from the institution or about indiscretions or misdemeanors they (or others) may have committed or plan to commit within the institution, such as smoking marijuana or stealing institutional supplies or property from peers or staff.

Situation 4. In conducting an intake interview with a client in a family agency, you observe that both of her young children are withdrawn. Further, one of the children is badly bruised, and the other, an infant, also appears malnourished. Throughout the interview, the client seems defensive and suspicious and also ambivalent about having come for the interview. At one point, the client states that she feels overwhelmed with her parenting responsibilities and is having some difficulty in coping with her children. She also alludes to her fear that she may hurt them but then abruptly changes the subject. As you encourage her to return to the discussion of her problems with the children, your client says she had changed her mind about wanting help, takes her children in hand, and leaves the office.

Situation 5. You have seen a husband and wife and their adolescent daughter twice regarding relationship problems between the parents and the girl. The parents are united in their approach to the problem—both extremely negative and blaming in their attitude toward their daughter, feeling that their troubles would be over if she would just “shape up.” Today, during an individual interview with the girl, she breaks into tears and tells you that she is pregnant and plans to “go somewhere” with her boyfriend this weekend to get an abortion. She pleads with you not to tell her parents, who she feels would be extremely angry if they knew.

Situation 6 In a mental health agency, you have been working with a male client who has a past history, when angered, of becoming violent and physically abusive. He has been under extreme psychological pressure lately because of problems relating to a recent separation from his wife. In an interview today, he is extremely angry, clenching his fists as he tells you that he has heard that his wife has initiated divorce proceedings and plans to move to another state. “If this is true,” he loudly protests, “she is doing it to take the kids away from me, and I’ll kill her rather than let her do that.”

Situation 7 A colleague and close friend sees you at a casual event and remarks that she knows you are seeing a friend in therapy. She begins to talk about problems she knows your client is experiencing and then asks you whether it is true that the client has been hospitalized previously for depression.

Situation 8 In the last several interviews, a 15-year-old girl has seemed troubled, but despite repeated inquiries and expressions of concern, she did not confide in you. In the course of today's interview, however, she blurts out that her brother-in-law has been making sexual advances and pressuring her to have intercourse with him. Your client, who has been living in the home of her brother-in-law and her sister, indicates that she has resisted the man's sexual attempts thus far, but it is evident that she is frightened and perplexed. Although embarrassed and guarded about disclosing details of the situation, she indicates strongly that she does not want her sister to know about this problem. After exploring the problem to the extent your client is willing and able, you discuss and role-play approaches she can take to confront her brother-in-law and quell his advances. But in view of her fright and the difficulty she has in rehearsing assertive behavior, you are worried that she may be unable to manage the situation if the brother-in-law were to intensify his pressure.

(pp72-73)

Each of these scenarios creates a type of dilemma regarding confidentiality, without being clear cut. The framework already provided from Reamer, and a solid knowledge of your professions code of ethics would be helpful in making decisions for each of these scenarios. Another resource to be seriously considered is that which has also already been discussed—a consultant.

B. HIPAA Regulations

No doubt either you or your agency had to make some significant changes in regards to how you gather and maintain clients' information. I have noticed as a patient/consumer such things as how sign-in sheets are handled differently at both doctors' offices and pharmacies. Somebody is making good money on those little adhesive strips that cover patients' names after signing in. I have to admit that I had never given it a second thought before then that my name would be on a sign-in sheet. In fact if someone had presented the idea of it I would have told them that it was ridiculous and another instance of the

government becoming over regulatory, and in some ways I probably still feel that way about a lot of regulations. However, if I were to go to have a procedure done, or go to counseling, that I would prefer others not know about, it would become more important to me that my name is not out there for all to see.

The regulations were primarily intended to provide patients with greater access and control of their records, which makes a lot of sense. We should have the freedom to transfer care providers and expect that if we desire our records would follow in a timely manner. Being able to send these records electronically provides the convenience and timeliness we would all like. It also cuts down on office work, having to make copies of large files, and then finding ways to physically transport them. With electronic means it is as easy as sending an email. So easy, in fact, that such information could be sent nearly anywhere and everywhere—probably not something that we would prefer as patients or consumers. As a result, regulations were put in place to ensure steps were taken for the private and secure transfer of this information. The caution is with reason: just look at the news on some of the private information, such as social security numbers and credit card information and that has accidentally been sent out to locations unintended. No doubt there will be mistakes made and we will be hearing about them, and lawsuits will be occurring as a result. Some will be because of the evil intentions of some; others will be caused by human error. Thus, it is important to implement the safeguards provided and to be able to show due diligence in complying with the regulations.

Whether we like them or not, it doesn't really matter. The fact is that we are now governed by the Health Insurance Portability and Accountability Act (HIPAA) and we need to

comply in our practice as professionals. The following is from the US department of Health and Human Services website. It contains information and FAQs that are helpful in our effort to understand and comply with the regulations. The following information is provided by the United States Department of Health and Human Services (HHS). It provides an overview of the regulations and the process by which privacy statutes became a part of the regulations. The link to this and further information is provided here. I have attempted to provide that which is most pertinent: <http://www.hhs.gov/ocr/hipaa>.

PROTECTING THE PRIVACY OF PATIENTS' HEALTH INFORMATION

Overview: *The first-ever federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Developed by the Department of Health and Human Services (HHS), these new standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country. State laws providing additional protections to consumers are not affected by this new rule.*

Congress called on HHS to issue patient privacy protections as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA included provisions designed to encourage electronic transactions and also required new safeguards to protect the security and confidentiality of health information. The final regulation covers health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions (e.g., enrollment, billing and eligibility verification) electronically. Most health insurers, pharmacies, doctors and other health care providers were required to comply with these federal standards beginning April 14, 2003. As provided by Congress, certain small health plans have an additional year to comply. HHS has conducted extensive outreach and provided guidance and technical assistance to these providers and businesses to make it as easy as possible for them to implement the new privacy protections. These efforts include answers to hundreds of common questions about the rule, as well as explanations and descriptions about key elements of the rule. These materials are available at <http://www.hhs.gov/ocr/hipaa>.

PATIENT PROTECTIONS

The new privacy regulations ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. Key provisions of these new standards include:

- **Access To Medical Records.** Patients generally should be able to see and obtain copies of their medical records and request corrections if they identify errors and mistakes. Health plans, doctors, hospitals, clinics, nursing homes and other covered entities generally should provide access these records within 30 days and may charge patients for the cost of copying and sending the records.
- **Notice of Privacy Practices.** Covered health plans, doctors and other health care providers must provide a notice to their patients how they may use personal medical information and their rights under the new privacy regulation. Doctors, hospitals and other direct-care providers generally will provide the notice on the patient's first visit following the April 14, 2003, compliance date and upon request. Patients generally will be asked to sign, initial or otherwise acknowledge that they received this notice. Health plans generally must mail the notice to their enrollees by April 14 and again if the notice changes significantly. Patients also may ask covered entities to restrict the use or disclosure of their information beyond the practices included in the notice, but the covered entities would not have to agree to the changes.
- **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. To promote the best quality care for patients, the rule does not restrict the ability of doctors, nurses and other providers to share information needed to treat their patients. In other situations, though, personal health information generally may not be used for purposes not related to health care, and covered entities may use or share only the minimum amount of protected information needed for a particular purpose. In addition, patients would have to sign a specific authorization before a covered entity could release

their medical information to a life insurer, a bank, a marketing firm or another outside business for purposes not related to their health care.

- **Prohibition on Marketing.** The final privacy rule sets new restrictions and limits on the use of patient information for marketing purposes. Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before disclosing their patient information for marketing. At the same time, the rule permits doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.
- **Stronger State Laws.** The new federal privacy standards do not affect state laws that provide additional privacy protections for patients. The confidentiality protections are cumulative; the privacy rule will set a national "floor" of privacy standards that protect all Americans, and any state law providing additional protections would continue to apply. When a state law requires a certain disclosure -- such as reporting an infectious disease outbreak to the public health authorities -- the federal privacy regulations would not preempt the state law.
- **Confidential communications.** Under the privacy rule, patients can request that their doctors, health plans and other covered entities take reasonable steps to ensure that their communications with the patient are confidential. For example, a patient could ask a doctor to call his or her office rather than home, and the doctor's office should comply with that request if it can be reasonably accommodated.
- **Complaints.** Consumers may file a formal complaint regarding the privacy practices of a covered health plan or provider. Such complaints can be made directly to the covered provider or health plan or to HHS' Office for Civil Rights (OCR), which is charged with investigating complaints and enforcing the privacy regulation. Information about filing complaints should be included in each covered entity's notice of privacy practices. Consumers can find out more information about filing a complaint at <http://www.hhs.gov/ocr/hipaa> or by calling (866) 627-7748.

HEALTH PLANS AND PROVIDERS

The privacy rule requires health plans, pharmacies, doctors and other covered entities to establish policies and procedures to protect the confidentiality of protected health information about their patients. These requirements are flexible and scalable to allow different covered entities to implement them as appropriate for their businesses or practices. Covered entities must provide all the protections for patients cited above, such as providing a notice of their privacy practices and limiting the use and disclosure of information as required under the rule. In addition, covered entities must take some additional steps to protect patient privacy:

- **Written Privacy Procedures.** The rule requires covered entities to have written privacy procedures, including a description of staff that has access to protected information, how it will be used and when it may be disclosed. Covered entities generally must take steps to ensure that any business associates who have access to protected information agree to the same limitations on the use and disclosure of that information.
- **Employee Training and Privacy Officer.** Covered entities must train their employees in their privacy procedures and must designate an individual to be responsible for ensuring the procedures are followed. If covered entities learn an employee failed to follow these procedures, they must take appropriate disciplinary action.
- **Public Responsibilities.** In limited circumstances, the final rule permits -- but does not require --covered entities to continue certain existing disclosures of health information for specific public responsibilities. These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or the cause of death; public health needs; research that involves limited data or has been independently approved by an Institutional Review Board or privacy board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. The privacy rule generally establishes new safeguards and limits on these disclosures. Where no other law requires disclosures in these situations, covered entities may continue to use their professional judgment to decide whether to make such disclosures based on their own policies and ethical principles.

- **Equivalent Requirements For Government.** The provisions of the final rule generally apply equally to private sector and public sector covered entities. For example, private hospitals and government-run hospitals covered by the rule have to comply with the full range of requirements.

OUTREACH AND ENFORCEMENT

HHS' Office for Civil Rights (OCR) oversees and enforces the new federal privacy regulations. Led by OCR, HHS has issued extensive guidance and technical assistance materials to make it as easy as possible for covered entities to comply with the new requirements. Key elements of OCR's outreach and enforcement efforts include:

- **Guidance and technical assistance materials.** HHS has issued extensive guidance and technical materials to explain the privacy rule, including an extensive, searchable collection of frequently asked questions that address major aspects of the rule. HHS will continue to expand and update these materials to further assist covered entities in complying. These materials are available at <http://www.hhs.gov/ocr/hipaa/assist.html>.
- **Conferences and seminars.** HHS has participated in hundreds of conferences, trade association meetings and conference calls to explain and clarify the provisions of the privacy regulation. These included a series of regional conferences sponsored by HHS, as well as many held by professional associations and trade groups. HHS will continue these outreach efforts to encourage compliance with the privacy requirements.
- **Information line.** To help covered entities find out information about the privacy regulation and other administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, OCR and HHS' Centers for Medicare & Medicaid Services have established a toll-free information line. The number is (866) 627-7748.
- **Complaint investigations.** Enforcement will be primarily complaint-driven. OCR will investigate complaints and work to make sure that consumers receive the privacy rights and protections required under the new regulations. When appropriate, OCR can impose civil monetary penalties for violations of the privacy rule provisions. Potential

criminal violations of the law would be referred to the U.S. Department of Justice for further investigation and appropriate action.

- **Civil and Criminal Penalties.** Congress provided civil and criminal penalties for covered entities that misuse personal health information. For civil violations of the standards, OCR may impose monetary penalties up to \$100 per violation, up to \$25,000 per year, for each requirement or prohibition violated. Criminal penalties apply for certain actions such as knowingly obtaining protected health information in violation of the law. Criminal penalties can range up to \$50,000 and one year in prison for certain offenses; up to \$100,000 and up to five years in prison if the offenses are committed under "false pretenses"; and up to \$250,000 and up to 10 years in prison if the offenses are committed with the intent to sell, transfer or use protected health information for commercial advantage, personal gain or malicious harm.

C. Mental Health Information

HIPAA Privacy Rule and Sharing Information Related to Mental Health

<https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html>

Background

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers.

Ensuring strong privacy protections is critical to maintaining individuals' trust in their health care providers and willingness to obtain needed health care services, and these protections are especially important where very sensitive information is concerned, such as mental health information. At the same time, the Privacy Rule recognizes circumstances arise where health information may need to be shared to ensure the patient receives the best

treatment and for other important purposes, such as for the health and safety of the patient or others. The Rule is carefully balanced to allow uses and disclosures of information—including mental health information—for treatment and these other purposes with appropriate protections.

In this guidance, we address some of the more frequently asked questions about when it is appropriate under the Privacy Rule for a health care provider to share the protected health information of a patient who is being treated for a mental health condition. We clarify when HIPAA permits health care providers to:

- Communicate with a patient’s family members, friends, or others involved in the patient’s care;
- Communicate with family members when the patient is an adult;
- Communicate with the parent of a patient who is a minor;
- Consider the patient’s capacity to agree or object to the sharing of their information;
- Involve a patient’s family members, friends, or others in dealing with patient failures to adhere to medication or other therapy;
- Listen to family members about their loved ones receiving mental health treatment;
- Communicate with family members, law enforcement, or others when the patient presents a serious and imminent threat of harm to self or others; and
- Communicate to law enforcement about the release of a patient brought in for an emergency psychiatric hold.

In addition, the guidance provides relevant reminders about related issues, such as the heightened protections afforded to psychotherapy notes by the

Privacy Rule, a parent's right to access the protected health information of a minor child as the child's personal representative, the potential applicability of Federal alcohol and drug abuse confidentiality regulations or state laws that may provide more stringent protections for the information than HIPAA, and the intersection of HIPAA and FERPA in a school setting.

Questions and Answers about HIPAA and Mental Health

Does HIPAA allow a health care provider to communicate with a patient's family, friends, or other persons who are involved in the patient's care?

Yes. In recognition of the integral role that family and friends play in a patient's health care, the HIPAA Privacy Rule allows these routine – and often critical – communications between health care providers and these persons. Where a patient is present and has the capacity to make health care decisions, health care providers may communicate with a patient's family members, friends, or other persons the patient has involved in his or her health care or payment for care, so long as the patient does not object. See 45 CFR 164.510(b). The provider may ask the patient's permission to share relevant information with family members or others, may tell the patient he or she plans to discuss the information and give them an opportunity to agree or object, or may infer from the circumstances, using professional judgment, that the patient does not object. A common example of the latter would be situations in which a family member or friend is invited by the patient and present in the treatment room with the patient and the provider when a disclosure is made.

Where a patient is not present or is incapacitated, a health care provider may share the patient's information with family, friends, or others involved in the patient's care or payment for care, as long as the health care provider determines, based on professional judgment, that doing so is in the best interests of the patient. Note that, when someone other than a friend or family member is involved, the health care provider must be reasonably sure

that the patient asked the person to be involved in his or her care or payment for care.

In all cases, disclosures to family members, friends, or other persons involved in the patient's care or payment for care are to be limited to only the protected health information directly relevant to the person's involvement in the patient's care or payment for care.

OCR's website contains additional information about disclosures to family members and friends in fact sheets developed for consumers

(http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/consumer_ffg.pdf) and providers

(http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/provider_ffg.pdf).

Does HIPAA provide extra protections for mental health information compared with other health information?

Generally, the Privacy Rule applies uniformly to all protected health information, without regard to the type of information. One exception to this general rule is for psychotherapy notes, which receive special protections. The Privacy Rule defines psychotherapy notes as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record. Psychotherapy notes do not include any information about medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, or results of clinical tests; nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Psychotherapy notes also do not include any information that is maintained in a patient's medical record. See 45 CFR 164.501.

Psychotherapy notes are treated differently from other mental health information both because they contain particularly sensitive information and because they are the personal notes of the therapist that typically are not required or useful for treatment, payment, or health care operations purposes, other than by the mental health professional who created the notes.

Therefore, with few exceptions, the Privacy Rule requires a covered entity to obtain a patient's authorization prior to a disclosure of psychotherapy notes for any reason, including a disclosure for treatment purposes to a health care provider other than the originator of the notes. See 45 CFR 164.508(a)(2). A notable exception exists for disclosures required by other law, such as for mandatory reporting of abuse, and mandatory "duty to warn" situations regarding threats of serious and imminent harm made by the patient (State laws vary as to whether such a warning is mandatory or permissible).

Is a health care provider permitted to discuss an adult patient's mental health information with the patient's parents or other family members?

In situations where the patient is given the opportunity and does not object, HIPAA allows the provider to share or discuss the patient's mental health information with family members or other persons involved in the patient's care or payment for care. For example, if the patient does not object:

- A psychiatrist may discuss the drugs a patient needs to take with the patient's sister who is present with the patient at a mental health care appointment.
- A therapist may give information to a patient's spouse about warning signs that may signal a developing emergency.

BUT:

- A nurse may not discuss a patient's mental health condition with the

patient's brother after the patient has stated she does not want her family to know about her condition.

In all cases, the health care provider may share or discuss only the information that the person involved needs to know about the patient's care or payment for care. See 45 CFR 164.510(b). Finally, it is important to remember that other applicable law (e.g., State confidentiality statutes) or professional ethics may impose stricter limitations on sharing personal health information, particularly where the information relates to a patient's mental health.

When does mental illness or another mental condition constitute incapacity under the Privacy Rule? For example, what if a patient who is experiencing temporary psychosis or is intoxicated does not have the capacity to agree or object to a health care provider sharing information with a family member, but the provider believes the disclosure is in the patient's best interests?

Section 164.510(b)(3) of the HIPAA Privacy Rule permits a health care provider, when a patient is not present or is unable to agree or object to a disclosure due to incapacity or emergency circumstances, to determine whether disclosing a patient's information to the patient's family, friends, or other persons involved in the patient's care or payment for care, is in the best interests of the patient.¹ Where a provider determines that such a disclosure is in the patient's best interests, the provider would be permitted to disclose only the PHI that is directly relevant to the person's involvement in the patient's care or payment for care.

This permission clearly applies where a patient is unconscious. However, there may be additional situations in which a health care provider believes, based on professional judgment, that the patient does not have the capacity to agree or object to the sharing of personal health information at a particular time and that sharing the information is in the best interests of the patient at that time. These may include circumstances in which a patient is suffering

from temporary psychosis or is under the influence of drugs or alcohol. If, for example, the provider believes the patient cannot meaningfully agree or object to the sharing of the patient's information with family, friends, or other persons involved in their care due to her current mental state, the provider is allowed to discuss the patient's condition or treatment with a family member, if the provider believes it would be in the patient's best interests. In making this determination about the patient's best interests, the provider should take into account the patient's prior expressed preferences regarding disclosures of their information, if any, as well as the circumstances of the current situation. Once the patient regains the capacity to make these choices for herself, the provider should offer the patient the opportunity to agree or object to any future sharing of her information.

If a health care provider knows that a patient with a serious mental illness has stopped taking a prescribed medication, can the provider tell the patient's family members?

So long as the patient does not object, HIPAA allows the provider to share or discuss a patient's mental health information with the patient's family members. See 45 CFR 164.510(b). If the provider believes, based on professional judgment, that the patient does not have the capacity to agree or object to sharing the information at that time, and that sharing the information would be in the patient's best interests, the provider may tell the patient's family member. In either case, the health care provider may share or discuss only the information that the family member involved needs to know about the patient's care or payment for care.

Otherwise, if the patient has capacity and objects to the provider sharing information with the patient's family member, the provider may only share the information if doing so is consistent with applicable law and standards of ethical conduct, and the provider has a good faith belief that the patient poses a threat to the health or safety of the patient or others, and the family member is reasonably able to prevent or lessen that threat. See 45 CFR 164.512(j).

For example, if a doctor knows from experience that, when a patient's medication is not at a therapeutic level, the patient is at high risk of committing suicide, the doctor may believe in good faith that disclosure is necessary to prevent or lessen the threat of harm to the health or safety of the patient who has stopped taking the prescribed medication, and may share information with the patient's family or other caregivers who can avert the threat. However, absent a good faith belief that the disclosure is necessary to prevent a serious and imminent threat to the health or safety of the patient or others, the doctor must respect the wishes of the patient with respect to the disclosure.

Can a minor child's doctor talk to the child's parent about the patient's mental health status and needs?

With respect to general treatment situations, a parent, guardian, or other person acting in loco parentis usually is the personal representative of the minor child, and a health care provider is permitted to share patient information with a patient's personal representative under the Privacy Rule. However, section 164.502(g) of the Privacy Rule contains several important exceptions to this general rule. A parent is not treated as a minor child's personal representative when: (1) State or other law does not require the consent of a parent or other person before a minor can obtain a particular health care service, the minor consents to the health care service, and the minor child has not requested the parent be treated as a personal representative; (2) someone other than the parent is authorized by law to consent to the provision of a particular health service to a minor and provides such consent; or (3) a parent agrees to a confidential relationship between the minor and a health care provider with respect to the health care service.² For example, if State law provides an adolescent the right to obtain mental health treatment without parental consent, and the adolescent consents to such treatment, the parent would not be the personal representative of the adolescent with respect to that mental health treatment information.

Regardless, however, of whether the parent is otherwise considered a personal representative, the Privacy Rule defers to State or other applicable laws that expressly address the ability of the parent to obtain health information about the minor child. In doing so, the Privacy Rule permits a covered entity to disclose to a parent, or provide the parent with access to, a minor child's protected health information when and to the extent it is permitted or required by State or other laws (including relevant case law). Likewise, the Privacy Rule prohibits a covered entity from disclosing a minor child's protected health information to a parent when and to the extent it is prohibited under State or other laws (including relevant case law). See 45 CFR 164.502(g)(3)(ii).

In cases in which State or other applicable law is silent concerning disclosing a minor's protected health information to a parent, and the parent is not the personal representative of the minor child based on one of the exceptional circumstances described above, a covered entity has discretion to provide or deny a parent access to the minor's health information, if doing so is consistent with State or other applicable law, and the decision is made by a licensed health care professional in the exercise of professional judgment. For more information about personal representatives under the Privacy Rule, see OCR's guidance for consumers (http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/personal_reps.html) and providers (<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/personalreps.html>).

In situations where a minor patient is being treated for a mental health disorder and a substance abuse disorder, additional laws may be applicable. The Federal confidentiality statute and regulations that apply to federally-funded drug and alcohol abuse treatment programs contain provisions that are more stringent than HIPAA. See 42 USC § 290dd-2; 42 CFR 2.11, et. seq.

At what age of a child is the parent no longer the personal representative of the child for HIPAA purposes?

HIPAA defers to state law to determine the age of majority and the rights of parents to act for a child in making health care decisions, and thus, the ability of the parent to act as the personal representative of the child for HIPAA purposes. See 45 CFR 164.502(g).

Does a parent have a right to receive a copy of psychotherapy notes about a child's mental health treatment?

No. The Privacy Rule distinguishes between mental health information in a mental health professional's private notes and that contained in the medical record. It does not provide a right of access to psychotherapy notes, which the Privacy Rule defines as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record. See 45 CFR 164.501. Psychotherapy notes are primarily for personal use by the treating professional and generally are not disclosed for other purposes. Thus, the Privacy Rule includes an exception to an individual's (or personal representative's) right of access for psychotherapy notes. See 45 CFR 164.524(a)(1)(i).

However, parents generally are the personal representatives of their child and, as such, are able to receive a copy of their child's mental health information contained in the medical record, including information about diagnosis, symptoms, treatment plans, etc. Further, although the Privacy Rule does not provide a right for a patient or personal representative to access psychotherapy notes regarding the patient, HIPAA generally gives providers discretion to disclose the individual's own protected health information (including psychotherapy notes) directly to the individual or the individual's personal

representative. As any such disclosure is purely permissive under the Privacy Rule, mental health providers should consult applicable State law for any prohibitions or conditions before making such disclosures.

What options do family members of an adult patient with mental illness have if they are concerned about the patient’s mental health and the patient refuses to agree to let a health care provider share information with the family?

The HIPAA Privacy Rule permits a health care provider to disclose information to the family members of an adult patient who has capacity and indicates that he or she does not want the disclosure made, only to the extent that the provider perceives a serious and imminent threat to the health or safety of the patient or others and the family members are in a position to lessen the threat. Otherwise, under HIPAA, the provider must respect the wishes of the adult patient who objects to the disclosure. However, HIPAA in no way prevents health care providers from listening to family members or other caregivers who may have concerns about the health and well-being of the patient, so the health care provider can factor that information into the patient’s care.

In the event that the patient later requests access to the health record, any information disclosed to the provider by another person who is not a health care provider that was given under a promise of confidentiality (such as that shared by a concerned family member), may be withheld from the patient if the disclosure would be reasonably likely to reveal the source of the information. 45 CFR 164.524(a)(2)(v). This exception to the patient’s right of access to protected health information gives family members the ability to disclose relevant safety information with health care providers without fear of disrupting the family’s relationship with the patient.

Does HIPAA permit a doctor to contact a patient’s family or law enforcement if the doctor believes that the patient might hurt herself or someone else?

Yes. The Privacy Rule permits a health care provider to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons, when the provider believes the patient presents a serious and imminent threat to self or others. The scope of this permission is described in a letter to the nation's health care providers issued on January 15, 2013 (available at <http://www.hhs.gov/ocr/office/lettertonationhcp.pdf>), and below.

Specifically, when a health care provider believes in good faith that such a warning is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the Privacy Rule allows the provider, consistent with applicable law and standards of ethical conduct, to alert those

persons whom the provider believes are reasonably able to prevent or lessen the threat. These provisions may be found in the Privacy Rule at 45 CFR § 164.512(j).

Under these provisions, a health care provider may disclose patient information, including information from mental health records, if necessary, to law enforcement, family members of the patient, or any other persons who may reasonably be able to prevent or lessen the risk of harm. For example, if a mental health professional has a patient who has made a credible threat to inflict serious and imminent bodily harm on one or more persons, HIPAA permits the mental health professional to alert the police, a parent or other family member, school administrators or campus police, and others who may be able to intervene to avert harm from the threat.

In addition to professional ethical standards, most States have laws and/or court decisions which address, and in many instances require, disclosure of patient information to prevent or lessen the risk of harm. Providers should consult the laws applicable to their profession in the States where they

practice, as well as 42 USC 290dd-2 and 42 CFR Part 2 under Federal law (governing the disclosure of alcohol and drug abuse treatment records) to understand their duties and authority in situations where they have information indicating a threat to public safety. Note that, where a provider is not subject to such State laws or other ethical standards, the HIPAA permission still would allow disclosures for these purposes to the extent the other conditions of the permission are met.

If a law enforcement officer brings a patient to a hospital or other mental health facility to be placed on a temporary psychiatric hold, and requests to be notified if or when the patient is released, can the facility make that notification?

The Privacy Rule permits a HIPAA covered entity, such as a hospital, to disclose certain protected health information, including the date and time of admission and discharge, in response to a law enforcement official's request, for the purpose of locating or identifying a suspect, fugitive, material witness, or missing person. See 45 CFR § 164.512(f)(2). Under this provision, a covered entity may disclose the following information about an individual: name and address; date and place of birth; social security number; blood type and rh factor; type of injury; date and time of treatment (includes date and time of admission and discharge) or death; and a description of distinguishing physical characteristics (such as height and weight). However, a covered entity may not disclose any protected health information under this provision related to DNA or DNA analysis, dental records, or typing, samples, or analysis of body fluids or tissue. The law enforcement official's request may be made orally or in writing.

Other Privacy Rule provisions also may be relevant depending on the circumstances, such as where a law enforcement official is seeking information

about a person who may not rise to the level of a suspect, fugitive, material witness, or missing person, or needs protected health information not permitted under the above provision. For example, the Privacy Rule's law enforcement provisions also permit a covered entity to respond to an administrative request from a law enforcement official, such as an investigative demand for a patient's protected health information, provided the administrative request includes or is accompanied by a written statement specifying that the information requested is relevant, specific and limited in scope, and that de-identified information would not suffice in that situation. The Rule also permits covered entities to respond to court orders and court-ordered warrants, and subpoenas and summonses issued by judicial officers. See 45 CFR § 164.512(f)(1). Further, to the extent that State law may require providers to make certain disclosures, the Privacy Rule would permit such disclosures of protected health information as "required-by-law" disclosures. See 45 CFR § 164.512(a).

Finally, the Privacy Rule permits a covered health care provider, such as a hospital, to disclose a patient's protected health information, consistent with applicable legal and ethical standards, to avert a serious and imminent threat to the health or safety of the patient or others. Such disclosures may be to law enforcement authorities or any other persons, such as family members, who are able to prevent or lessen the threat. See 45 CFR § 164.512(j).

If a doctor believes that a patient might hurt himself or herself or someone else, is it the duty of the provider to notify the family or law enforcement authorities?

A health care provider's "duty to warn" generally is derived from and defined by standards of ethical conduct and State laws and court decisions such as *Tarasoff v. Regents of the University of California*. HIPAA permits a covered health care provider to notify a patient's family members of a serious and imminent threat to the health or safety of the patient or others if those family members are in a position to lessen or avert the threat. Thus, to the

extent that a provider determines that there is a serious and imminent threat of a patient physically harming self or others, HIPAA would permit the provider to warn the appropriate person(s) of the threat, consistent with his or her professional ethical obligations and State law requirements. See 45 CFR 164.512(j). In addition, even where danger is not imminent, HIPAA permits a covered provider to communicate with a patient's family members, or others involved in the patient's care, to be on watch or ensure compliance with medication regimens, as long as the patient has been provided an opportunity to agree or object to the disclosure and no objection has been made. See 45 CFR 164.510(b)(2).

Does HIPAA prevent a school administrator, or a school doctor or nurse, from sharing concerns about a student's mental health with the student's parents or law enforcement authorities?

Student health information held by a school generally is subject to the Family Educational Rights and Privacy Act (FERPA), not HIPAA. HHS and the Department of Education have developed guidance clarifying the application of HIPAA and FERPA, which is available at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hipaaferpajointguide.pdf>.

In the limited circumstances where the HIPAA Privacy Rule, and not FERPA, may apply to health information in the school setting, the Rule allows disclosures to parents of a minor patient or to law enforcement in various situations. For example, parents generally are presumed to be the personal representatives of their unemancipated minor child for HIPAA privacy purposes, such that covered entities may disclose the minor's protected health information to a parent. See 45 CFR § 164.502 (g)(3). In addition, disclosures to prevent or lessen serious and imminent threats to the health or safety of the patient or others are permitted for notification to those who are able to lessen the threat, including law enforcement, parents or others, as relevant. See 45 CFR § 164.512(j).

¹ The Privacy Rule permits, but does not require, providers to disclose information in these situations. Providers who are subject to more stringent privacy standards under other laws, such as certain state confidentiality laws or 42 C.F.R. Part 2, would need to consider whether there is a similar disclosure permission under those laws that would apply in the circumstances.

² A parent also may not be a personal representative if there are safety concerns. A provider may decide not to treat the parent as the minor's personal representative if the provider believes that the minor has been or may be subject to violence, abuse, or neglect by the parent or the minor may be endangered by treating the parent as the personal representative; and the provider determines, in the exercise of professional judgment, that it is not in the best interests of the patient to treat the parent as the personal representative. See 45 CFR 164.502(g)(5).

D. Record Keeping in Organizational Settings

Organizational settings, often present unique record keeping challenges. Record keeping requirements for organizations may be substantially different from requirements in other settings. You may run into conflicts between the organizations' practices and establish professional guidelines, legal and regulatory requirements, or ethical standards. In addition, ownership of and responsibility for a record is not always clearly defined. A number of service providers may access and contribute to the record, potentially affecting the degree to which you may execute control of the record and its confidentiality.

This may be summarized as potential:

1. Conflicts between organizational and other requirements
2. Ownership of the records
3. Access to the records

You, your colleagues, and your agency's management may need to consult with one another to define record keeping procedures that serve the needs of different disciplines, while at the same time meeting acceptable record keeping guidelines and requirements. In this consultation, you'll need to review local, state, and federal regulations and laws that pertain to the organization. If there is a conflict between an ethics code and the organization's policies, you'll need to clarify the nature of the conflict, make your (and others involved) ethical commitments known, and resolve the conflict in a way that is compatible with those ethical commitments.

The nature of your legal relationship with the organization may dictate record keeping practices. The physical record of your services may be owned by the organization and you may not take it with you. However, if the relationship is one of consultation, you may be the one who owns and is responsible for the record. It will be helpful to clarify these issues when you begin your relationship with an organization, minimizing the possibility of misunderstandings.

If a team of people from different disciplines is involved in service delivery, there may need to be wider access to records than usual. Because others (e.g., nurses, physicians, paraprofessionals, etc.) may have access to and may make entries into the client's record, you may have much less direct control over it. This is another call for you to help in developing and refining organizational record keeping policies.

Note that because multidisciplinary records may not have the highest level of confidentiality, you and your supervisees will want to record only information that matches organizational requirements and that is necessary to correctly picture the service provided. Other information may then be kept in a separate and confidential file (American Psychological Association, 2007).

Multiple Client Records

Record keeping issues may be more complex when you provide services to multiple clients, such as in a group therapy session. If the records include information about more than one specific client, legitimate disclosure of information regarding that client may put another client's confidentiality in jeopardy.

It's the responsibility of you and your supervisees to keep records in a fashion that assists authorized disclosures but at the same time protects privacy of other clients. When you provide services to several people who have a relationship (e.g., spouses or parents and children), you must define at the beginning:

1. Which individuals are clients

2. Your relationship with each person, including your role and the likely uses of the services you give or the information obtained.

If it looks like you may be asked to play potentially conflicting roles (e.g., family therapist and then witness for one part in divorce proceedings), you must take judicious steps to appropriately clarify, modify, or withdraw from a specific role or roles.

In a group therapy setting, you must describe at the beginning each party's role and responsibility, and the limits of confidentiality. If you're asked to provide services to someone who is already receiving similar services elsewhere, you must consider carefully any treatment issues and potential welfare of the client(s). Discuss these issues with the client (or the client's guardian or other legal representative) to diminish risks of conflict and confusion. Also, when appropriate, consult with the other service providers, always being cautious and sensitive to therapeutic issues (American Psychological Association, 2010).

Other precautionary steps you can take include:

- In the informed consent form, include whether information is kept jointly or separately and who can authorize its release.
- In couples, family or group therapy, clarify the identified clients, then create and maintain completely separate records for all identified clients.
- If the family itself is the identified client, you may need to keep a single record, dependent upon practical concerns, ethical guidelines, and third-party reporting requirements.

To successfully "pull all of this off," you'll need to be familiar with regulatory and legal requirements concerning the release of a record that contains information about more than one client (American Psychological Association, 2007).

Financial Records

Financial records are considered by HIPAA to be part of the protected psychotherapy notes; at least they're not on the list of unprotected information. As a rule, a fee agreement or policy will be part of the record, and is the foundation for documenting reimbursement for services. Precise financial records aid payers to evaluate the nature of the payment obligation, and also aid in knowing which services have been billed and paid. Records that are up-to-date can forewarn both the provider and the client of accruing balances that, if not addressed, could adversely affect the professional relationship.

Financial records include (American Psychological Association, 2007), as appropriate:

- Type and duration of the service given
- Client's name
- Fees paid for the service
- Agreements concerning fees
 - Fee agreements or policies identify the amount to be charged for service and the terms of any payment agreement. It will identify how missed appointments will be handled, acknowledge third-party payer preauthorization requirements, copayment agreements, payment schedule, interest that an unpaid balance will accumulate, suspension of confidentiality when collection procedures must be used, and methods that may be used to solve financial disputes.
- Barter agreements
 - An accurate recording of bartering agreements and transactions ensures that the record clearly shows how the provider was compensated. Reporting the source, nature, and date of each barter transaction gives clear indication when needed about the exchange of goods for services. Because the provider could potentially have more power in negotiating a bartering agreement, painstaking documentation protects both parties. The

documentation may include the provider's basis for initially concluding that the arrangement is neither clinically contraindicated nor exploitive.

- Balance adjustment issues
 - The rationale for, description of, and date of any balance adjustment made with either the client or a third-party payer should be part of the record. This can decrease the potential for misunderstandings or perceived obligations that might affect the relationship.
- Copayment issues
- Date, amount, and source of payment received
- Concerns about collection
 - Often also useful is documentation of collection efforts, including notification of the intention of using a collection service.

Disposition of Records

Certain events require collection, storage, transfer, or disposal of client records. These events are:

1. Unexpected events (disability, death, or involuntary termination of practice)
2. Planned events (retirement, closing a practice, voluntarily leaving employment)

Disposition of client records must be handled in such a way that confidentiality is maintained and client welfare safeguarded (American Psychological Association, 2007). This refers to all private information--written or unwritten--such as communications during the time of providing service, computer files, e-mail or fax communications, written records, and video-tapes. This means that the therapist needs to have suitable plans in place from the beginning of her job. Also to be planned for, in case of unexpected changes, are contingencies for continuation of services (Barnett and Zur, 2011).

In the circumstance of unexpected events, the plans might include control and management of closed records by an agency or trained individual. In the circumstance

of planned events, depending on who the employer is, the provider may wish to retain custody and control of the closed records.

It may be helpful to have a method for notifying clients regarding any changes in the custody of their records, especially recently terminated services or open cases. You'll want to check legal and regulatory requirements to see if you should post a public notice about changes in this custody, such as a notice in the newspaper.

If records are to be disposed of permanently, they must be disposed of in such a way that they cannot be recovered, such as shredding. You must provide for confidentiality in transportation to the shredding facility, as well as in that facility. This might require accompanying the records through the disposal process or having a confidentiality agreement with those responsible for the disposal.

Disposal of electronic records have unique challenges, because you may not have the technical expertise to fully erase or otherwise delete records before, as an example, disposing of an external back-up storage device or a computer hard drive or other electronic record repository. Even though efforts may be made to erase or delete records, they may still be accessible for some "geeks" with specialized knowledge. You'll possibly need to work with a technical consultant to find a satisfactory method for destruction of electronic records. These could include physical destruction of the entire medium or demagnetizing the storage device.

Conclusion

As mentioned at the beginning of this course, Laws and Ethics are necessary to providing quality services to the consumer. Maybe nowhere is this more important than in the healthcare field. This course has covered many of the Laws, Regulations and Ethics pertaining to the professional conduct of LCSWs, MFTs and Nurses. It is your challenge as a licensed professional to implement the information in this course for the betterment of yourself as a clinician in helping the most vulnerable among us.

Well, it appears you have survived the course.

THE END

[Now, go take the test before you forget everything]

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The Author

Lance Parks, LCSW has a rich and diverse history of educational, clinical, training and administrative experience. Mr. Parks is a certified Group Home Administrator in the state of California and serves as an Associate Director and Licensed Clinical Social Worker at a residential placement facility for adolescents ages 13-18. Mr. Parks' counseling experience includes the following populations and settings: HIV positive inmates at CIM in Chino, California, outpatient Spanish speaking clinic, private psychiatric hospital, skilled nursing facilities (nursing homes), private family counseling clinic, and adolescent residential placement.

In addition, Mr. Parks has helped plan, develop and/or present training programs and conferences for the following personnel: group home staff, state certified group home administrators, probation officers, social workers, mental health personnel, LCSWs and MFTs. Since 1999 Mr. Parks has served on the continuing education committee, residential care committee and juvenile justice committee for a statewide association of private nonprofit child and family serving agencies.

Mr. Parks received his Bachelor of Science in Family Sciences with a minor in Spanish from Brigham Young University, and his Master of Social Work from the University of Southern California.