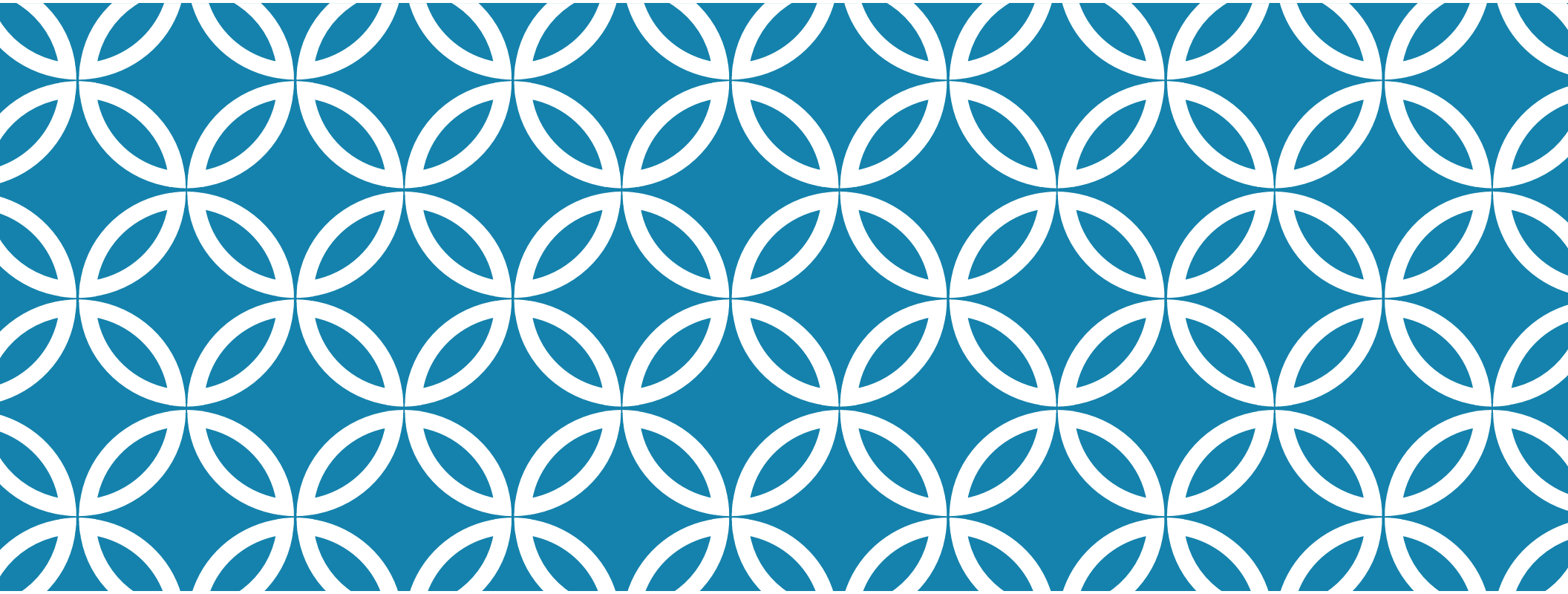


ETHICAL CONSIDERATIONS FOR THE SUBSTANCE USE PROFESSIONAL

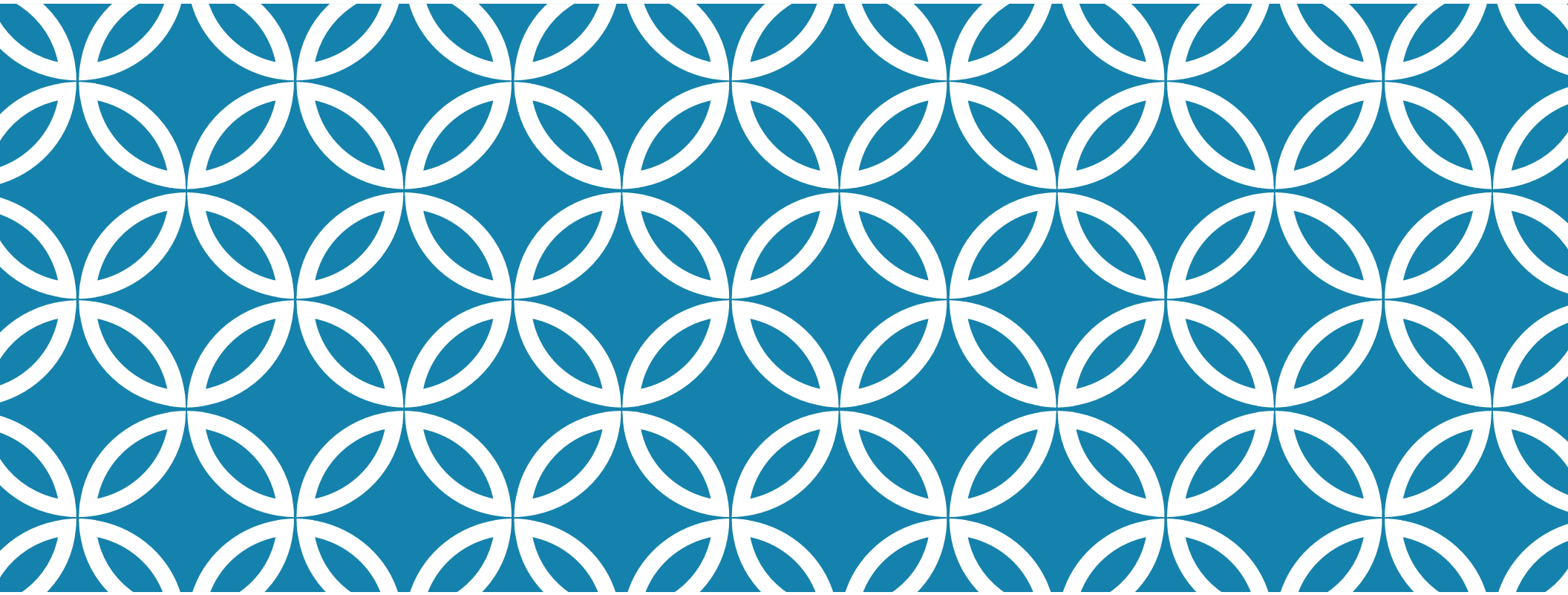
Presented By: Stephanie Galbreath, LPC

STEPHANIE GALBREATH, LPC

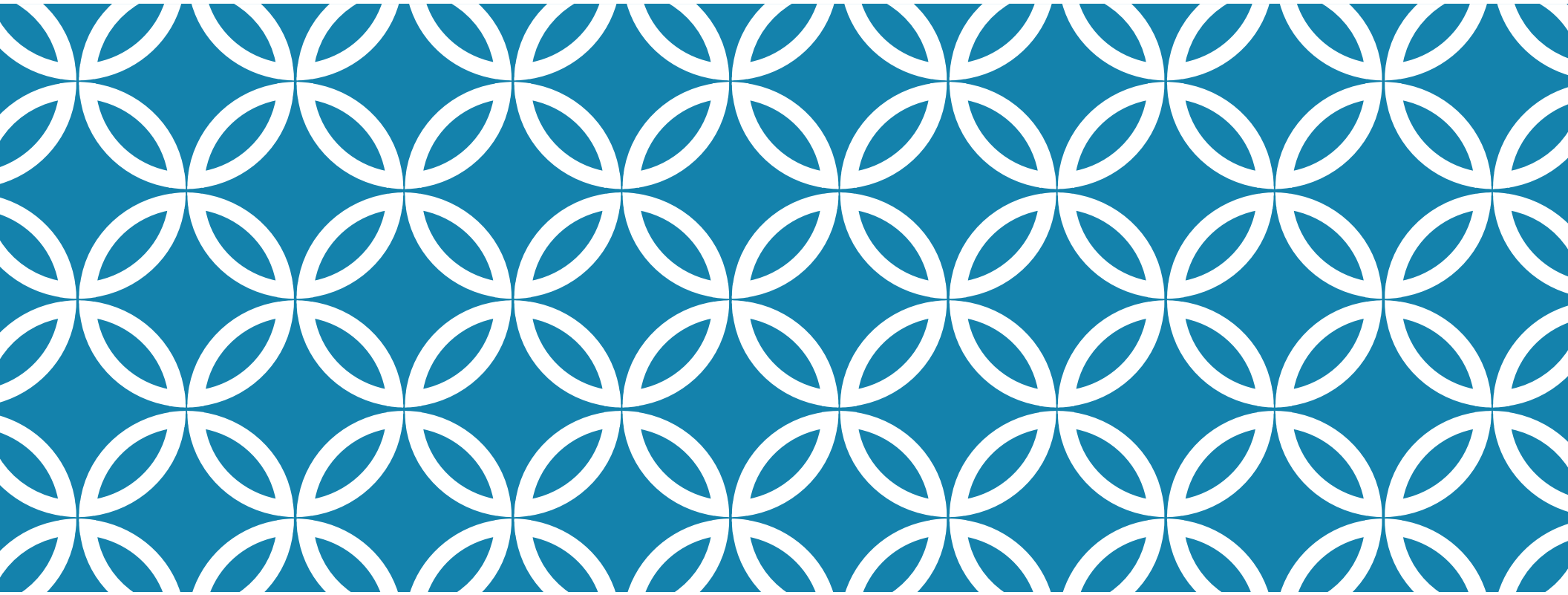
Licensed Professional Counselor (LPC04864)

15 Years Substance Use Treatment Experience with UAB

Clinical Program Director for Family and Adolescent Services at Jefferson County Family Court



LATEST NEWS AND DEVELOPMENTS



TERMINOLOGY, FRAMEWORK, AND APPLICATION

DEFINITION OF ETHICS

Ethics are generally regarded as **standards that govern** the conduct of a person in their profession.

They are guidelines for professional behavior that are **developed to protect** the profession, the professional, the client, and society.

Purpose:

- **Educate** members about sound ethical conduct
- **Maintain** professional accountability
- **Improve** practice by defining mandatory and aspirational ethics

WHAT TERMS OR PRINCIPLES DO YOU ASSOCIATE WITH ETHICAL PRACTICE?

Non-malfeasance
- **Do no harm**

Beneficence
- **Do the right thing**

Justice
- **Fairness, equality**

Fidelity
- **Trustworthy, congruent, honorable, faithful**

Veracity
- **Honest, accurate**

Autonomy
- **Value each as an individual; self-directive**

VALUES / MORALS VS. ETHICS

There is a difference between personal values, morals and our professional ethical standards

Personal values are reflections of our needs, desires, and what we care about most in life

Personal morals are reflections of how we categorize ideas, actions, decisions

Good or bad

Right or wrong

RESPECTING DIFFERENCES

Licensed professional counselors will actively attempt to understand the diverse cultural backgrounds of the clients with whom they work. This includes, but is not limited to, **learning how the counselor's own cultural /ethnic / racial identity impacts their values** and beliefs about the counseling process (ABEC)

…avoid actions that seek to meet their [the counselor's] personal needs at the expense of clients.

…are aware of their [the professional's] own values, attitudes, beliefs, and behaviors and how these apply in a diverse society, and **avoid imposing their values on clients.**

...SO, LET'S REVISIT SOME OF THOSE ETHICAL PRINCIPLES

Justice

- Free of biases or favoritism **(DOC, method of use)**

Autonomy

- Value each as an individual; self-directive
- Ability to make own choices **(could include controlled drinking, harm reduction, or abstinence)**= *"never let the best be the enemy of the good"*

Non-Malfeasance

- Do no harm
- Issues like Practitioner Burnout
- Decisions about Discharge / Discontinuation—objective response or reflection of staff frustration **(punitive)**?

Fidelity

- Keep promises—inform and stick to boundaries **(confidentiality and exceptions)**

STIGMATIZATION

Language matters

Demonstration of bias/judgment **(even inadvertently)**

Recommendation:

- Use “Person First” Language
- Person with a substance use disorder
- “Patient with schizophrenia” vs. “the schizophrenic”

Table 4. Non-Stigmatizing Language Versus Stigmatizing Language[32]

Non-Stigmatizing Language	Stigmatizing Language
• Person with a substance use disorder	• Substance abuser or drug abuser • Alcoholic • Addict • User • Abuser • Drunk • Junkie
• Substance use disorder or addiction • Use, misuse • Risky, unhealthy, or heavy use • Relapse	• Drug habit • Abuse • Problem
• Person in recovery • Abstinent • Not drinking or taking drugs	• Clean
• Treatment or medication for addiction • Medication for Addiction Treatment or Medication-Assisted Recovery • Long-term Recovery • Pharmacotherapy • Positive, negative (toxicology screen results)	• Substitution or replacement therapy • Medication-Assisted Treatmer • Clean, dirty

ETHICAL RESPONSIBILITY

Primary Responsibility

Client/Patient

Secondary Responsibility

Members of patient's family

Employing Agency

Referring Agency, Individual

Society

Profession

Themselves

ALLEGATIONS OF WRONGDOING

Allegation	Percentage of Closed Claims
Sexual/romantic interactions/relationships with current clients, client's partners or family members	32%
Failure to practice within boundaries of competency	17%
Improper sexual/romantic interaction or relationship with current supervisees	7%
Multiple relationships with client despite potential for client harm	6%
Sexual relationships with former clients, their partners or family members	4%
Improper sharing of confidential information without client consent or legal justification	4%

Distribution of Top Six Primary Allegations, CNA and HPSO Counselor Liability Claim Report: 2nd Edition. (2019)

OTHER COMMON BOARD CITATIONS AND DISCIPLINARY ACTIONS

Common Violations:

- Failure to meet CE req.
- Dual relationships
- Unprofessional conduct
- Fraudulent billing
- Counseling without proper license
- Non-counseling related crime (ex. DUI)

Common Disciplinary Action:

- Fine
- Mandatory CE or Supervision
- Reprimand
- Suspension
- Probation
- Revocation

AL COMPLAINTS

- Received: 41
- Closed: 9
  - 2= cease and desist
  - 1=administratively closed
  - 1=no jurisdiction
  - 1=letter of concern
  - 1=complaint withdrawn
- Pending: 32

- Source: as presented during 3/22/24 Board Meeting and provided via email on 3/28/24.

Tips to Avoid Malpractice

- KEEP YOUR PROFESSIONAL BOUNDARIES IN PLACE
- Understand your state's standard of care – and stick to it.
- Manage client expectations—Informed Consent!
- Keep thorough and accurate notes
- Terminate** any client who crosses your boundaries
- Know when to recommend a specialist

PROPER TERMINATION (ACA, A.11)

Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives.

Counselors refrain from referring patients based solely on the counselor's personally held values, attitudes, beliefs, or behaviors

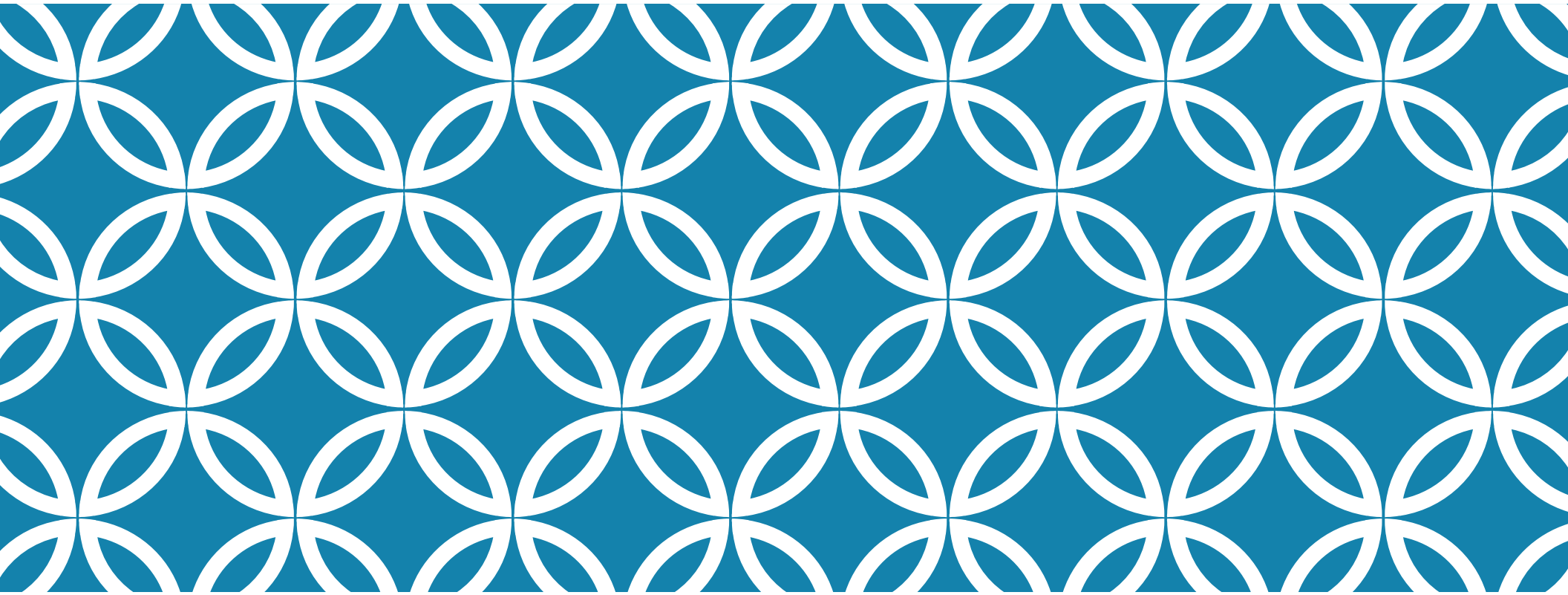
Counselors terminate a counseling relationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, or is being harmed by continued counseling

Counselors provide pretermination counseling and recommend other service providers when necessary

Counselors do not abandon or neglect clients in counseling

MANY STATES HAVE ETHICAL GUIDELINES WRITTEN INTO STATE CODE

YOU CAN BE UNETHICAL AND NOT VIOLATE A LAW



COMPETENCY

COMPETENCY

Practitioners engage in professional activity only in those areas for which they clearly have the ability, knowledge, training, and experience.

- **What can you "competently" do?**
- **How do you know you are competent to do it?**
- **What are the "boundaries" of your competence?**

TELE SCOPE OF COMPETENCE

States differ in way practitioner must demonstrate competence. Some states/professions require completion of certification or CE prior to delivery of distance counseling.

Minimum expectation is that practitioner has knowledge and skills to address issues related to:

1) The technology platform itself and ways of addressing unplanned circumstances (such as technology outages)

2) An understanding of the risks/benefits of telecounseling which is included in Informed Consent

TELE-SPECIFIC INFORMED CONSENT

- Define telecounseling / telebehavioral health
- Identify the platform, method of communication
- Risks and benefits of engaging in the use of telebehavioral health services
- Technology failure plan and alternate methods of service delivery
- Review boundaries and social media policy of the practitioner
- Emergency procedures to follow when the counselor is not available or tech failure
- Review time zone differences (if applicable)
- Discuss cultural and language differences that may affect the delivery of services
- Review financial policies and the possible denial of insurance benefits
- Discuss coverage and continuity of care plans in the event the counselor become sick or unable to work
- Review anticipated response time

SUBSTANCE USE DISORDER COMPETENCY AREAS

Common drugs / trends

Signs of intoxication / overdose

Overdose reversal

Medications to treat substance use disorders

Co-occurring mental health conditions

Suicide risk correlation with SUD

Other process addictions, compulsive behaviors *(cross-addiction risk)*

Family systems

Recovery resources and vernacular

SCOPE OF PRACTICE

"Ability" or "skill" vs. qualification

Training, certification

Continuing education—never ending

Diagnosing vs. "Assisting"

Impairment

DEFINING YOUR ROLE

HPSO Risk Advisor Bulletin (11/19/23), "Failure to differentiate between counseling and life coaching"

- For one individual, who offered both services, the blurring of the lines led to board involvement. Some take-aways:
  - Understand the scope and boundaries of counseling and life coaching
  - Who regulates each discipline? If there is license/certification available these should be current
  - Does your professional liability insurance cover each role?

IMPAIRMENT, DEFINED BY ACA (2014)

Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and **refrain from offering or providing professional services when impaired.**

They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work.

Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients.

Impairment: a significantly diminished capacity to perform professional functions.

IMPAIRMENT, DEFINED BY ABEC (2016)

Licensed professional counselors refrain from offering professional counseling services to clients or supervision of counselors-in-training when their physical, mental or emotional problems **are likely to harm a client or others.**

- Better defined in Subsection C, "Professional Responsibility": "Licensed professional counselors must refrain from offering professional services **when their personal problems or conflicts may cause harm to a client or others**."

Licensed professional counselors are alert to the signs of impairment, seek assistance for problems, and, if necessary, limit, suspend, or terminate their professional responsibilities until they can resume their duties.

Should a licensed professional counselor be incapacitated, temporary care and continuity for clients may be undertaken by competent professional peers acting in the best interests of those clients.

RESOLVING ETHICAL ISSUES, ACA

When counselors have reason to believe that another counselor is violating or has violated an ethical standard and **substantial harm has not occurred, they attempt to first resolve the issue informally with the other counselor if feasible,** provided such action does not violate confidentiality rights that may be involved.

RESOLVING ETHICAL ISSUES, ABEC

Licensed professional counselors who suspect ethical violations by other licensees **must report the suspected violations to the office of the Alabama Board of Examiners in Counseling** unless this action conflicts with confidentiality rights or existing legal codes.

Licensed professional counselors must not initiate, participate in, or encourage the filing of ethics complaints that are unwarranted or intended to harm a mental health professional rather than to protect clients or the public.

Licensed professional counselors must cooperate with investigations, proceedings, and requirements of the Alabama Board of Examiners in Counseling and its jurisdiction over those charged with a violation.

EXAMPLES OF POTENTIAL IMPAIRMENT

BURNOUT

COMPASSION FATIGUE

SECONDARY TRAUMATIC STRESS & VICARIOUS TRAUMA

BURNOUT

State of emotional, physical, and mental exhaustion caused by excessive and prolonged stress

Expanded in ICD-11, recognized by WHO as an **"occupational phenomenon"**:

1. feelings of energy depletion or exhaustion
2. increased mental distance from one's job, or feelings of negativism or cynicism related to one's job
3. reduced professional efficacy

r/o Adjustment, Mood Disorders

Imbalance of demand and resources

Associated with situation, not individual

COMPASSION FATIGUE

Compassion fatigue is the physical, emotional, and spiritual result of chronic self-sacrifice and/or prolonged exposure to difficult situations that renders a person **unable to love, nurture, care for, or empathize with another's suffering**.

Symptoms of Compassionate Fatigue

Physical	Emotional	Work-Related
Headaches	**Mood swings**	**Avoidance** or dread of working with certain patients
Digestive problems: diarrhea, constipation, upset stomach	**Restlessness**	**Reduced** ability to feel empathy towards patients or families
Muscle tension	**Irritability**	**Frequent** use of sick days
Sleep disturbances: inability to sleep, insomnia, too much sleep	**Oversensitivity**	**Lack** of joyfulness
Fatigue	**Anxiety**	
Cardiac symptoms: chest pain/pressure, palpitations, tachycardia	**Excessive use of substances:** nicotine, alcohol, illicit drugs	
	Depression	
	Anger and resentment	
	Loss of objectivity	
	Memory issues	
	Poor concentration, focus, and judgment	

Lanier & Brunt, 2019

COMPASSION FATIGUE VS. BURNOUT

Compassion fatigue develops as a result of the **caregiver's exposure to patients' experiences** combined with their empathy for their patients.

Compassion fatigue, like burnout, can challenge a caregiver's ability to render effective services and maintain personal and professional relationships.

Compassion fatigue is sudden and acute, while burnout is a gradual wearing down of workers *(Collins & Long, 2003)*

Burnout	Compassion Fatigue
Anyone who works in difficult work environments is at risk	Health care professionals who regularly observe or listen to experiences of fear and pain and suffering are at risk
Adapt to exhaustion by becoming less empathetic and more withdrawn Reduced personal achievement	Continue to give but cannot maintain a healthy balance between empathy and objectivity
Response to work situation	Response to people. Personally identify with patient and personally absorb patient's trauma or pain
Results from being busy	Results from giving high levels of energy and compassion over a prolonged period of time.
Evolves gradually when differences between the expectations of the individual and the organization are in conflict	(Lanier & Brunt, 2019)

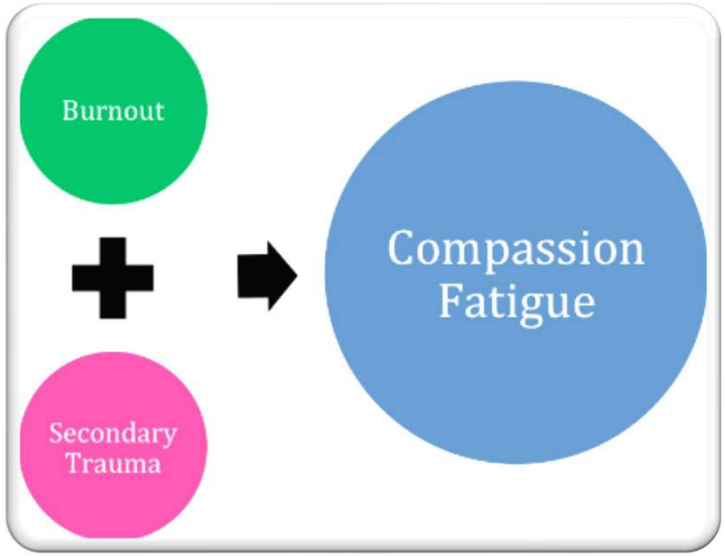
SECONDARY TRAUMATIC STRESS

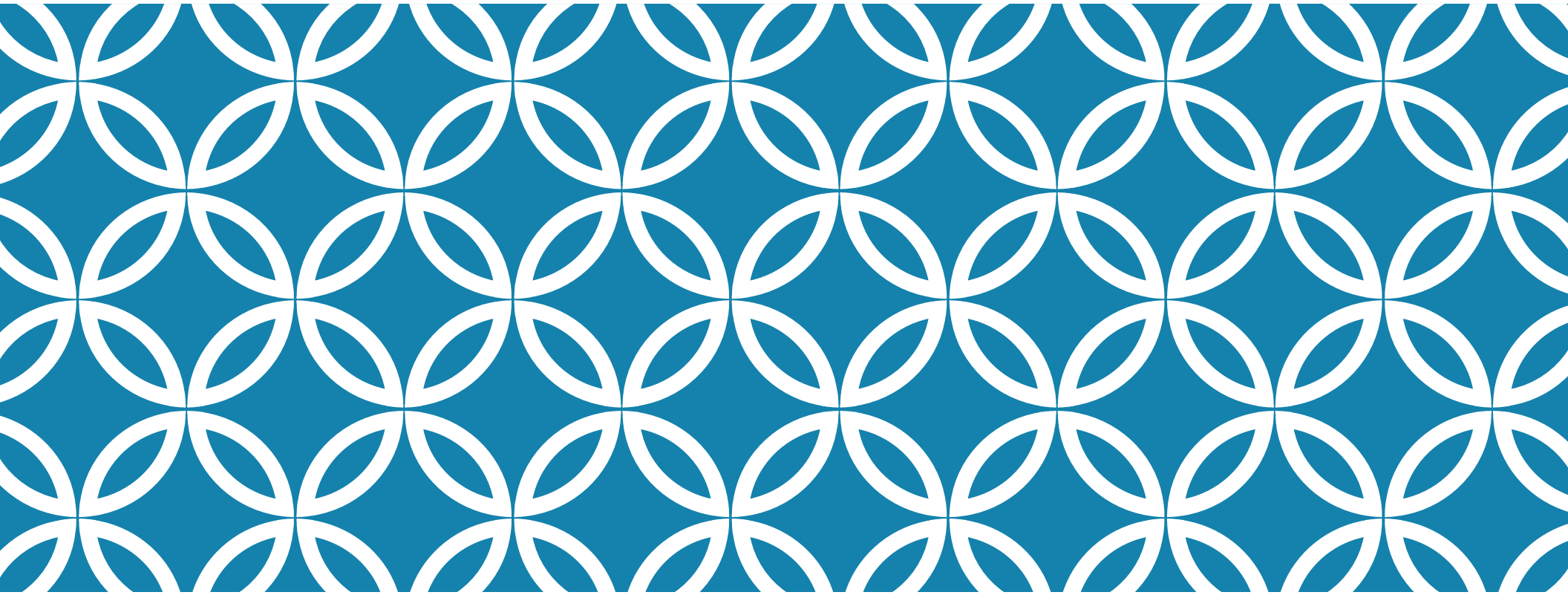
Often term **"Vicarious trauma"** is used interchangeably

Emotional duress that results when an individual **hears about the firsthand trauma experiences of another**

Signs: trouble sleeping, intrusive thoughts, fear, avoidance

May be more susceptible to experiencing STS/VT if experiencing burnout or compassion fatigue





CONFIDENTIALITY

CONFIDENTIALITY

Many ethical problems in clinical work arise out of questions of confidentiality

Respect the dignity, privacy, and worth of all individuals and organizations involved.

Protected from "unauthorized disclosures of information given in the therapeutic environment."

SECURITY AND CONFIDENTIALITY

Reasonable steps must be taken to ensure that information is secure and confidential

Using a non-secure platform for communication, even with patient assent, still places the practitioner liable for inappropriate disclosures

The interactive technologies used in telecounseling incorporate network and software security protocols to protect the confidentiality of patient information transmitted

HIPAA Requires:

- Min. 128-bit level encryption
- Omnibus Rule → BAA

CONFIDENTIALITY BEST PRACTICES

Pursue professional / healthcare platform version of software

Partner with a tele-platform that will sign BAA

Obtain written authorizations for consent to treat and for disclosures

HIPAA compliance is only as strong as setting configuration

- How do you assess your security risks and take precautions?
- Secure WiFi
- Password-protections
- End-to-end encryption

Legal Framework

HIPAA: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (1996)

42 CFR Part 2: federal law and regulations protecting confidentiality of alcohol and drug treatment and prevention information

HIPAA

Designed to ensure maintenance of health insurance coverage

Administrative simplification

- Healthcare processes becoming very complex – look to standardize information

Protects privacy of health information held by health plans, health care clearinghouses and most providers, especially to assist with exchange of information

Establishes a minimum to protect the privacy and protected health information (PHI) of individuals

- Applies to all PHI no matter how transmitted (written, verbal)
- Establishes patient rights to access/ability to amend their information
- Aspires to control the cost of treatment

Regulated by Health & Human Services (HHS)

42 CFR PART 2

Purpose:

- Protects the confidentiality of substance abuse records of any person who has applied for or been given a diagnosis or treatment for alcohol or drug abuse at a ***federally-assisted program.***
- Encourages people to seek treatment without fear that their privacy will be compromised or that they will face legal charges due to their substance use
- Regulated by SAMHSA

Coverage:

- Records of the identity, diagnosis, prognosis, or treatment of any patient, which are maintained in connection with the performance of any program or activity relating to drug abuse, alcoholism or drug/alcohol abuse education that is conducted, regulated or assisted by the Federal government must be confidential.

PART 2 REFORM DEBATE

Enacted in the 1970s (prior to HIPAA)

Long before the partition of health conditions (substance use vs. medical health) were (in part) devolved by Mental Health Parity and Addiction Equity Act (2008) & Affordable Care Act (2010)

Partitioning can lead to inadequate integration of data in health records

- HIPAA's framework (in theory) was to balance patient rights and system workflows

Purpose of Part 2 was to address history of discrimination against SUD patients; encourage people to enter treatment

- Weakening protections may result in fewer seeking treatment

SAMHSA argues that disclosure of information can lead to myriad of problems for individual

CHANGES

Over the last few years, there has been increased momentum to adopt changes to Part 2

- Coronavirus Aid, Relief, and Economic Act (CARES Act), 3/2020
  - Push to align w HIPAA; perpetual consent introduced; changed penalty/reporting obligations; anti-discriminatory language
- August 2020
  - Expanded “emergency” examples; TPO allowable with written consent; no longer necessary to identify specific recipient within a larger entity

LATEST PART 2 CHANGES (2/8/2024)

- Allows for “single consent for all future uses and disclosures for treatment, payment, and health care operations (TPO)”
  - Requires a specialized authorization for use/disclosure of records for “civil, criminal, administrative, or legislative proceedings”
- Requires Accounting of Disclosures for three years prior to the date of request
- Allows HIPAA covered entities and business associates that receive records under this consent to redisclose the records in accordance with the HIPAA regulations
  - Segregation of Part 2 records is not required.
- Aligns breach notification and penalties with HIPAA
- New Term: “SUD Counseling Notes.” Maintained separately from record and requires specific consent from an individual for disclosure. Similar to Psychotherapy Notes.
- Final Rule effective 4/16/24; compliance deadline 2/16/26

HIPAA 2025 CHANGES

- Major overhaul to cybersecurity requirements
  - Asset inventory, risk analysis, contingency planning (restore data within 72 hours), vulnerability scans every six months, penetration tests every 12 months, business associate cybersecurity, MORE
- Simultaneously, the OCR has increased its enforcement action
  - In 2024, there were 22 enforcement actions that resulted in settlements or civil monetary penalties—one of the most active years of HIPAA enforcement to date
  - $9.9 million in fees; many violations related to violation of the Security Rule (violations of the risk analysis requirement)
    - Montefiore Medical Center alone paid $4,750,000

DISCLOSURE RULES

Disclosure of information that identifies a patient (directly or indirectly) as having a current or past drug or alcohol problem (or as participating in a drug or alcohol program) is generally prohibited, unless…

1) Patient consents in writing or
2) Another exception applies…

PERMITTED DISCLOSURE

Medical emergency

Reporting child abuse/neglect

Crimes on the premises

- An arrest/search warrant is not sufficient

Internal communications

- Important to define scope of the treatment team—who really needs to know?

Qualified Service Organization Agreement

- Written agreement between program and an outside agency that provides supportive service
- Also called Professional Service Agreements (PSA) or BAA (Business Associates Agreements)

Outside auditors, central registries and researchers – funders, licensing agencies permitted to audit, provided there is a signed agreement regarding re-disclosure (usually found in contracts, care agreements)

Communications that do not disclose patient-identifying information, e.g. aggregate data

Research – No identifying information and must either have a consent or a waiver from an Institutional Review Board (IRB)

Response to a valid court order (not subpoena) that contains specialized protective language

INABILITY TO GIVE CONSENT

When counseling **minors**, counselors seek the assent of clients to services and include them in decision making as appropriate.

Counselors recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf. (ACA, A.2.d.)

BEST PRACTICE

"Confidentiality exists for the benefit of the client (even if he/she is a minor)" [perhaps especially!]

Majority of literature supports that minors have same confidentiality rights as adults

- In legal practice, confidentiality is actually an *extension* of parental rights.

A counselor *cannot promise* a minor that information will be kept from a parent who has legal custody

- However, a counselor's position of **advocacy** must include discussions that it may be counterproductive for a parent to exercise that right.

MINIMAL DISCLOSURE

To the *extent possible*, clients are informed before confidential information is disclosed and are involved in the disclosure decision-making process.

When circumstances require the disclosure of confidential information, only essential information is revealed. (ACA, B.2.e)

"Circumscribed information" provided to parents to keep them abreast of therapeutic process instead of full disclosures (even though that is protected by law)

- In Re Mark L, 2001
- Alabama: *Ex Parte Emily E. Holm, LPC, RPT, NCC,* (3/29/19)

AL SB10 (2021)

VULNERABLE CHILD COMPASSION AND PROTECTION ACT

"Section 4. No nurse, counselor, teacher, principal, or other administrative official at a public or private school attended by a minor shall do either of the following: (1) Encourage or coerce a minor to withhold from the minor's parent or legal guardian the fact that the minor's perception of his or her gender or sex is inconsistent with the minor's sex. (2) Withhold from a minor's parent or legal guardian information related to a minor's perception that his or her gender or sex is inconsistent with his or her sex."

- **"At this point an amendment has been proposed that will move counselors, psychologists, and psychological technicians into a new section in the bill and in the words of the amendment sponsor, 'allow counselors to do their jobs'."**
  - Dr. Nancy Fox, Executive Director Alabama Counseling Association, email 3/13/21.
- **Despite a federal judge blocking part of this law, the provision as stated above was left in place**

AL SB101 (2025)

An Act specific to changing age at which minor can make decisions about their medical care

- When introduced proposed changing age from 14 to 18 in Alabama
  - Unless married, divorced, pregnant, emancipated, or living independently
- Would apply to participation in school counseling services (to include guidance counseling and bullying prevention programs), donating bone marrow, and receiving a vaccine
- The bill has transformed:
  - Changed age from 18 to 16
  - Ensures that health care providers and governmental entities cannot deny parents access to their minor child's health information, with exceptions for court orders that prohibit the access or criminal investigations (that involve the child)
  - Affirms the "fundamental right of parents to make health care decisions for their children, while establishing that no minor under 16 can receive mental health services without parental consent."
  - The bill specifies that minors aged 16 to 19 can have treatment authorized by parents or guardians even if the minor refuses, contingent upon a mental health professional's agreement on the necessity of intervention.

COMPLEXITY

The most complex ethical issues arise in the context of two ethical behaviors that conflict.

For instance, when a counselor wants to respect a client's privacy and confidentiality but it is in the best interest for the counselor to contact someone about his or her care.

If a counselor feels strongly that revealing information to a parent could harm the patient or be destructive to treatment (even with parent's request) this restriction *may* be legally supportable.

Consider times when working with children who have history of "untrustworthy adults"	Fearful of punishment/shame if parents/guardians are informed	Seek consultation

Breaches of Confidentiality

DANGER TO SELF

Danger to Others

- Tarasoff v. Regents of UC, 1976
- “Duty to Warn” / “Duty to Protect”
- Mandated when client poses a “clear and imminent danger to an identifiable victim”

Child Neglect

CHILD ABUSE

All states require social workers and mental health professionals to make a report with an appropriate authority whenever they know or suspect that child abuse has occurred

There is no time limit on reporting

- As long as victim is still a minor, counselors have an obligation to file a child abuse report

If an adult victim (18+) reports historical abuse as child—no requirement to report

- Unless there is reason to believe that the abuser is still victimizing a minor

MANDATED REPORTING

Report should not be delayed, obligated under legal penalty to make report

File in county child resides (if unknown, in county of the occurrence) [check your state standards]

All states have “good faith” (immunity) clause for reporters

Parental Substance Use

DIFFERENT STATE STANDARDS INCLUDE (OR EXCLUDE):

- Adult providing (selling or giving) to child
- Manufacturing in presence or premise occupied by child
- Exposing child to where manufacturing chemicals/equipment stored
- Using controlled substance that impairs that caregiver's ability to adequately care for the child
- Exposing a child to the criminal sale or distribution of drugs ("illegal drug activity")

What about expecting mothers?

PREGNANT WOMEN

AL: "DHR does not take abuse/neglect reports on unborn children."

- Mandated reporters will be provided information about other DHR programs or community resources that may be of assistance.

GA: "Georgia does not require the reporting of pregnant women who engage in alcohol or substance abuse; however, if a baby is born showing the harmful effects of substance abuse…then a report should be made"

"PREGNANT WOMEN HELD FOR MONTHS IN ONE ALABAMA JAIL TO PROTECT FETUSES FROM DRUGS" 9/8/2022, AL.COM

A 23-yo Gadsden woman was arrested for possession of a small amount of marijuana

- She admitted to smoking marijuana on the same day she found out she was pregnant, two days prior to the arrest for possession

In Etowah Co., due to a special bond condition, she could not post bail until she entered rehab (and produced the money to support a

$10,000 bond)

According to her petition, she was evaluated and did not qualify for residential treatment

Etowah Co. appears to have a high rate of incarceration related to chemical endangerment and imposes restrictions that are not aligned with reality


UAB Comprehensive Addiction in Pregnancy Program
CAPP

MANDATED REPORTING

AL Department of Human Resources (DHR): Adult and Child Mandatory Reporters Training

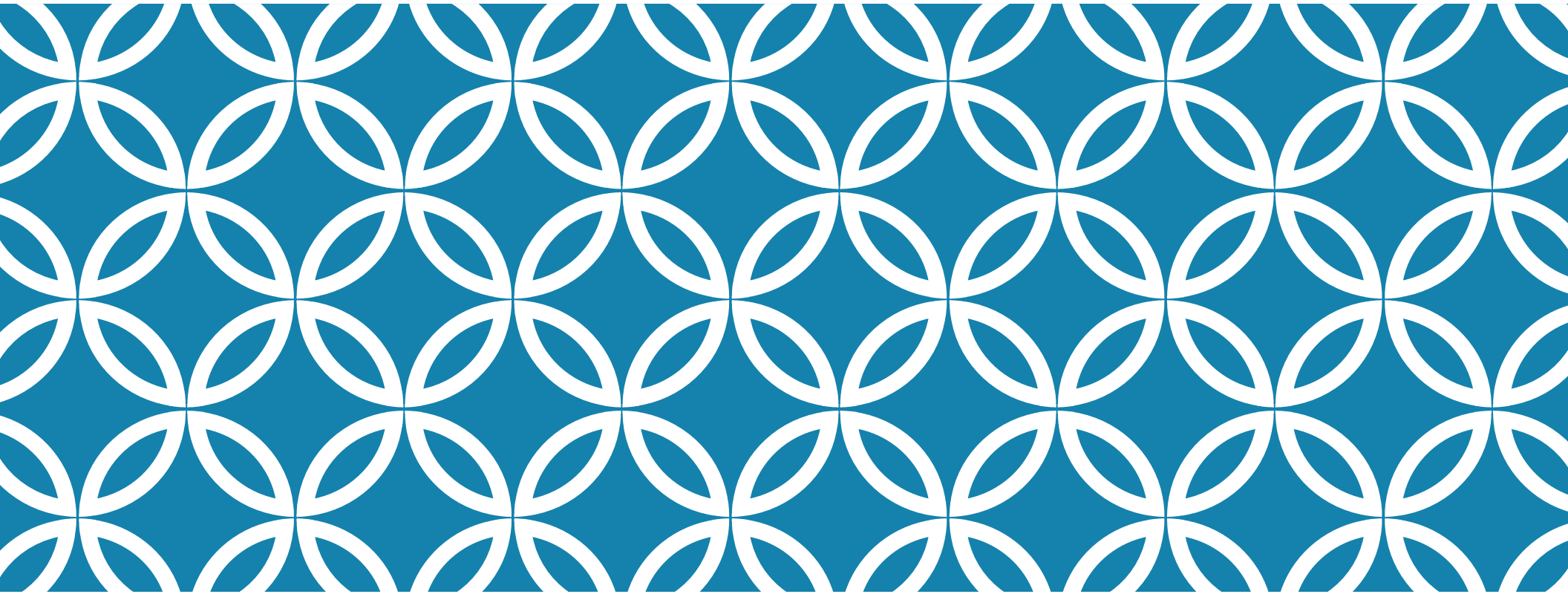
- https://aldhr.remote-learner.net/

TN DCS Training:

- https://www.tn.gov/dcs/program-areas/child-safety/reporting/faqs.html

GA: https://oca.georgia.gov/training/mandated-reporting

Failure to report breaches legal and ethical standards



DUAL RELATIONSHIPS

DUAL RELATIONSHIPS

Dual relationships occur when professional assumes two or more roles at the same time with a patient.

"Once a client, always a client."

This is based on the idea that professional helpers never lose their power to exploit a relationship.	Time standards for this will vary, based on the license or certification an individual holds, but it is often a *minimum* of 2 to 5 years from point of last service.

DUAL RELATIONSHIPS—PROVIDER / PATIENT

When a professional holds 2 or more relationships with a client at the same time or sequentially.

For example:

- Provider and friend
- Provider and family member
- Provider and supervisor/supervisee
- Provider and business partner
- Provider and sexual partner
- Provider and sponsor/sponsee

"I'm right there in the room, and no one even acknowledges me."

IF DUAL RELATIONSHIP EXISTS...

Maintain clear boundaries with patients regarding potential blended roles

- Consult
- Notify supervisor
- Document

Consider:

- Former patients may need therapy in future (rather than a friendship)
- Power differential difficult to change
- **Safest to avoid social relationships with former clients**

DUAL RELATIONSHIP QUESTIONS

Is the dual relationship necessary?

Is the dual relationship exploitive?

Who does the dual relationship benefit?

Is there a risk that the dual relationship could damage the patient?

Is there a risk that the dual relationship could disrupt the therapeutic relationship?

Are you being objective in your evaluation of this matter?

- How do you know? Did you seek consultation?

Have you adequately documented the decision-making process?

Was the patient involved in the decision-making?

- Did the patient give informed consent regarding the risks to engage in the dual relationship?

BOUNDARY CROSSING VS. VIOLATIONS

Boundary crossings are benign deviations from standard practice and are non-exploitative.

- A decision to deviate from an established boundary for a *specific purpose*; usually with expectation to return to the boundaries of the professional relationship.
- It can move the clinician from a "strictly objective perspective."

Boundary violations are significant deviations from standard practice, are harmful and exploit the relationship.

- A boundary crossing can become a violation when/if it becomes harmful (*or has the potential to be harmful*) to the patient—it can be difficult to determine when the harm is caused. This puts clinicians and patients in a vulnerable position.

The responsibility for setting boundaries is always the responsibility of the provider.

BOUNDARY CROSSINGS**

Accepting gifts

Clinician self-disclosure (if “too much”)

Extending time with patient beyond what was initially agreed upon

Making allowances for a patient that is not typical

Unplanned interactions with patient outside of work setting

**All of these have the potential to cause harm / be exploitative which could make them Boundary Violations

GIVING / RECEIVING GIFTS

Giving gifts to patients is never appropriate

Receiving gifts

- Consider the messaging behind the gift
- Most guidelines recommend consideration of value of item
- Weigh the impact of receiving vs. refusing on therapeutic relationship
- Consider the cultural aspects of gift-giving
- Policy will often dictate additional guidelines

SELF-DISCLOSURE

Deliberate

- Intentional disclosure of personal information about self (experience, impressions) intended to benefit client

Unavoidable

- Appearance, accent, disability, pregnancy

Accidental

- Unplanned reactions, public encounters

Inappropriate

- For practitioner's benefit, potentially harmful

PREFERENTIAL TREATMENT

No patient should be treated preferentially above another

Even with the ***best of intentions***, how could an "act of kindness" be interpreted?

- Other people will see it and it can create a lot of trouble.
- Demonstrates a lack of consistency and "unfairness"
- Depending on situation, could call into question infringement of patient rights/prejudice

CONFLICTS OF INTEREST

Engaging in an *avoidable* dual relationship is a violation

Erode and distort the professional nature of the therapeutic relationship

Creates unequal footing between practitioner and patient

Examples:

- Self-referring to one's own private practice
- Entering into a business relationship with a patient or patient's relative
- Providing services to someone with whom there was a pre-existing personal relationship
- Sponsoring a current or former patient to whom the clinician provided services

ABSOLUTELY **NO-GO** EXAMPLES

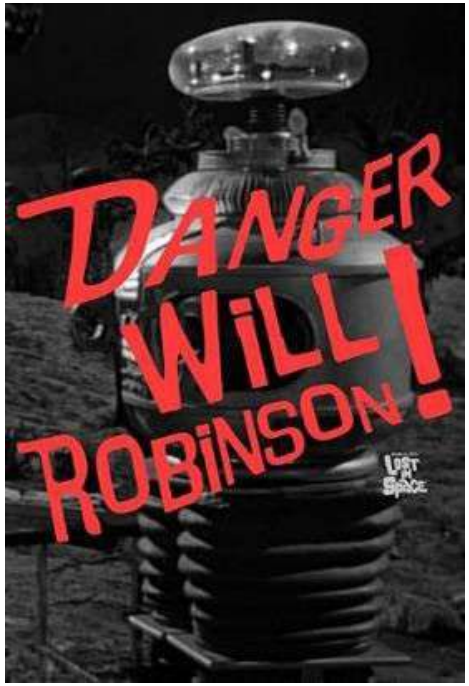
Danger, Danger!

Becoming “emotionally involved” with a patient or former patient

Becoming sexually involved with a patient or former patient

Providing treatment to a person with whom there was a previous romantic and/or sexual involvement

These can result in termination and for licensed/certified individuals, loss of profession



WHY DO BOUNDARY CROSSINGS/VIOLATIONS OCCUR?

Intentional malfeasance

True naivety, acting without knowing the rules of the road

A gradual lowering of boundaries (slippery slope)

Inexperience

- Often coupled with undercurrents of:
  - Transference, Counter-Transference
  - Discomfort in uncomfortable situations
  - “Need” to: be liked/accepted, respected, feared, etc.
  - Excessive need to please others
  - Caretaker/rescuer qualities
  - Personal life crisis or inability to balance personal and processional life

AVOIDING BOUNDARY CROSSINGS & VIOLATIONS

Education

- Understand the ethical codes and boundaries of a professional relationship

Self-awareness and monitoring for burnout, lack of self-care

Seek out peer consultation, feedback

Confront colleagues if behavior is unprofessional

- Report to supervisor and, if indicated, professional board

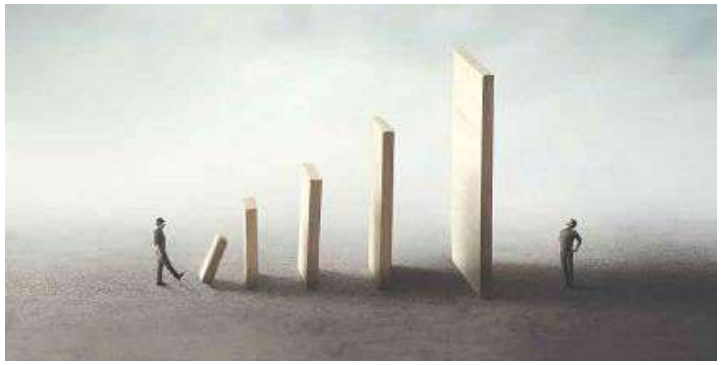
CONSEQUENCES OF BOUNDARY DEVIATIONS

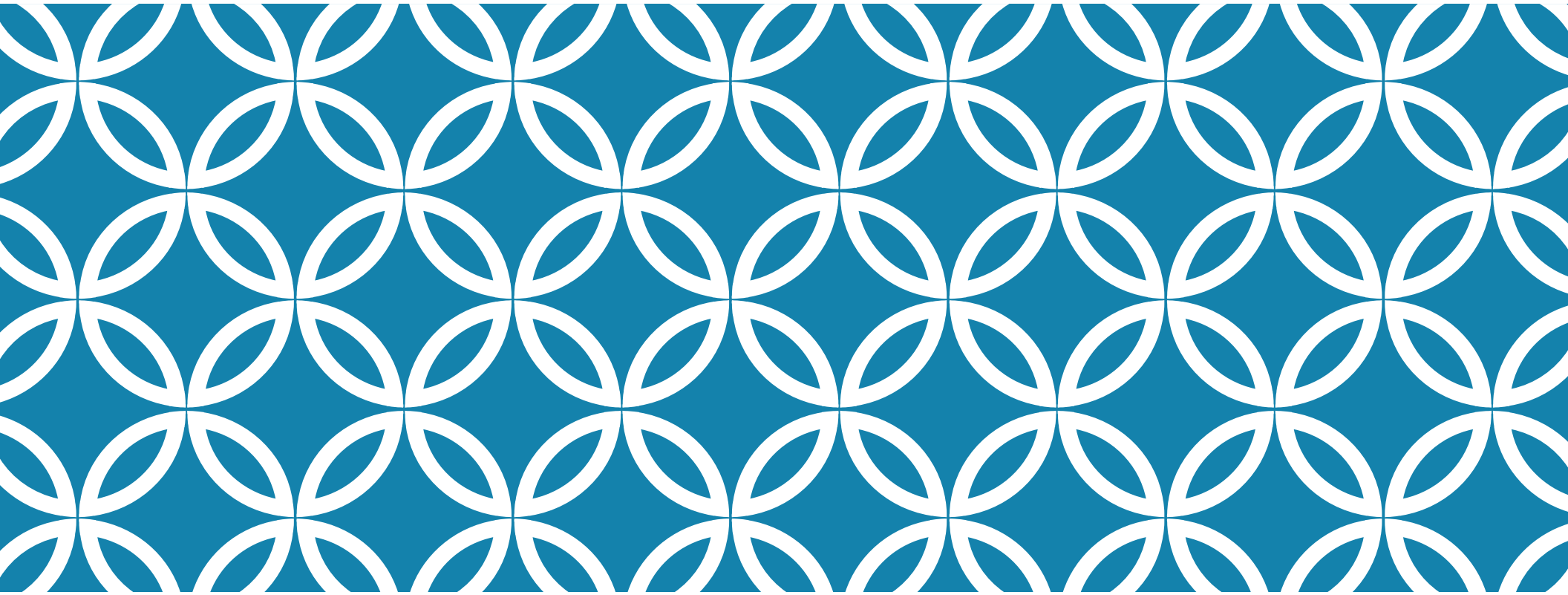
For Patient:

- Disengagement from services
- Mistrust of the helping profession
- Emotional and cognitive distortions about self and relationship to others
- Traumatization or re-traumatization

For Practitioner:

- Loss of job
- Loss of license and/or disciplinary action by board
- Loss of professional identity
- Loss of colleagues
- Interpersonal impact





TECHNOLOGY

NBCC AND TECHNOLOGY

In the latest revision of the NBCC Code of Ethics (8/23), 18% of the document is dedicated to rules/boundaries around the use of Telemental Health, Social Media, and Technology.

There is no mention of AI

A document, "Ethical Principles for Artificial Intelligence in Counseling," was published online by NBCC on 4/12/24

DEFINING AI

Artificial intelligence is the simulation of human intelligence processes by machines (computer systems)

"Machine learning" works when the system ingests large amounts of labeled training data, analyzes the data for correlations and patterns, and uses these patterns to make predictions about future states.

- Chatbot is given examples of text that is "learned" and used to generate future lifelike exchanges with people
- A system can recognize images and identify objects because the system has been provided millions of examples before that it compares against

"Generative AI" is a machine learning model that is trained to create new data, rather than making a prediction about a specific dataset.

AI PREVALENCE

AI is already in our space

Chat boxes (bots) on organization websites used for intake, scheduling, and after-hours responses

Learning systems that organize and present information based on user-driven parameters (EHR analytics, Salesforce)

AI-Integrated Therapy Options Apps

- Earkick, Mindspa, Wysa, and Youper

PRACTICE ISSUES

Koko, a mental health startup, received criticism in early 2023 for allegedly using AI chatbot to conduct mental health counseling without obtaining informed consent from participants.

- “The controversy started when Koko’s co-founder, Rob Morris, tweeted that OpenAI's GPT-3 was used to provide mental health support to about 4,000 people. In the tweet thread, Morris said that the AI generated messages were rated higher than those written exclusively by humans but, once users learned that the messages were written by AI, the mental health support “didn’t work” because “simulated empathy feels weird.”” (1/6/2023)

In early 2023, the National Eating Disorders Association (NEDA) moved from a long-standing national helpline to use of a chatbot called “Tessa.”

- When users probed about how Tessa can help with eating disorders, the chat provided information about dieting and healthy eating.
- "We recognize and regret that certain decisions taken by NEDA have disappointed members of the eating disorders community," she (NEDA’s CEO, Liz Thompson) said in an emailed statement. "Like all other organizations focused on eating disorders, NEDA's resources are limited and this requires us to make difficult choices... We always wish we could do more and we remain dedicated to doing better."

AI USE-CASE PRINCIPLES AND CONSIDERATIONS

Accountability

- You are responsible for clinical decisions!

Client Welfare

- Helping vs. hurting

Competency

- In use and limitations

Confidentiality

- Where does this information go?

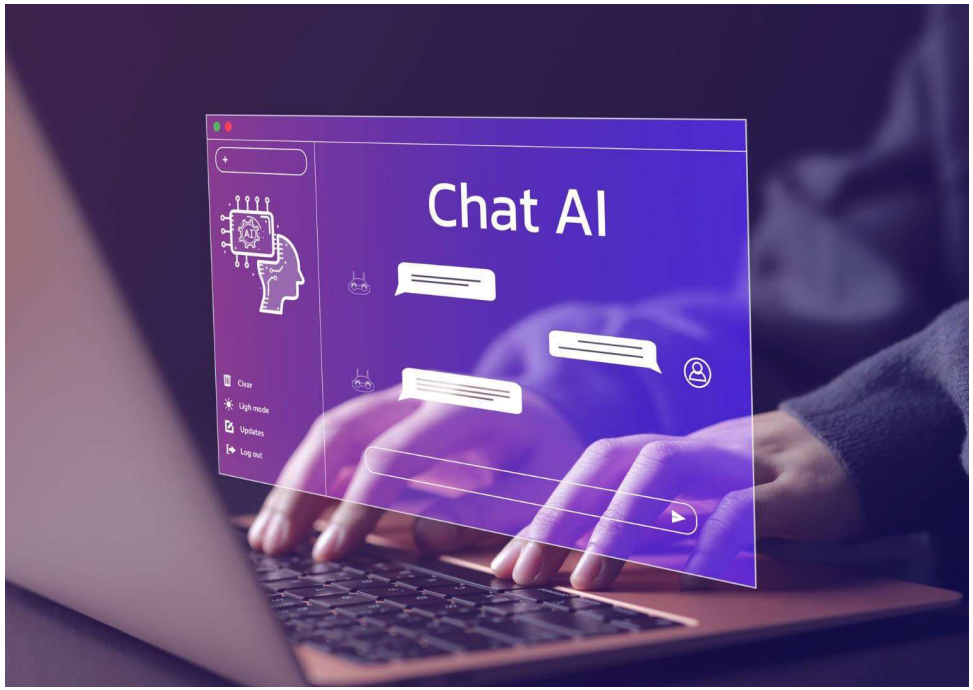
Transparency

- Knowledgeable and able to consent to utilization
- Aware of the capabilities and limitations of technology
- Document instances when technology is used, how, and justification thereof

EXPERIMENT

How easy is it to use AI to simulate some of the functions of my job??

Hey, ChatGPT, “Write a counseling progress note that incorporates relapse prevention for SUD.”



- Progress Note: Date: March 19, 2024 Client: John Doe Therapist: Jane Smith
- Session Summary: During today's session, John and I focused on developing strategies for relapse prevention in his substance use disorder (SUD) recovery journey. John demonstrated a strong commitment to maintaining his sobriety and actively engaged in the discussion regarding potential triggers and coping mechanisms.
- Assessment: John reported feeling confident in his ability to remain abstinent from substances but acknowledged the presence of triggers in his environment that could potentially lead to relapse. He expressed a heightened awareness of the importance of implementing effective coping strategies to manage cravings and prevent a recurrence of substance use.
- Intervention: We began the session by exploring specific triggers that John has identified in his daily life, including stress, social gatherings where alcohol is present, and certain locations associated with past substance use. Together, we worked on developing a personalized relapse prevention plan tailored to John's individual needs and circumstances.
- Key components of John's relapse prevention plan include:

1. Identifying Triggers: John and I discussed strategies for identifying and avoiding triggers, such as practicing mindfulness techniques to recognize early signs of cravings and implementing a plan to navigate high-risk situations.
2. Coping Skills: We reviewed various coping skills that John can utilize when faced with triggers or cravings, including deep breathing exercises, progressive muscle relaxation, and engaging in healthy activities such as exercise or hobbies.
3. Social Support: John identified the importance of maintaining a strong support network and actively involving his family and close friends in his recovery process. We discussed ways to communicate his needs effectively and seek support when feeling vulnerable.
4. Lifestyle Changes: John expressed a willingness to make positive lifestyle changes to support his recovery, including establishing a structured daily routine, prioritizing self-care activities, and avoiding situations or individuals that may jeopardize his sobriety.
5. Developing a Crisis Plan: Together, we developed a crisis plan outlining steps for John to take in the event of a potential relapse, including contacting his support network, attending a support group meeting, or seeking professional help if necessary.

- John demonstrated a strong understanding of the relapse prevention strategies discussed during the session and expressed a commitment to implementing them into his daily life.
- Plan: Moving forward, John and I will continue to monitor his progress in implementing the relapse prevention strategies discussed today. We will also explore additional coping skills and resources that may further support his recovery journey. Our next session is scheduled for March 26, 2024.

"HEY, CHATGTP, INCLUDE DBT IN THE NOTE."

- Progress Note: Date: March 19, 2024 Client: John Doe Therapist: Jane Smith
- Session Summary: During today's session, John and I focused on developing strategies for relapse prevention in his substance use disorder (SUD) recovery journey, incorporating elements of Dialectical Behavior Therapy (DBT). John demonstrated a strong commitment to maintaining his sobriety and actively engaged in the discussion regarding potential triggers and coping mechanisms.
- Assessment: John reported feeling confident in his ability to remain abstinent from substances but acknowledged the presence of triggers in his environment that could potentially lead to relapse. He expressed a heightened awareness of the importance of implementing effective coping strategies to manage cravings and prevent a recurrence of substance use.
- Intervention: Incorporating DBT principles into our session, we began by exploring specific triggers that John has identified in his daily life, including stress, social gatherings where alcohol is present, and certain locations associated with past substance use. Together, we worked on developing a personalized relapse prevention plan tailored to John's individual needs and circumstances.
- Key components of John's relapse prevention plan, incorporating DBT strategies, include:

1. Mindfulness: John and I discussed the practice of mindfulness as a tool for increasing awareness of his thoughts, emotions, and physical sensations in the present moment. We explored mindfulness exercises that John can integrate into his daily routine to help him recognize and cope with cravings and triggers as they arise.
2. Distress Tolerance: We reviewed distress tolerance skills aimed at helping John tolerate uncomfortable emotions without resorting to substance use. These skills include distraction techniques, self-soothing activities, and radical acceptance of situations beyond his control.
3. Emotion Regulation: John expressed a desire to better regulate his emotions without turning to substances for relief. We explored strategies for identifying and labeling emotions, increasing emotional awareness, and practicing effective emotion regulation techniques such as opposite action and problem-solving.
4. Interpersonal Effectiveness: Recognizing the importance of healthy relationships in John's recovery, we discussed interpersonal effectiveness skills to help him navigate social interactions and communicate his needs assertively. John identified specific communication techniques to use when faced with challenging interpersonal situations, including setting boundaries and expressing his feelings openly.
5. Creating a Dialectical Framework: We worked together to create a dialectical framework for John's recovery journey, acknowledging the coexistence of acceptance and change as essential elements in his path towards sobriety. By embracing both acceptance of his current reality and a commitment to change, John aims to cultivate resilience and flexibility in his recovery process.

- John demonstrated a strong understanding of the DBT-informed relapse prevention strategies discussed during the session and expressed a commitment to integrating them into his daily life.
- Plan: Moving forward, John and I will continue to incorporate DBT principles into our sessions as we monitor his progress in implementing the relapse prevention strategies discussed today. We will also explore additional DBT skills and resources that may further support his recovery journey. Our next session is scheduled for March 26, 2024.


SOUNDS LIKE WE'RE OUT OF A JOB
DON'T YOU MEAN "EXTINCT"?
yarn.co

AI PRO / CON

Increase access (time of day, rural areas)

Some people will prefer the platform, anonymity(?)

May increase consistency of methodology (diagnosis, intervention, plan)

A potentially valuable training tool for human counselors

Limitation to inputs (depends on robustness of the AI)

Multi-cultural considerations

Questions about confidentiality

May remove practice errors (i.e., the “human element”)

Will malpractice insurance cover use of AI?

Boards/codes are not explicitly addressing these uses cases currently

SOCIAL MEDIA

High risk for exploitation and/or inappropriate contact with current/former clients

High risk for self-indulgence and self-promotion

You are responsible for content on your page

- And you're **ESPECIALLY** responsible for what **YOU** share!

Clinicians are prohibited from engaging in a personal virtual relationship with individuals with whom they have a current counseling relationship (e.g., through social and other media) [ACA Code of Ethics]

- Even after services are discontinued, consider the risk of dual relationships and if these contacts can be avoided.
- If they can be avoided then there is no reason to engage in this type of "virtual relationship."

SOCIAL MEDIA AND OTHER PROFESSIONALS

Set up rules for yourself about “friending” or “connecting” with colleagues

Be mindful about promoting others...

Be mindful about sharing posts...

Be mindful about liking or re-tweeting content.....

- This will reflect *you* and *your* practice.

TECHNOLOGY BOUNDARIES

Communication

- There are established channels for communication between staff, patients, and involved others (like family)
- Ideally, these channels are defined (work *vs*. personal email/phone number)
  - If not, provider must create these boundaries

Electronic Medical Records

- Access to patient information is on a need-to-know basis
- Only designated staff who are providing services to a patient/family should have access to record content
- Accessing patient records when it is not related to work operations is prohibited

TELEHEALTH ETHICAL CONSIDERATIONS

- Licensure and Jurisdiction
- HIPPA Compliant Platforms
- Emergency Protocols
- Consent
  - Risk/Benefit of Technology
  - Possibility of Technology Failure
  - Anticipated Response Time
  - Emergency Procedures
  - Time Zone Differences
  - Privacy in home settings
  - Identity Verification

THINGS TO REMEMBER

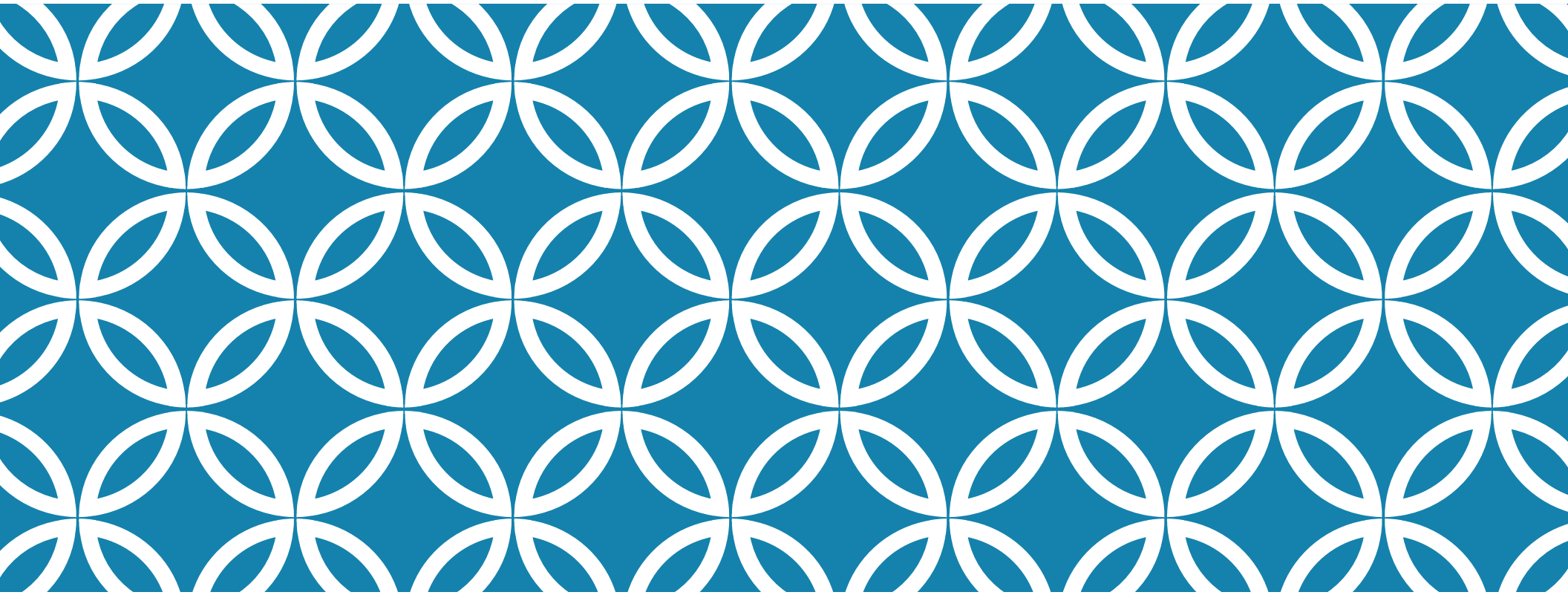
Ethical decision-making is an active, continuous process.

Ethical standards are not a cookbook.

- They tell you what to do but not always how to do it.

Each situation is unique.

- Therefore, it is imperative that all personnel learn how to “think ethically” and how to make sound legal and ethical decisions.



QUESTIONS

CONNECT WITH UAB FAMILY AND ADOLESCENT SERVICES

Comprehensive Addiction in Pregnancy Program (CAPP)

Family Wellness

BEYOND Program

Adolescent Substance Use Program (ASAP)

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RESOURCES

- https://www.samhsa.gov/data/release/2018-national-survey-drug-use-and-health-nsduh-releases
- http://factn.org/legislation-bill-tracking-state-legislature/counselors-bill-hb-1840-fact-sheet/
- https://www.nashvillescene.com/news/pith-in-the-wind/article/20845882/one-antigay-counseling-bill-wasnt-enough-now-theres-a-second-one
- http://www.hpso.com/risk-education/individuals/Counselor-Claim-Reports?utm_source=internal&utm_medium=email&utm_campaign=
- http://www.tennlegal.com/files/430/File/Statistics_of_Ethical_Violations.pdf
- https://alliedhealth.ceconnection.com/files/ProtectingYourCounselorLicense-1484916161638.pdf;jsessionid=4C8A3A6252200B55F6BF8E74D399CC9B
- Isaacs, M. L., & Stone, C. (2001). Confidentiality with minors: Mental health counselors' attitudes toward breaching or preserving confidentiality. *Journal of Mental Health Counseling, 23*(4), 342-356.