Avoiding Ethical and Legal Pitfalls in Mental Health Practice
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Avoiding Ethical and Legal Pitfalls in Mental Health Practice

Written and Presented by:
Bob Stinson Psy.D., J.D., ABPP

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Ground Rules

- Please do not provide any private or confidential information.
- All situations and scenarios should be construed as, and will be treated as, hypotheticals.
- "Passing" is allowed if called on.
- Have fun and be a part of the day!!

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Who Are You & Why Are You Here?
Risk Areas

- Clinical Management (e.g., suicidal patient, homicidal client, record keeping) – 21.5%
- Confidentiality / Release of Records – 18.5%
- Divorce / Custody – 10.5%
- Reporting Responsibilities – 10.5%

From APAT, 05/2009

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Goals & Objectives

- Model for balancing variables (e.g., law, ethics, clinical judgment, personal morals and values) in gray-area judgment calls
- Addressing conflicts in ethics codes, regulatory boards, and laws
- Accessing and staying up to date on ethics, regulations, and laws
- Creating and maintaining records

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Goals and Objectives

- Confidentiality and Privilege (differences, who holds the right, waiving the right)
- Release of records (when is it OK, special situations—divorce, child custody, couples therapy, children, not in best interest)
- Subpoenas (recognizing valid and invalid; knowing what to do and not to do)
- Reporting (mandatory and optional; who, what, and to whom)

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Ethics Decision Making Model

1. Determine whether the matter truly involves ethics (or a legal or regulatory rule).
2. Consult guidelines already available that might apply as a possible mechanism for resolution.
3. Pause to consider, as best as is possible, all factors that might influence the decision you will make.
4. Consult with a trusted colleague.
Steps In Ethical Decision Making

5. Evaluate the rights, responsibilities, and vulnerabilities of all affected parties.
6. Generate alternative decisions.
7. Enumerate the consequences of making each decision.
8. Make the decision.
   - Pause to consider ways to minimize harm to others (e.g., involve client in reporting)

Steps In Ethical Decision Making

1. State the question, dilemma, or concern as clearly as possible.
2. Anticipate who will be affected by the decision.
3. Figure out who, if anyone, is the client.
4. Assess your areas of competence.
5. Review formal ethical standards.
7. Review research and theory.
8. Consider personal feelings, biases, & self-interest.
9. Consider social, cultural, religious factors.
10. Consider consultation.
11. Develop alternative courses of action.
12. Think through the alternative courses.
13. Adopt the perspective of each person affected.
14. Decide what to do, then reconsider it.
15. Document the process & assess the results.
Nonmaleficence

- *Primum non nocere* (First, do no harm!)
- This prohibition against doing no harm is very broad and not only applies specifically to treatment but can also include administrative aspects of the treatment relationship.
- Requires you to think about “worst case” scenarios

Beneficence

- Help
- Promote well-being
- Provide a benefit
- Fundamental to all health care is a belief that the provider is attempting to improve the patient’s condition through the delivery of professional services.
Fidelity

• Fidelity addresses a person’s responsibility to be loyal, truthful, and to keep promises in their relationships with others. In health care, it extends beyond the regular responsibilities of business or contractual fulfillment to the creation of a relationship based on trust: the trust the patient has that the professional will always operate in a patient’s best interest.
• Treatment providers are “fiduciaries” for their patients.

Justice

• The ethical principle of Justice is the foundation for other very valuable healthcare concepts like fairness and equity.
• Fairness
• Non-Discrimination
• Don’t Condone Unjust Practices

Autonomy

• Respect for autonomy is tied to the belief that a person has a right to hold views and make choices that are reflective of his or her own beliefs and that these beliefs do not need to be shared with, or approved by, others.
• Foundation for informed consent
• Key component of HIPAA
**7 Basic Assumptions About Ethics**

1. Ethical awareness is a continuous, active process that involves constant questioning and personal responsibility.

Conflicts with managed care companies, the urgency of patients’ needs, the lack of adequate support, the possibility of formal complaints, mind-deadening routines, endless paperwork, worrying about making ends meet, fatigue, and so much else can begin to block our personal responsiveness and dull our sense of personal responsibility. They can overwhelm us, drain us, distract us, and lull us into ethical sleep. It is crucial to practice continued alertness and mindful awareness of the ethical implications of what we choose to do and not do.
2. Awareness of ethical codes and legal standards is important, but formal codes and standards cannot take the place of an active, thoughtful, creative approach to our ethical responsibilities.

Codes and standards inform rather than determine our ethical considerations. They can never substitute for thinking and feeling our way through ethical dilemmas, and cannot protect us from ethical struggles and uncertainty. Each new client, regardless of similarities to other clients, is unique. Each therapist is unique. Each situation is unique and constantly evolves. Our theoretical orientation, the nature of our community and the client’s community, our culture and the client’s culture, and so many other contexts influence what we see and how we see it – every ethical decision must take account of these contexts. Standards and codes may identify some approaches as clearly unethical. They may identify significant ethical values and concerns, but they cannot tell us what these values and concerns will take. They may set forth essential tasks, but they cannot spell out the best way to accomplish those tasks with a unique client facing unique problems in a specific time and place with limited resources.

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From Pope & Vasquez, 2007.

3. Awareness of the evolving research and theory in the scientific and professional literature is another important aspect of ethical competence, but the claims and conclusions emerging in the literature can never be passively accepted or reflexively applied no matter how popular, authoritative, or seemingly obvious.

A necessary response to published claims and conclusions is active, careful, informed, persistent, and comprehensive questioning.

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From Pope & Vasquez, 2007.

4. We believe that the overwhelming majority of therapists and counselors are conscientious, dedicated, caring individuals, committed to ethical behavior. But none of us is infallible. All of us can – and do – sometimes make mistakes, overlook something important, work from a limited perspective, reach conclusions that are wrong, hold tight to a cherished belief that is misguided.

An important part of our work is questioning ourselves, asking “What if I’m wrong about this? Is there something I’m overlooking? Could there be another way of understanding this situation? Are there other possibilities? Could there be a more creative, more effective, better way of responding?”

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From Pope & Vasquez, 2007.
7 Basic Assumptions About Ethics

5. Many of us find it easier to question the ethics of others than to question our own beliefs, assumptions, and actions.

It is worth noticing if we find ourselves preoccupied with how wrong others are in some area of ethics and certain that we are the ones to set them right, or at least to point out repeatedly how wrong they are. It is a red flag if we spend more time trying to point out the supposed weaknesses, flaws, mistakes, ethical blindness, destructive actions, or error-filled beliefs of a colleague or group of colleagues than we spend questioning and challenging ourselves in positive, effective, and productive ways that awaken us to new perspectives and possibilities. It is important to question ourselves at least as much as we question others.

6. Many of us find it easier and more natural to question ourselves in areas where we are uncertain. It tends to be much harder -- but often much more productive -- to question ourselves about what we are most sure of, what seems beyond doubt or question.

Nothing can be placed off-limits for this questioning. We must follow this questioning wherever it leads us, even if we venture into territories that some might view as “politically incorrect” or -- much more difficult for most of us -- “psychologically incorrect.”

7. As psychologists, we often encounter ethical dilemmas without clear and easy answers.

We confront overwhelming needs unmatched by adequate resources, conflicting responsibilities that seem impossible to reconcile, frustrating limits to our understanding and interventions, and countless other challenges as we seek to help people who come to us because they are hurting and in need, sometimes because they are desperate and have no where else to turn.

There is no legitimate way to avoid these ethical struggles. They are part of our work.
Laws, Rules, and Codes - Differences

<table>
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<th>Laws</th>
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<th>Codes of Conduct</th>
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<td>Who Must Follow?</td>
<td>Everyone in the covered jurisdiction</td>
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<td>Members</td>
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<td>Criminal conviction</td>
<td>Fines, Reprimands,</td>
<td>Censureship, expulsion from membership</td>
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<td>Violation?</td>
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<td>Suspensions,</td>
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<td></td>
<td></td>
<td>Revocation of License</td>
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</tbody>
</table>

Note: There is much overlap between laws, administrative rules, and professional codes of conduct. Each may cite to the other. Administrative rules, for example, are written statements of law adopted by an administrative agency pursuant to authority granted by the General Assembly to carry out the policies and intent of a statute enacted by the General Assembly.
Laws, Rules, and Codes – Staying Informed

- The law itself
- State board
- Professional organizations
- Colleagues
- Listservs / blogs
- Continuing education workshops / seminars
- Lawyer

Records Handling

- Make A Record
  - Legible
  - Accurate
  - Timely
  - Organized

Records Handling

- Appropriate Content
  - Good Care
  - Continuity of Care
  - Supervision
  - Reimbursement
  - Risk Management (Complaints, Litigation, Etc.)
- Consider the following:
  - Presenting problem
  - Date and purpose
  - Fee arrangement
  - Testing and other evaluative results
  - Test data
  - Test or evaluative reports
  - Notation / results of formal contacts with other providers
  - Authorization for release of information

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Records Handling

- Confidentiality of Records
  - Familiar with ethical standards
  - Know state and federal law (HIPAA)
  - Train paraprofessional staff
  - Know when mandatory reporting is required
- Disclose Record Keeping Policy
  - Make part of informed consent
  - Who else might have access
  - Discuss potential for re-disclosure if you release records

- Maintenance of Records
  - Make them handoff-ready
  - Psychotherapy notes kept separate (HIPAA)
  - Consider having different sections to a chart/file
  - Consider whether to re-release information
- Security of Records
  - Protect from unauthorized access
  - Protect from damage and destruction
  - Limit to those who need to know
  - HIPAA privacy and security provisions

- Retention of Records
  - Know your state/Board's requirements
    - In accordance with Ohio Revised Code, psychologists are required to keep records for at least 5 years (this is six years for the HIPAA forms) post-termination of services and then the "general record" or "summary thereof" for an additional 7 years.
    - APA record keeping guidelines: 7 years after last date of service; 3 years after age of majority for minors (whichever is later)
Records Handling

- **Preserve Context of Records**
  - Protect against misuse / mis-representation
    - Crisis
    - Great stress
- **Electronic Records**
  - Email?
  - The ease of creating, transmitting, and sharing electronic records may expose psychologists to risks of unintended disclosure of confidential information.
  - Consider case # instead of social security #
  - Passwords and encryption
  - Consultation and training

---

Records Handling

- **Organizational Policies**
  - Conflicts
  - Ownership
  - Access
- **Multiple Client Records**
  - Who’s the client
  - Records kept jointly or separately
- **Financial Records**
  - Be clear from the outset (how much, when, collections)
  - Don’t surprise the client with a high unpaid bill

---

Records Handling

- **Disposition of Records**
  - Records transfer plan
  - Proper disposal
  - Notification of change of custody
  - Technical consultation for electronic records
Confidentiality v. Privilege

One day you receive a telephone call from someone whose voice you do not recognize. The caller asks, “Do you see _______ (insert the name of one of your clients) as a patient in your practice?” Because you are trained in your ethical and legal responsibilities, you answer appropriately. Later that week, in a consultation with a colleague, you explain that you answered the way that you did because the information requested was:

a) Not protected  
b) Privileged  
c) Confidential  
d) Privileged and Confidential  
e) None of the above

Confidentiality v. Privilege Definitions

- Confidentiality refers to a general standard of professional conduct that obliges a professional not to discuss information about a client with anyone.
- Confidentiality may also be based in statutes (i.e., laws enacted by legislatures) or case law (i.e., interpretations of laws by courts).
- When cited as an ethical principle, confidentiality implies an explicit contract or promise not to reveal anything about a client except under certain circumstances agreed to by both parties.

Confidentiality v. Privilege Definitions

- Privilege (or privileged communication) is a legal term describing certain specific types of relationships that enjoy protection from disclosure in legal proceedings. Privilege is granted by law and belongs to the client in the relationship.
Confidentiality v. Privilege

<table>
<thead>
<tr>
<th>Confidentiality</th>
<th>Privilege</th>
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</thead>
<tbody>
<tr>
<td>Standard of professional conduct</td>
<td>Legal concept</td>
</tr>
<tr>
<td>Promise not to discuss with anyone</td>
<td>Protects disclosure in legal proceedings</td>
</tr>
<tr>
<td>Professional decides if confidential</td>
<td>Judge will decide if privileged</td>
</tr>
<tr>
<td>Client need not assert confidentiality</td>
<td>Client usually must assert privilege</td>
</tr>
<tr>
<td>Client can selectively release information</td>
<td>Usually can't waive selectively</td>
</tr>
<tr>
<td>Can revoke</td>
<td>Can't revoke</td>
</tr>
<tr>
<td>Right to confidentiality even if tell others</td>
<td>May waive privilege by telling others</td>
</tr>
<tr>
<td>May have re-release protections</td>
<td>Usually no re-release protection</td>
</tr>
</tbody>
</table>

Confidentiality - Privacy

- Court Decision: 573 New York Supplement, 2d Series 828; 1991 Jul 2 (date of decision). Strong Memorial Hospital (Rochester, NY) and one of its physicians brought a third-party action against the Gannett newspaper company to force it to contribute to the payment of a $35,000 judgment that an HIV-positive patient, Cornell Anderson, had won against the hospital and doctor. The patient’s suit was based on the publication in the newspaper of a photo in which he could be identified. The Gannett photographer, however, had promised the hospital and doctor that such an identification would not be possible. The Supreme Court of Monroe County, New York, denied the claim of the hospital and doctor because they had negligently failed to maintain the confidentiality of the patient’s identity.
Jaffee v. Redmond, SCOTUS, 1996

- Federal psychotherapist-patient privilege for psychiatrists, psychologists, and licensed social workers in the course of psychotherapy
  - Not for social worker evaluations; only psychotherapy
- Information must be:
  - Obtained by interview or physical examination
  - Transmitted directly in professional relationship

Exceptions to Privilege

- Third party non-agent present
- Client-litigant exception (putting mental state at issue)
- Court ordered evaluations or treatment
- Therapist asked to aid in crime or tort
- After death (e.g., contesting a will); waived by rep of deceased
- Danger to self / others
- Client testifies about some aspect of privileged info
- Suit against therapist; suit by therapist (e.g., $)
- Child custody cases (weigh probative value)
- Criminal cases in most jurisdictions (think relevance)
- Judge determines disclosure necessary to the administration of justice

Lifschutz, 1970

- H.S. teacher sues student for assault & emotional distress
- Patient treated by Dr. Lifschutz
- Defendant requested records
- Dr. Lifschutz refused to answer questions or turn over records
- Found in contempt; upheld in appeals court
- Spent 3 days in jail before compromise for judge to do in-camera inspection
- Records ruled irrelevant; not revealed in open court
- Moral: Privilege belongs to patient!
**ROIs - Required Elements**

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
- The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.
- The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure.
- A description of each purpose of the requested use or disclosure. The statement “at the request of the individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement “end of the research study,” “none,” or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including the creation and maintenance of a research database or research repository.
- Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of such representative’s authority to act for the individual must also be provided.

45 C.F.R. § 164.508 Uses and disclosures for which an authorization is required
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**ROIs - Required Statements**

- The individual’s right to revoke the authorization in writing, the exceptions to the right to revoke, and a description of how the individual may revoke the authorization.
- The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization.
- The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected.

Also:
- Use plain language
- Provide client a copy

45 C.F.R. § 164.508 Uses and disclosures for which an authorization is required
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**Release of Records - General**

- Always contact client; then document this.
- Release only what is necessary to comply with the request.
- Keep a log of all disclosures.

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Release of Records in Special Situations

- Children as Clients
- Divorce / Child Custody
- Couples / Marital / Family Therapy
- Release Not in Best Interest of Client

Release of Records in Special Situations

- Informed Consent – Clarify at Outset

Release of Records with Child Clients

- Basic legal principle that parents have the right to make treatment decisions for minor children.
- It is “as if” the parent is the client.
- Where State law requires consent of a parent, guardian, or other person for a minor to obtain alcohol or drug abuse treatment, any written consent for disclosure must be given by both the minor and his or her parent, guardian, or other person authorized under State law to act in the minor’s behalf. 42 CFR 2.14(c)
- Children have some confidentiality rights when they become adults.
Release of Records After Divorce

- Custody v. Parenting Time
- Sole Custody v. Joint Custody
  - Joint Legal Custody v. Joint Physical Custody
- Custody Order
- Divorce Decree
- When in doubt, records should be withheld pending consent of all parties or a court order

Release of Records After Divorce

- Consider requiring the parent to affirm custody, right to seek treatment, and right to records.
- If releasing records to one parent, consider informing other parent if that parent is also entitled to records.

Release of Records in Couples / Marital / Family Therapy

- Informed Consent
- Who’s the Client?
- Informed Consent
- Should allow the preservation of each individual’s confidentiality should the records of one party be released. (Koocher & Keith Spiegel, 2008).
- Informed Consent!
Release of Records When Not in Best Interest of Client

- Ethics
- Law
- Be Practical

Subpoenas – What are They?

- A subpoena is a legal order commanding the person or organization named in the subpoena to give sworn testimony at a specified time and place about a matter concerned in an investigation or a legal proceeding, such as a trial.
- A subpoena duces tecum substitutes the requirement of your appearance to testify with a requirement that you supply specific physical material in your possession.
- A deposition subpoena means that your sworn testimony will be taken during a phase of the trial process known as discovery, and will likely occur at a lawyer’s office.

Subpoenas – Who Can Issue

- Judge presiding over the legal proceedings
- Clerk of the court where the lawsuit has been filed
- Lawyer representing one of the parties in the lawsuit
Subpoenas

- A subpoena compels a response
- A court order compels disclosure

Subpoenas – What to Do

- Look for full name of the court
- Look for the word “Subpoena” in bold type
- “You are commanded to report” or similar wording
- Your name
- A specific date, time, and location for you to appear or produce requested documents
- Respond!

Subpoenas – What Not to Do

- Ignore it
- Comply without consideration of confidentiality issues
Subpoenas – Motion to Quash

• Contains a request to the court asking to modify or terminate the subpoena based on certain objections, and a memorandum explaining how the law supports the objections.

Subpoenas – Reasons to Object

• Improper service
• Scope of request
• Confidentiality / Privilege
• Violation of law (e.g., copyrighted material)
• Self-incrimination

Subpoenas - Tips

1. Request a ROI from the client (not the attorney). If a ROI is included and you worry the information could be damaging, contact client
2. Ask for a limited release to communicate with requesting attorney
3. Ask your client’s attorney to work out the privilege issue with opposing counsel or to quash the subpoena
4. Get a written excuse from the attorney issuing the subpoena
Subpoenas - Tips

5. Consider writing a letter to the judge.
6. In court, ask for an in-camera inspection of the records.
7. Request a limiting order
8. Request a protection order:
   a) One copy to each attorney, to be returned
   b) No one in the courtroom during testimony
   c) Seal the transcript of the proceedings.

Subpoenas - Tips

- Negotiate Payment for Services
  - In many states, you can demand appropriate payment for depositions.
  - In many states, an attorney cannot use you as an expert witness without paying your professional fee.
  - If you have a contract with your client, you can charge him/her for your time
  - Payment for treating experts is less clear

Subpoena

- Flow Chart
- Sample
Reporting

• Research has demonstrated that 75% of psychologists are misinformed about their legal duties when confronted with clients who are potentially dangerous to others.

• 90% of that same sample of psychologists described themselves as confident in the accuracy of their legal knowledge in this area.

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Reporting

• Crime
• Document Domestic Violence
• Child Abuse / Neglect
• Elder Abuse
• Developmentally Disabled Abuse
• Suicidal
• Homicidal

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Mandatory v. Optional Reporting

• Who
• What
• To Whom
  – Ethics
  – Personal Values / Morals
  – State Specific Laws

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Child Therapy Contract (From APAIT)

Introduction
This document provides one model for agreement between the therapist and the parents or guardians of a child undergoing treatment. Such an agreement can help establish ground rules that clarify the psychologist’s role in therapy and define the limits of parental involvement. It can also help define the conditions of the therapist’s role in divorce and custody proceedings. However, it should be seen as only an initial step in the broader informed consent process, and it should be the basis for additional and possibly ongoing discussion – anchored in the real world – with parents or guardians regarding ethics, law, confidentiality, and other elements of informed consent. We believe that the value of such dialogue, particularly in divorce and custody scenarios, outweighs its potential to subvert the therapeutic process.

This model contract assumes theoretical and practical variance among therapists who work with children. For example, regarding the extent to which they emphasize the safety or autonomy of their child patients, the safety-oriented therapist may adopt a lower threshold for informing parents of risky adolescent behavior than an autonomy-oriented colleague. We encourage contract modification that is consistent with the substance and process of the work being done.

We also recognize the wide variance in state laws regarding parental access to records. For example, any person age twelve and older can block parental access to records in New York and Illinois. In such states, the therapist might use the contract to obtain an adolescent client’s consent to share certain information with parents. Another variation can be signed by both parents and the child even in states where parents have sole decision-making authority. In those states granting confidentiality rights to adolescent patients, an additional specific “release-of-information” agreement allowing information exchange between therapist and parents may be needed.

The therapist should note that contract ratification, particularly the parents’ or patient’s agreement to discourage subpoenas from attorneys, is not legally binding and may not prevent a judge from issuing a subpoena. However, sufficient anecdotal evidence suggests that such a contract discourages the utilization of child therapists in the divorce process. The parent who willfully violates a commitment to protect the child’s privacy risks being judged as putting his or her gain before the best interest of the child. The contract also serves to remind the court of the strong correlation between privacy and therapeutic effectiveness.

Note that we include an abbreviated version of the contract for those preferring less detail in the written agreement, but we recommend its use only if accompanied by more detailed discussions with patients/parents and detailed notes regarding such discussion.

Finally, your constructive feedback will help us build better contracts. Please email your comments to {web address add address}. And, when you hit a snag or have a question regarding contract modification, call the Trust’s 800-Advocate consultation service at 1-800-477-1200. This unique free and confidential risk management service is available to those insured in the Trust-sponsored Professional Liability Program.

Draft Contract

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child’s confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Therapist Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child’s therapeutic progress.
Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a “zone of privacy” whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child’s treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child’s consent. I will tell you if your child does not attend sessions. At the end of your child’s treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent’s custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $XXX per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Abbreviated Contract Draft

- If you decide to terminate treatment, I have the option of having a few closing sessions with your child to properly end the treatment relationship.

- You are waiving your right to access to your child’s treatment records.

- I will inform you if your child does not attend the treatment sessions.
At the end of treatment, I will provide you with a summary that includes a general description of goals, progress made, and potential areas that may require intervention in the future.

If necessary to protect the life of your child or another person, I have the option of disclosing information to you without your child’s consent.

You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).

You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, I will provide general information about the child which will not include recommendations concerning custody or custody arrangements.

If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $XXX per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.
SUBPOENA RECEIVED

Will your client sign an authorization form so you can release the information?

No

Ask your client sign a limited authorization form so you can acknowledge you are treating the client.

Encourage your client to contact his or her attorney to have the subpoena quashed.

Contact the attorney who issued the subpoena. Assert confidentiality on behalf of your client. Be careful not to disclose confidential information. Attempt to get released (in writing) by the attorney.

Consider writing a letter to the judge, notifying him or her that you have not been able to resolve the issue through the attorney, and need to assert confidentiality on behalf of your client.

Judge makes a ruling. Follow the judge’s order.

Suggest the following in a protective order:

1. Each attorney gets one set of the records, to be returned to the mental health professional at the conclusion of the proceedings.
2. All parties are prohibited from revealing the contents of the records outside the court proceedings.
3. The court room is closed to the public during proceedings in which the records are discussed or about which testimony is taken.
4. The record is sealed for any portion of the transcript of the proceedings during which the records were discussed or about which testimony was taken.

Appear at the time and location required. Assert confidentiality on behalf of your client. Ask the judge to do an in-camera review.

Request a “Limiting Order” so that only the relevant records are turned over.

Request a “Protective Order” so that what does get turned over is protected to the extent it can be.

Yes

Is it valid and was it properly served?

No

Yes

Produce the records.

May not need to produce.

Released by the attorney

Not released by the attorney

Avoiding Ethical and Legal Pitfalls in Mental Health Practice
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Rule 45. Subpoena

(a) In General.

(1) Form and Contents.

(A) Requirements—In General. Every subpoena must:

(i) state the court from which it issued;

(ii) state the title of the action, the court in which it is pending, and its civil-action number;

(iii) command each person to whom it is directed to do the following at a specified time and place: attend and testify; produce designated documents, electronically stored information, or tangible things in that person's possession, custody, or control; or permit the inspection of premises; and

(iv) set out the text of Rule 45(c) and (d).

(B) Command to Attend a Deposition—Notice of the Recording Method. A subpoena commanding attendance at a deposition must state the method for recording the testimony.

(C) Combining or Separating a Command to Produce or to Permit Inspection; Specifying the Form for Electronically Stored Information. A command to produce documents, electronically stored information, or tangible things or to permit the inspection of premises may be included in a subpoena commanding attendance at a deposition, hearing, or trial, or may be set out in a separate subpoena. A subpoena may specify the form or forms in which electronically stored information is to be produced.

(D) Command to Produce; Included Obligations. A command in a subpoena to produce documents, electronically stored information, or tangible things requires the responding party to permit inspection, copying, testing, or sampling of the materials.

(2) Issued from Which Court. A subpoena must issue as follows:

(A) for attendance at a hearing or trial, from the court for the district where the hearing or trial is to be held;

(B) for attendance at a deposition, from the court for the district where the deposition is to be taken; and
(C) for production or inspection, if separate from a subpoena commanding a person's attendance, from the court for the district where the production or inspection is to be made.

(3) Issued by Whom. The clerk must issue a subpoena, signed but otherwise in blank, to a party who requests it. That party must complete it before service. An attorney also may issue and sign a subpoena as an officer of:

(A) a court in which the attorney is authorized to practice; or

(B) a court for a district where a deposition is to be taken or production is to be made, if the attorney is authorized to practice in the court where the action is pending.

(b) Service.

(1) By Whom; Tendering Fees; Serving a Copy of Certain Subpoenas. Any person who is at least 18 years old and not a party may serve a subpoena. Serving a subpoena requires delivering a copy to the named person and, if the subpoena requires that person's attendance, tendering the fees for 1 day's attendance and the mileage allowed by law. Fees and mileage need not be tendered when the subpoena issues on behalf of the United States or any of its officers or agencies. If the subpoena commands the production of documents, electronically stored information, or tangible things or the inspection of premises before trial, then before it is served, a notice must be served on each party.

(2) Service in the United States. Subject to Rule 45(c)(3)(A)(ii), a subpoena may be served at any place:

(A) within the district of the issuing court;

(B) outside that district but within 100 miles of the place specified for the deposition, hearing, trial, production, or inspection;

(C) within the state of the issuing court if a state statute or court rule allows service at that place of a subpoena issued by a state court of general jurisdiction sitting in the place specified for the deposition, hearing, trial, production, or inspection; or

(D) that the court authorizes on motion and for good cause, if a federal statute so provides.

(3) Service in a Foreign Country. 28 U.S.C. §1783 governs issuing and serving a subpoena directed to a United States national or resident who is in a foreign country.

(4) Proof of Service. Proving service, when necessary, requires filing with the issuing court a statement showing the date and manner of service and the names of the persons served. The statement must be certified by the server.
(c) Protecting a Person Subject to a Subpoena.

(1) Avoiding Undue Burden or Expense; Sanctions. A party or attorney responsible for issuing and serving a subpoena must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena. The issuing court must enforce this duty and impose an appropriate sanction—which may include lost earnings and reasonable attorney's fees—on a party or attorney who fails to comply.

(2) Command to Produce Materials or Permit Inspection.

(A) Appearance Not Required. A person commanded to produce documents, electronically stored information, or tangible things, or to permit the inspection of premises, need not appear in person at the place of production or inspection unless also commanded to appear for a deposition, hearing, or trial.

(B) Objections. A person commanded to produce documents or tangible things or to permit inspection may serve on the party or attorney designated in the subpoena a written objection to inspecting, copying, testing or sampling any or all of the materials or to inspecting the premises—or to producing electronically stored information in the form or forms requested. The objection must be served before the earlier of the time specified for compliance or 14 days after the subpoena is served. If an objection is made, the following rules apply:

(i) At any time, on notice to the commanded person, the serving party may move the issuing court for an order compelling production or inspection.

(ii) These acts may be required only as directed in the order, and the order must protect a person who is neither a party nor a party's officer from significant expense resulting from compliance.

(3) Quashing or Modifying a Subpoena.

(A) When Required. On timely motion, the issuing court must quash or modify a subpoena that:

(i) fails to allow a reasonable time to comply;

(ii) requires a person who is neither a party nor a party's officer to travel more than 100 miles from where that person resides, is employed, or regularly transacts business in person—except that, subject to Rule 45(c)(3)(B)(iii), the person may be commanded to attend a trial by traveling from any such place within the state where the trial is held;

(iii) requires disclosure of privileged or other protected matter, if no exception or waiver applies; or

(iv) subjects a person to undue burden.
(B) **When Permitted.** To protect a person subject to or affected by a subpoena, the issuing court may, on motion, quash or modify the subpoena if it requires:

(i) disclosing a trade secret or other confidential research, development, or commercial information;

(ii) disclosing an unretained expert's opinion or information that does not describe specific occurrences in dispute and results from the expert's study that was not requested by a party; or

(iii) a person who is neither a party nor a party's officer to incur substantial expense to travel more than 100 miles to attend trial.

(C) **Specifying Conditions as an Alternative.** In the circumstances described in Rule 45(c)(3)(B), the court may, instead of quashing or modifying a subpoena, order appearance or production under specified conditions if the serving party:

(i) shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship; and

(ii) ensures that the subpoenaed person will be reasonably compensated.

(d) **Duties in Responding to a Subpoena.**

(1) **Producing Documents or Electronically Stored Information.** These procedures apply to producing documents or electronically stored information:

(A) **Documents.** A person responding to a subpoena to produce documents must produce them as they are kept in the ordinary course of business or must organize and label them to correspond to the categories in the demand.

(B) **Form for Producing Electronically Stored Information Not Specified.** If a subpoena does not specify a form for producing electronically stored information, the person responding must produce it in a form or forms in which it is ordinarily maintained or in a reasonably usable form or forms.

(C) **Electronically Stored Information Produced in Only One Form.** The person responding need not produce the same electronically stored information in more than one form.

(D) **Inaccessible Electronically Stored Information.** The person responding need not provide discovery of electronically stored information from sources that the person identifies as not reasonably accessible because of undue burden or cost. On motion to compel discovery or for a protective order, the person responding must show that the information is not reasonably accessible because of undue burden or cost. If that showing is made, the court may nonetheless order discovery from such sources if the requesting
party shows good cause, considering the limitations of Rule 26(b)(2)(C). The court may specify conditions for the discovery.

(2) **Claiming Privilege or Protection.**

(A) **Information Withheld.** A person withholding subpoenaed information under a claim that it is privileged or subject to protection as trial-preparation material must:

(i) expressly make the claim; and

(ii) describe the nature of the withheld documents, communications, or tangible things in a manner that, without revealing information itself privileged or protected, will enable the parties to assess the claim.

(B) **Information Produced.** If information produced in response to a subpoena is subject to a claim of privilege or of protection as trial-preparation material, the person making the claim may notify any party that received the information of the claim and the basis for it. After being notified, a party must promptly return, sequester, or destroy the specified information and any copies it has; must not use or disclose the information until the claim is resolved; must take reasonable steps to retrieve the information if the party disclosed it before being notified; and may promptly present the information to the court under seal for a determination of the claim. The person who produced the information must preserve the information until the claim is resolved.

(e) **Contempt.** The issuing court may hold in contempt a person who, having been served, fails without adequate excuse to obey the subpoena. A nonparty's failure to obey must be excused if the subpoena purports to require the nonparty to attend or produce at a place outside the limits of Rule 45(c)(3)(A)(ii).
Avoiding Ethical and Legal Pitfalls in Mental Health Practice

Bob Stinson, Psy.D., J.D., ABPP

35
PROOF OF SERVICE

DATE

PLACE

SERVED

SERVED ON: (PRINT NAME)
MANNER OF SERVICE

SERVED BY: (PRINT NAME)
TITLE

DECLARATION OF SERVER

I declare under penalty of perjury under the laws of the United States of America that the foregoing information contained in the Proof of Service is true and correct.

Executed on ________________

DATE

SIGNATURE OF SERVER

ADDRESS OF SERVER

Rule 45, Federal Rules of Civil Procedure, Subdivisions (c), (d), and (e), as amended on December 1, 2006:

(c) PROTECTION OF PERSONS SUBJECT TO SUBPOENA.
(1) A party or attorney who fails to allow a reasonable time for compliance; or
(2) A party or attorney who fails to produce or permit the production of any evidence that the party or attorney is required to produce.

(d) DUTIES IN RESPECT OF SUBPOENA.
(1) A party or attorney who fails to allow a reasonable time for compliance; or
(2) A party or attorney who fails to produce or permit the production of any evidence that the party or attorney is required to produce.

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Mission

The mission of the American Counseling Association is to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity.

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ACA Code of Ethics Preamble

The American Counseling Association is an educational, scientific, and professional organization whose members work in a variety of settings and serve in multiple capacities. ACA members are dedicated to the enhancement of human development throughout the life span. Association members recognize diversity and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts.

Professional values are an important way of living out an ethical commitment. Values inform principles. Inherently held values that guide our behaviors or exceed prescribed behaviors are deeply ingrained in the counselor and developed out of personal dedication, rather than the mandatory requirement of an external organization.

ACA Code of Ethics Purpose

The ACA Code of Ethics serves five main purposes:

1. The Code enables the association to clarify to current and future members, and to those served by members, the nature of the ethical responsibilities held in common by its members.
2. The Code helps support the mission of the association.
3. The Code establishes principles that define ethical behavior and best practices of association members.
4. The Code serves as an ethical guide designed to assist members in constructing a professional course of action that best serves those utilizing counseling services and best promotes the values of the counseling profession.
5. The Code serves as the basis for processing of ethical complaints and inquiries initiated against members of the association.

The ACA Code of Ethics contains eight main sections that address the following areas:

Section A: The Counseling Relationship
Section B: Confidentiality, Privileged Communication, and Privacy
Section C: Professional Responsibility
Section D: Relationships With Other Professionals
Section E: Evaluation, Assessment, and Interpretation
Section F: Supervision, Training, and Teaching
Section G: Research and Publication
Section H: Resolving Ethical Issues

Each section of the ACA Code of Ethics begins with an Introduction. The introductions to each section discuss what counselors should aspire to with regard to ethical behavior and responsibility. The Introduction helps set the tone for that particular section and provides a starting point that invites reflection on the ethical mandates contained in each part of the ACA Code of Ethics.

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

Through a chosen ethical decision-making process and evaluation of the context of the situation, counselors are empowered to make decisions that help expand the capacity of people to grow and develop.

A brief glossary is given to provide readers with a concise description of some of the terms used in the ACA Code of Ethics.
Section A
The Counseling Relationship

Introduction
Counselors encourage client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relationships. Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve. Counselors also explore their own cultural identities and how these affect their values and beliefs about the counseling process.

Counselors are encouraged to contribute to society by devoting a portion of their professional activity to services for which there is little or no financial return (pro bono publico).

A.1. Welfare of Those Served by Counselors

A.1.a. Primary Responsibility
The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients.

A.1.b. Records
Counselors maintain records necessary for rendering professional services to their clients and as required by laws, regulations, or agency or institution procedures. Counselors include sufficient and timely documentation in their client records to facilitate the delivery and continuity of needed services. Counselors take reasonable steps to ensure that documentation in records accurately reflects client progress and services provided. If errors are made in client records, counselors take steps to properly note the correction of such errors according to agency or institutional policies. (See A.12.g, B.5., B.6.b., E.3., E.13.b., F.1.c., G.2.n.)

A.1.c. Counseling Plans
Counselors and their clients work jointly in devising integrated counseling plans that offer reasonable promise of success and are consistent with abilities and circumstances of clients. Counselors and clients regularly review counseling plans to assess their continued viability and effectiveness, respecting the freedom of choice of clients. (See A.2.a., A.2.d., A.12.g.)

A.1.d. Support Network Involvement
Counselors recognize that support networks hold various meanings in the lives of clients and consider enlisting the support, understanding, and involvement of others (e.g., religious/spiritual/community leaders, family members, friends) as positive resources, when appropriate, with client consent.

A.1.e. Employment Needs
Counselors work with their clients considering employment in jobs that are consistent with the overall abilities, vocational limitations, physical restrictions, general temperament, interest and aptitude patterns, social skills, education, general qualifications, and other relevant characteristics and needs of clients. When appropriate, counselors appropriately trained in career development will assist in the placement of clients in positions that are consistent with the interest, culture, and the welfare of clients, employers, and/or the public.

A.2. Informed Consent in the Counseling Relationship
(See A.12.g., B.5., B.6.b., E.3., E.13.b., F.1.c., G.2.n.)

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

A.2.b. Types of Information Needed
Counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor’s qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a counselor; and other pertinent information. Counselors take steps to ensure that clients understand the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements.

A.3. Clients Served by Others

A.3.a. Avoiding Harm and Imposing Values
Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm.

A.3.b. Personal Values
Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that

Clients have the right to confidentiality and to be provided with an explanation of its limitations (including how supervisors and/or treatment team professionals are involved); to obtain clear information about their records; to participate in the ongoing counseling plans; and to refuse any services or modality change and to be advised of the consequences of such refusal.

A.2.c. Developmental and Cultural Sensitivity
Counselors communicate information in ways that are both developmentally and culturally appropriate. Counselors use clear and understandable language when discussing issues related to informed consent. When clients have difficulty understanding the language used by counselors, they provide necessary services (e.g., arranging for a qualified interpreter or translator) to ensure comprehension by clients. In collaboration with clients, counselors consider cultural implications of informed consent procedures and, where possible, counselors adjust their practices accordingly.

A.2.d. Inability to Give Consent
When counseling minors or persons unable to give voluntary consent, 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.

A.4. Avoiding Harm and Imposing Values

A.4.a. Avoiding Harm
Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that
are inconsistent with counseling goals. Counselors respect the diversity of clients, trainees, and research participants.

A.5. Roles and Relationships

With Clients
(See F.3., F.10., G.3.)

A.5.a. Current Clients
Sexual or romantic counselor–client interactions or relationships with current clients, their romantic partners, or their family members are prohibited.

A.5.b. Former Clients
Sexual or romantic counselor–client interactions or relationships with former clients, their romantic partners, or their family members are prohibited for a period of 5 years following the last professional contact. Counselors, before engaging in sexual or romantic interactions or relationships with clients, their romantic partners, or client family members after 5 years following the last professional contact, demonstrate forethought and document (in written form) whether the interactions or relationships can be viewed as exploitive in some way and/or whether there is still potential to harm the former client; in cases of potential exploitation and/or harm, the counselor avoids entering such an interaction or relationship.

A.5.c. Nonprofessional Interactions or Relationships (Other Than Sexual or Romantic Interactions or Relationships)
Counselor–client nonprofessional relationships with clients, former clients, their romantic partners, or their family members should be avoided, except when the interaction is potentially beneficial to the client. (See A.5.d.)

A.5.d. Potentially Beneficial Interactions
When a counselor–client nonprofessional interaction with a client or former client may be potentially beneficial to the client or former client, the counselor must document in case records, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. Such interactions should be initiated with appropriate client consent. Where unintentional harm occurs to the client or former client, or to an individual significantly involved with the client or former client, due to the nonprofessional interaction, the counselor must show evidence of an attempt to remedy such harm. Examples of potentially beneficial interactions include, but are not limited to, attending a formal ceremony (e.g., a wedding/commitment ceremony or graduation); purchasing a service or product provided by a client or former client (excepting unrestricted bartering); hospital visits to an ill family member; mutual membership in a professional association, organization, or community. (See A.5.c.)

A.5.e. Role Changes in the Professional Relationship
When a counselor changes a role from the original or most recent contracted relationship, he or she obtains informed consent from the client and explains the right of the client to refuse services related to the change. Examples of role changes include:

1. changing from individual to relationship or family counseling, or vice versa;
2. changing from a nonforensic evaluative role to a therapeutic role, or vice versa;
3. changing from a counselor to a researcher role (e.g., enlisting clients as research participants), or vice versa; and
4. changing from a counselor to a mediator role, or vice versa.

Clients must be fully informed of any anticipated consequences (e.g., financial, legal, personal, or therapeutic) of counselor role changes.

A.6. Roles and Relationships at Individual, Group, Institutional, and Societal Levels

A.6.a. Advocacy
When appropriate, counselors advocate at individual, group, institutional, and societal levels to examine potential barriers and obstacles that inhibit access and/or the growth and development of clients.

A.6.b. Confidentiality and Advocacy
Counselors obtain client consent prior to engaging in advocacy efforts on behalf of an identifiable client to improve the provision of services and to work toward removal of systemic barriers or obstacles that inhibit client access, growth, and development.

A.7. Multiple Clients
When a counselor agrees to provide counseling services to two or more persons who have a relationship, the counselor clarifies at the outset which person or persons are clients and the nature of the relationships the counselor will have with each involved person. If it becomes apparent that the counselor may be called upon to perform potentially conflicting roles, the counselor will clarify, adjust, or withdraw from roles appropriately. (See A.8.a., B.4.)

A.8. Group Work
(See B.4.a.)

A.8.a. Screening
Counselors screen prospective group counseling/therapy participants. To the extent possible, counselors select members whose needs and goals are compatible with goals of the group, who will not impede the group process, and whose well-being will not be jeopardized by the group experience.

A.8.b. Protecting Clients
In a group setting, counselors take reasonable precautions to protect clients from physical, emotional, or psychological trauma.

A.9. End-of-Life Care for Terminally Ill Clients

A.9.a. Quality of Care
Counselors strive to take measures that enable clients

1. to obtain high quality end-of-life care for their physical, emotional, social, and spiritual needs;
2. to exercise the highest degree of self-determination possible;
3. to be given every opportunity possible to engage in informed decision making regarding their end-of-life care; and
4. to receive complete and adequate assessment regarding their ability to make competent, rational decisions on their own behalf from a mental health professional who is experienced in end-of-life care practice.

A.9.b. Counselor Competence, Choice, and Referral
Recognizing the personal, moral, and competence issues related to
end-of-life decisions, counselors may choose to work or not work with terminally ill clients who wish to explore their end-of-life options. Counselors provide appropriate referral information to ensure that clients receive the necessary help.

A.9.c. Confidentiality
Counselors who provide services to terminally ill individuals who are considering hastening their own deaths have the option of breaking or not breaking confidentiality, depending on applicable laws and the specific circumstances of the situation and after seeking consultation or supervision from appropriate professional and legal parties. (See B.5.c., B.7.c.)

A.10. Fees and Bartering
A.10.a. Accepting Fees From Agency Clients
Counselors refuse a private fee or other remuneration for rendering services to persons who are entitled to such services through the counselor’s employing agency or institution. The policies of a particular agency may make explicit provisions for agency clients to receive counseling services from members of its staff in private practice. In such instances, the clients must be informed of other options open to them should they seek private counseling services.

A.10.b. Establishing Fees
In establishing fees for professional counseling services, counselors consider the financial status of clients and locality. In the event that the established fee structure is inappropriate for a client, counselors assist clients in attempting to find comparable services of acceptable cost.

A.10.c. Nonpayment of Fees
If counselors intend to use collection agencies or take legal measures to collect fees from clients who do not pay for services as agreed upon, they first inform clients of intended actions and offer clients the opportunity to make payment.

A.10.d. Bartering
Counselors may barter only if the relationship is not exploitive or harmful and does not place the counselor in an unfair advantage, if the client requests it, and if such arrangements are an accepted practice among professionals in the community. Counselors consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract.

A.10.e. Receiving Gifts
Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and showing gratitude. When determining whether or not to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, a client’s motivation for giving the gift, and the counselor’s motivation for wanting or declining the gift.

A.11. Termination and Referral
A.11.a. Abandonment Prohibited
Counselors do not abandon or neglect clients in counseling. Counselors assist in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacations, illness, and following termination.

A.11.b. Inability to Assist Clients
If counselors determine an inability to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors should discontinue the relationship.

A.11.c. Appropriate Termination
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 may terminate counseling when in jeopardy of harm by the client, or another person with whom the client has a relationship, or when clients do not pay fees as agreed upon. Counselors provide pretermination counseling and recommend other service providers when necessary.

A.11.d. Appropriate Transfer of Services
When counselors transfer or refer clients to other practitioners, they ensure that appropriate clinical and administrative processes are completed and open communication is maintained with both clients and practitioners.

A.12. Technology Applications
A.12.a. Benefits and Limitations
Counselors inform clients of the benefits and limitations of using information technology applications in the counseling process and in business/billing procedures. Such technologies include but are not limited to computer hardware and software, telephones, the World Wide Web, the Internet, online assessment instruments and other communication devices.

A.12.b. Technology-Assisted Services
When providing technology-assisted distance counseling services, counselors determine that clients are intellectually, emotionally, and physically capable of using the application and that the application is appropriate for the needs of clients.

A.12.c. Inappropriate Services
When technology-assisted distance counseling services are deemed inappropriate by the counselor or client, counselors consider delivering services face to face.

A.12.d. Access
Counselors provide reasonable access to computer applications when providing technology-assisted distance counseling services.

A.12.e. Laws and Statutes
Counselors ensure that the use of technology does not violate the laws of any local, state, national, or international entity and observe all relevant statutes.

A.12.f. Assistance
Counselors seek business, legal, and technical assistance when using technology applications, particularly when the use of such applications crosses state or national boundaries.

A.12.g. Technology and Informed Consent
As part of the process of establishing informed consent, counselors do the following:

1. Address issues related to the difficulty of maintaining the confidentiality of electronically transmitted communications.
2. Inform clients of all colleagues, supervisors, and employees, such as Informational Technology (IT) administrators, who might have authorized or unauthorized access to electronic transmissions.
3. Urge clients to be aware of all authorized or unauthorized users
including family members and fellow employees who have access to any technology clients may use in the counseling process.

4. Inform clients of pertinent legal rights and limitations governing the practice of a profession over state lines or international boundaries.

5. Use encrypted Web sites and e-mail communications to help ensure confidentiality when possible.

6. When the use of encryption is not possible, counselors notify clients of this fact and limit electronic transmissions to general communications that are not client specific.

7. Inform clients if and for how long archival storage of transaction records are maintained.

8. Discuss the possibility of technology failure and alternate methods of service delivery.

9. Inform clients of emergency procedures, such as calling 911 or a local crisis hotline, when the counselor is not available.

10. Discuss time zone differences, local customs, and cultural or language differences that might impact service delivery.

11. Inform clients when technology-assisted distance counseling services are not covered by insurance. (See A.2.)

A.12.b. Sites on the World Wide Web

Counselors maintaining sites on the World Wide Web (the Internet) do the following:

1. Regularly check that electronic links are working and professionally appropriate.

2. Establish ways clients can contact the counselor in case of technology failure.

3. Provide electronic links to relevant state licensure and professional certification boards to protect consumer rights and facilitate addressing ethical concerns.


5. Obtain the written consent of the legal guardian or other authorized professional representative prior to rendering services in the event the client is a minor child, an adult who is legally incompetent, or an adult incapable of giving informed consent.

6. Strive to provide a site that is accessible to persons with disabilities.

7. Strive to provide translation capabilities for clients who have a different primary language while also addressing the imperfect nature of such translations.

8. Assist clients in determining the validity and reliability of information found on the World Wide Web and other technology applications.

B.2. Exceptions

B.2.a. Danger and Legal Requirements

The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end-of-life issues. (See A.9.c.)

B.2.b. Contagious, Life-Threatening Diseases

When clients disclose that they have a disease commonly known to be both communicable and life threatening, counselors may be justified in disclosing information to identifiable third parties, if they are known to be at demonstrable and high risk of contracting the disease. Prior to making a disclosure, counselors confirm that there is such a diagnosis and assess the intent of clients to inform the third parties about their disease or to engage in any behaviors that may be harmful to an identifiable third party.

B.2.c. Court-Ordered Disclosure

When subpoenaed to release confidential or privileged information without a client’s permission, counselors obtain written, informed consent from the client or take steps to prohibit the disclosure or have it limited as narrowly as possible due to potential harm to the client or counseling relationship.

B.2.d. 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.

B.3. Information Shared With Others

B.3.a. Subordinates

Counselors make every effort to ensure that privacy and confidentiality of clients are maintained by subordinates, including employees, supervisors, students, clerical assistants, and volunteers. (See F.1.c.)
B.3.b. Treatment Teams
When client treatment involves a continued review or participation by a treatment team, the client will be informed of the team’s existence and composition, information being shared, and the purposes of sharing such information.

B.3.c. Confidential Settings
Counselors discuss confidential information only in settings in which they can reasonably ensure client privacy.

B.3.d. Third-Party Payers
Counselors disclose information to third-party payers only when clients have authorized such disclosure.

B.3.e. Transmitting Confidential Information
Counselors take precautions to ensure the confidentiality of information transmitted through the use of computers, electronic mail, facsimile machines, telephones, voicemail, answering machines, and other electronic or computer technology. (See A.12.g.)

B.3.f. Deceased Clients
Counselors protect the confidentiality of deceased clients, consistent with legal requirements and agency or setting policies.

B.4. Groups and Families

B.4.a. Group Work
In group work, counselors clearly explain the importance and parameters of confidentiality for the specific group being entered.

B.4.b. Couples and Family Counseling
In couples and family counseling, counselors clearly define who is considered “the client” and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties having capacity to give consent concerning each individual’s right to confidentiality and any obligation to preserve the confidentiality of information known.

B.5. Clients Lacking Capacity to Give Informed Consent

B.5.a. Responsibility to Clients
When counseling minor clients or adult clients who lack the capacity to give voluntary, informed consent, counselors protect the confidentiality of information received in the counseling relationship as specified by federal and state laws, written policies, and applicable ethical standards.

B.5.b. Responsibility to Parents and Legal Guardians
Counselors inform parents and legal guardians about the role of counselors and the confidential nature of the counseling relationship. Counselors are sensitive to the cultural diversity of families and respect the inherent rights and responsibilities of parents/guardians over the welfare of their children/charges according to law. Counselors work to establish, as appropriate, collaborative relationships with parents/guardians to best serve clients.

B.5.c. Release of Confidential Information
When counseling minor clients or adult clients who lack the capacity to give voluntary consent to release confidential information, counselors seek permission from an appropriate third party to disclose information. In such instances, counselors inform clients consistent with their level of understanding and take culturally appropriate measures to safeguard client confidentiality.

B.6. Records

B.6.a. Confidentiality of Records
Counselors ensure that records are kept in a secure location and that only authorized persons have access to records.

B.6.b. Permission to Record
Counselors obtain permission from clients prior to recording sessions through electronic or other means.

B.6.c. Permission to Observe
Counselors obtain permission from clients prior to observing counseling sessions, reviewing session transcripts, or viewing recordings of sessions with supervisors, faculty, peers, or others within the training environment.

B.6.d. Client Access
Counselors provide reasonable access to records and copies of records when requested by competent clients. Counselors limit the access of clients to their records, or portions of their records, only when there is compelling evidence that such access would cause harm to the client. Counselors document the request of clients and the rationale for withholding some or all of the record in the files of clients. In situations involving multiple clients, counselors provide individual clients with only those parts of records that related directly to them and do not include confidential information related to any other client.

B.6.e. Assistance With Records
When clients request access to their records, counselors provide assistance and consultation in interpreting counseling records.

B.6.f. Disclosure or Transfer
Unless exceptions to confidentiality exist, counselors obtain written permission from clients to disclose or transfer records to legitimate third parties. Steps are taken to ensure that receivers of counseling records are sensitive to their confidential nature. (See A.3., E.4.)

B.6.g. Storage and Disposal After Termination
Counselors store records following termination of services to ensure reasonable future access, maintain records in accordance with state and federal statutes governing records, and dispose of client records and other sensitive materials in a manner that protects client confidentiality. When records are of an artistic nature, counselors obtain client (or guardian) consent with regards to handling of such records or documents. (See A.1.b.)

B.6.h. Reasonable Precautions
Counselors take reasonable precautions to protect client confidentiality in the event of the counselor’s termination of practice, incapacity, or death. (See C.2.h.)

B.7. Research and Training

B.7.a. Institutional Approval
When institutional approval is required, counselors provide accurate information about their research proposals and obtain approval prior to conducting their research. They conduct research in accordance with the approved research protocol.

B.7.b. Adherence to Guidelines
Counselors are responsible for understanding and adhering to state, federal, agency, or institutional policies or applicable guidelines regarding confidentiality in their research practices.

B.7.c. Confidentiality of Information Obtained in Research
Violations of participant privacy and confidentiality are risks of participation in research involving human participants. Investigators maintain all research records in a secure manner.
They explain to participants the risks of violations of privacy and confidentiality and disclose to participants any limits of confidentiality that reasonably can be expected. Regardless of the degree to which confidentiality will be maintained, investigators must disclose to participants any limits of confidentiality that reasonably can be expected. (See G.2.e.)

B.7.d. Disclosure of Research Information

Counselors do not disclose confidential information that reasonably could lead to the identification of a research participant unless they have obtained the prior consent of the person. Use of data derived from counseling relationships for purposes of training, research, or publication is conditional to content that is disguised to ensure the anonymity of the individuals involved. (See G.2.e., G.2.d.)

B.7.e. Agreement for Identification

Identification of clients, students, or supervisees in a presentation or publication is permissible only when they have reviewed the material and agreed to its presentation or publication. (See G.4.d.)

B.8. Consultation

B.8.a. Agreements

When acting as consultants, counselors seek agreements among all parties involved concerning each individual’s rights to confidentiality, the obligation of each individual to preserve confidential information, and the limits of confidentiality of information shared by others.

B.8.b. Respect for Privacy

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

B.8.c. Disclosure of Confidential Information

When consulting with colleagues, counselors do not disclose confidential information that reasonably could lead to the identification of a client or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided. They disclose information only to the extent necessary to achieve the purposes of the consultation. (See D.2.d.)

Section C

Professional Responsibility

Introduction

Counselors aspire to open, honest, and accurate communication in dealing with the public and other professionals. They practice in a nondiscriminatory manner within the boundaries of professional and personal competence and have a responsibility to abide by the ACA Code of Ethics. Counselors actively participate in local, state, and national associations that foster the development and improvement of counseling. Counselors advocate to promote change at the individual, group, institutional, and societal levels that improve the quality of life for individuals and groups and remove potential barriers to the provision or access of appropriate services being offered. Counselors have a responsibility to the public to engage in counseling practices that are based on rigorous research methodologies. In addition, counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.

C.1. Knowledge of Standards

Counselors have a responsibility to read, understand, and follow the ACA Code of Ethics and adhere to applicable laws and regulations.

C.2. Professional Competence

C.2.a. Boundaries of Competence

Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population. (See A.9.b., C.4.e., E.2., F.2., F.11.b.)

C.2.b. New Specialty Areas of Practice

Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm. (See F.6.f.)

C.2.c. Qualified for Employment

Counselors accept employment only for positions for which they are qualified by education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors hire for professional counseling positions only individuals who are qualified and competent for those positions.

C.2.d. Monitor Effectiveness

Counselors continually monitor their effectiveness as professionals and take steps to improve when necessary. Counselors in private practice take reasonable steps to seek peer supervision as needed to evaluate their efficacy as counselors.

C.2.e. Consultation on Ethical Obligations

Counselors take reasonable steps to consult with other counselors or related professionals when they have questions regarding their ethical obligations or professional practice.

C.2.f. Continuing Education

Counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. They take steps to maintain competence in the skills they use, are open to new procedures, and keep current with the diverse populations and specific populations with whom they work.

C.2.g. Impairment

Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment...
C.3. Advertising and Soliciting Clients

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

C.3.b. Testimonials
Counselors who use testimonials do not solicit them from current clients nor former clients nor any other persons who may be vulnerable to undue influence.

C.3.c. Statements by Others
Counselors make reasonable efforts to ensure that statements made by others about them or the profession of counseling are accurate.

C.3.d. Recruiting Through Employment
Counselors do not use their places of employment or institutional affiliation to recruit or gain clients, supervisees, or consultees for their private practices.

C.3.e. Products and Training Advertisements
Counselors who develop products related to their profession or conduct workshops or training events ensure that the advertisements concerning these products or events are accurate and disclose adequate information for consumers to make informed choices. (See C.6.d.)

C.3.f. Promoting to Those Served
Counselors do not use counseling, teaching, training, or supervisory relationships to promote their products or training events in a manner that is deceptive or would exert undue influence on individuals who may be vulnerable. However, counselor educators may adopt textbooks they have authored for instructional purposes.

C.4. Professional Qualifications

C.4.a. Accurate Representation
Counselors claim or imply only professional qualifications actually completed and correct any known misrepresentations of their qualifications by others. Counselors truthfully represent the qualifications of their professional colleagues. Counselors clearly distinguish between paid and volunteer work experience and accurately describe their continuing education and specialized training. (See C.2.a.)

C.4.b. Credentials
Counselors claim only licenses or certifications that are current and in good standing.

C.4.c. Educational Degrees
Counselors clearly differentiate between earned and honorary degrees.

C.4.d. Implying Doctoral-Level Competence
Counselors clearly state their highest earned degree in counseling or closely related field. Counselors do not imply doctoral-level competence when only possessing a master’s degree in counseling or a related field by referring to themselves as “Dr.” in a counseling context when their doctorate is not in counseling or related field.

C.4.e. Program Accreditation Status
Counselors clearly state the accreditation status of their degree programs at the time the degree was earned.

C.4.f. Professional Membership
Counselors clearly differentiate between current, active memberships and former memberships in associations. Members of the American Counseling Association must clearly differentiate between professional membership, which implies the possession of at least a master’s degree in counseling, and regular membership, which is open to individuals whose interests and activities are consistent with those of ACA but are not qualified for professional membership.

C.5. Nondiscrimination
Counselors do not condone or engage in discrimination based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis proscribed by law. Counselors do not discriminate against clients, students, employees, supervisors, or research participants in a manner that has a negative impact on these persons.

C.6. Public Responsibility

C.6.a. Sexual Harassment
Counselors do not engage in or condone sexual harassment. Sexual harassment is defined as sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with professional activities or roles, and that either

1. is unwelcome, is offensive, or creates a hostile workplace or learning environment, and counselors know or are told this; or
2. is sufficiently severe or intense to be perceived as harassment to a reasonable person in the context in which the behavior occurred.

Sexual harassment can consist of a single intense or severe act or multiple persistent or pervasive acts.

C.6.b. Reports to Third Parties
Counselors are accurate, honest, and objective in reporting their professional activities and judgments to appropriate third parties, including courts, health insurance companies, those who are the recipients of evaluation reports, and others. (See B.3., E.4.)

C.6.c. Media Presentations
When counselors provide advice or commentary by means of public lectures, demonstrations, radio or television programs, prerecorded tapes, technology-based applications, printed articles, mailed material, or other media, they take reasonable precautions to ensure that

1. the statements are based on appropriate professional counseling literature and practice;
2. the statements are otherwise consistent with the ACA Code of Ethics, and
3. the recipients of the information are not encouraged to infer that a professional counseling relationship has been established.

C.6.d. Exploitation of Others
Counselors do not exploit others in their professional relationships. (See C.6.e.)

C.6.e. Scientific Bases for Treatment Modalities
Counselors use techniques/procedures/modalities that are grounded in...
Section D

Relationships With Other Professionals

Introduction

Professional counselors recognize that the quality of their interactions with colleagues can influence the quality of services provided to clients. They work to become knowledgeable about colleagues within and outside the field of counseling. Counselors develop positive working relationships and systems of communication with colleagues to enhance services to clients.

D.1. Relationships With Colleagues, Employers, and Employees

D.1.a. Different Approaches

Counselors are respectful of approaches to counseling services that differ from their own. Counselors are respectful of traditions and practices of other professional groups with which they work.

D.1.b. Forming Relationships

Counselors work to develop and strengthen interdisciplinary relationships with colleagues from other disciplines to best serve clients.

D.1.c. Interdisciplinary Teamwork

Counselors who are members of interdisciplinary teams delivering multifaceted services to clients, keep the focus on how to best serve the clients.

They participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the counseling profession and those of colleagues from other disciplines. (See A.1.a.)

D.1.d. Confidentiality

When counselors are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, they clarify role expectations and the parameters of confidentiality with their colleagues. (See B.1.c., B.1.d., B.2.c., B.2.d., B.3.b.)

D.1.e. Establishing Professional and Ethical Obligations

Counselors who are members of interdisciplinary teams clarify professional and ethical obligations of the team as a whole and of its individual members. When a team decision raises ethical concerns, counselors first attempt to resolve the concern within the team. If they cannot reach resolution among team members, counselors pursue other avenues to address their concerns consistent with client well-being.

D.1.f. Personnel Selection and Assignment

Counselors select competent staff and assign responsibilities compatible with their skills and experiences.

D.1.g. Employer Policies

The acceptance of employment in an agency or institution implies that counselors are in agreement with its general policies and principles. Counselors strive to reach agreement with employers as to acceptable standards of conduct that allow for changes in institutional policy conducive to the growth and development of clients.

D.1.h. Negative Conditions

Counselors alert their employers of inappropriate policies and practices. They attempt to effect changes in such policies or procedures through constructive action within the organization. When such policies are potentially disruptive or damaging to clients or may limit the effectiveness of services provided and change cannot be effected, counselors take appropriate further action. Such action may include referral to appropriate certification, accreditation, or state licensure organizations, or voluntary termination of employment.

D.1.i. Protection From Punitive Action

Counselors take care not to harass or dismiss an employee who has acted in a responsible and ethical manner to expose inappropriate employer policies or practices.

Section E

Evaluation, Assessment, and Interpretation

Introduction

Counselors use assessment instruments as one component of the counseling process, taking into account the client personal and cultural context. Counselors promote the well-being of individual clients or groups of clients by developing and using appropriate educational, psychological, and career assessment instruments.

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E.1. General

E.1.a. Assessment
The primary purpose of educational, psychological, and career assessment is to provide measurements that are valid and reliable in either comparative or absolute terms. These include, but are not limited to, measurements of ability, personality, interest, intelligence, achievement, and performance. Counselors recognize the need to interpret the statements in this section as applying to both quantitative and qualitative assessments.

E.1.b. Client Welfare
Counselors do not misuse assessment results and interpretations, and they take reasonable steps to prevent others from misusing the information these techniques provide. They respect the client’s right to know the results, the interpretations made, and the bases for counselors’ conclusions and recommendations.

E.2. Competence to Use and Interpret Assessment Instruments

E.2.a. Limits of Competence
Counselors utilize only those testing and assessment services for which they have been trained and are competent. Counselors using technology assisted test interpretations are trained in the construct being measured and the specific instrument being used prior to using its technology based application. Counselors take reasonable measures to ensure the proper use of psychological and career assessment techniques by persons under their supervision. (See A.12.)

E.2.b. Appropriate Use
Counselors are responsible for the appropriate application, scoring, interpretation, and use of assessment instruments relevant to the needs of the client, whether they score and interpret such assessments themselves or use technology or other services.

E.2.c. Decisions Based on Results
Counselors responsible for decisions involving individuals or policies that are based on assessment results have a thorough understanding of educational, psychological, and career measurement, including validation criteria, assessment research, and guidelines for assessment development and use.

E.3. Informed Consent in Assessment

E.3.a. Explanation to Clients
Prior to assessment, counselors explain the nature and purposes of assessment and the specific use of results by potential recipients. The explanation will be given in the language of the client (or other legally authorized person on behalf of the client), unless an explicit exception has been agreed upon in advance. Counselors consider the client’s personal or cultural context, the level of the client’s understanding of the results, and the impact of the results on the client. (See A.2., A.12.g., F.1.c.)

E.3.b. Recipients of Results
Counselors consider the examinee’s welfare, explicit understandings, and prior agreements in determining who receives the assessment results. Counselors include accurate and appropriate interpretations with any release of individual or group assessment results. (See B.2.c., B.5.)

E.4. Release of Data to Qualified Professionals
Counselors release assessment data in which the client is identified only with the consent of the client or the client’s legal representative. Such data are released only to persons recognized by counselors as qualified to interpret the data. (See B.1., B.3., B.6.b.)

E.5. Diagnosis of Mental Disorders

E.5.a. Proper Diagnosis
Counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interview) used to determine client care (e.g., locus of treatment, type of treatment, or recommended follow-up) are carefully selected and appropriately used.

E.5.b. Cultural Sensitivity
Counselors recognize that culture affects the manner in which clients’ problems are defined. Clients’ socioeconomic and cultural experiences are considered when diagnosing mental disorders. (See A.2.c.)

E.5.c. Historical and Social Prejudices in the Diagnosis of Pathology
Counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment.

E.5.d. Refraining From Diagnosis
Counselors may refrain from making and/or reporting a diagnosis if they believe it would cause harm to the client or others.

E.6. Instrument Selection

E.6.a. Appropriateness of Instruments
Counselors carefully consider the validity, reliability, psychometric limitations, and appropriateness of instruments when selecting assessments.

E.6.b. Referral Information
If a client is referred to a third party for assessment, the counselor provides specific referral questions and sufficient objective data about the client to ensure that appropriate assessment instruments are utilized. (See A.9.b., B.3.)

E.6.c. Culturally Diverse Populations
Counselors are cautious when selecting assessments for culturally diverse populations to avoid the use of instruments that lack appropriate psychometric properties for the client population. (See A.2.c., E.5.b.)

E.7. Conditions of Assessment Administration

E.7.a. Administration Conditions
Counselors administer assessments under the same conditions that were established in their standardization. When assessments are not administered under standard conditions, as may be necessary to accommodate clients with disabilities, or when unusual behavior or irregularities occur during the administration, those conditions are noted in interpretation, and the results may be designated as invalid or of questionable validity.

E.7.b. Technological Administration
Counselors ensure that administration programs function properly and provide clients with accurate results when technological or other electronic methods are used for assessment administration.

E.7.c. Unsupervised Assessments
Unless the assessment instrument is designed, intended, and validated for self-administration and/or scoring,
counselors do not permit inadequately supervised use.

E.7.d. Disclosure of Favorable Conditions
Prior to administration of assessments, conditions that produce most favorable assessment results are made known to the examinee.

E.8. Multicultural Issues/Diversity in Assessment
Counselors use with caution assessment techniques that were normed on populations other than that of the client. Counselors recognize the effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpretation, and place test results in proper perspective with other relevant factors. (See A.2.c., E.5.b.)

E.9. Scoring and Interpretation of Assessments

E.9.a. Reporting
In reporting assessment results, counselors indicate reservations that exist regarding validity or reliability due to circumstances of the assessment or the inappropriateness of the norms for the person tested.

E.9.b. Research Instruments
Counselors exercise caution when interpreting the results of research instruments not having sufficient technical data to support respondent results. The specific purposes for the use of such instruments are stated explicitly to the examinee.

E.9.c. Assessment Services
Counselors who provide assessment scoring and interpretation services to support the assessment process confirm the validity of such interpretations. They accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use. The public offering of an automated test interpretations service is considered a professional-to-professional consultation. The formal responsibility of the consultant is to the consultee, but the ultimate and overriding responsibility is to the client. (See D.2.)

E.10. Assessment Security
Counselors maintain the integrity and security of tests and other assessment techniques consistent with legal and contractual obligations. Counselors do not appropriate, reproduce, or modify published assessments or parts thereof without acknowledgment and permission from the publisher.

E.11. Obsolete Assessments and Outdated Results
Counselors do not use data or results from assessments that are obsolete or outdated for the current purpose. Counselors make every effort to prevent the misuse of obsolete measures and assessment data by others.

E.12. Assessment Construction
Counselors use established scientific procedures, relevant standards, and current professional knowledge for assessment design in the development, publication, and utilization of educational and psychological assessment techniques.


E.13.a. Primary Obligations
When providing forensic evaluations, the primary obligation of counselors is to produce objective findings that can be substantiated based on information and techniques appropriate to the evaluation, which may include examination of the individual and/or review of records. Counselors are entitled to form professional opinions based on their professional knowledge and expertise that can be supported by the data gathered in evaluations. Counselors will define the limits of their reports or testimony, especially when an examination of the individual has not been conducted.

E.13.b. Consent for Evaluation
Individuals being evaluated are informed in writing that the relationship is for the purposes of an evaluation and is not counseling in nature, and entities or individuals who will receive the evaluation report are identified. Written consent to be evaluated is obtained from those being evaluated unless a court orders evaluations to be conducted without the written consent of individuals being evaluated. When children or vulnerable adults are being evaluated, informed written consent is obtained from a parent or guardian.

E.13.c. Client Evaluation Prohibited
Counselors do not evaluate individuals for forensic purposes they currently counsel or individuals they have counseled in the past. Counselors do not accept as counseling clients individuals they are evaluating or individuals they have evaluated in the past for forensic purposes.

E.13.d. Avoid Potentially Harmful Relationships
Counselors who provide forensic evaluations avoid potentially harmful professional or personal relationships with family members, romantic partners, and close friends of individuals they are evaluating or have evaluated in the past.

Section F
Supervision, Training, and Teaching

Introduction
Counselors aspire to foster meaningful and respectful professional relationships and to maintain appropriate boundaries with supervisees and students. Counselors have theoretical and pedagogical foundations for their work and aim to be fair, accurate, and honest in their assessments of counselors-in-training.

F.1. Counselor Supervision and Client Welfare

F.1.a. Client Welfare
A primary obligation of counseling supervisors is to monitor the services provided by other counselors or counselors-in-training. Counseling supervisors monitor client welfare and supervisee clinical performance and professional development. To fulfill these obligations, supervisors meet regularly with supervisees to review case notes, samples of clinical work, or live observations. Supervisees have a responsibility to understand and follow the ACA Code of Ethics.

F.1.b. Counselor Credentials
Counseling supervisors work to ensure that clients are aware of the qualifications of the supervisees who render services to the clients. (See A.2.b.)
F.1.c. Informed Consent and Client Rights
Supervisors make supervisees aware of client rights including the protection of client privacy and confidentiality in the counseling relationship. Supervisors provide clients with professional disclosure information and inform them of how the supervision process influences the limits of confidentiality. Supervisors make clients aware of who will have access to records of the counseling relationship and how these records will be used. (See A.2.b., B.1.d.)

F.2. Counselor Supervision Competence
F.2.a. Supervisor Preparation
Prior to offering clinical supervision services, counselors are trained in supervision methods and techniques. Counselors who offer clinical supervision services regularly pursue continuing education activities including both counseling and supervision topics and skills. (See C.2.a., C.2.f.)

F.2.b. Multicultural Issues/Diversity in Supervision
Counseling supervisors are aware of and address the role of multiculturalism/diversity in the supervisory relationship.

F.3. Supervisory Relationships
F.3.a. Relationship Boundaries With Supervisees
Counseling supervisors clearly define and maintain ethical professional, personal, and social relationships with their supervisees. Counseling supervisors avoid nonprofessional relationships with current supervisees. If supervisors must assume other professional roles (e.g., clinical and administrative supervisor, instructor) with supervisees, they work to minimize potential conflicts and explain to supervisees the expectations and responsibilities associated with each role. They do not engage in any form of nonprofessional interaction that may compromise the supervisory relationship.

F.3.b. Sexual Relationships
Sexual or romantic interactions or relationships with current supervisees are prohibited.

F.3.c. Sexual Harassment
Counseling supervisors do not condone or subject supervisees to sexual harassment. (See C.6.a.)

F.3.d. Close Relatives and Friends
Counseling supervisors avoid accepting close relatives, romantic partners, or friends as supervisees.

F.3.e. Potentially Beneficial Relationships
Counseling supervisors are aware of the power differential in their relationships with supervisees. If they believe nonprofessional relationships with a supervisee may be potentially beneficial to the supervisee, they take precautions similar to those taken by counselors when working with clients. Examples of potentially beneficial interactions or relationships include attending a formal ceremony; hospital visits; providing support during a stressful event; or mutual membership in a professional association, organization, or community. Counseling supervisors engage in open discussions with supervisees when they consider entering into relationships with them outside of their roles as clinical and/or administrative supervisors. Before engaging in nonprofessional relationships, supervisors discuss with supervisees and document the rationale for such interactions, potential benefits or drawbacks, and anticipated consequences for the supervisee. Supervisors clarify the specific nature and limitations of the additional role(s) they will have with the supervisee.

F.4. Supervisor Responsibilities
F.4.a. Informed Consent for Supervision
Supervisors are responsible for incorporating into their supervision the principles of informed consent and participation. Supervisors inform supervisees of the policies and procedures to which they are to adhere and the mechanisms for due process appeal of individual supervisory actions.

F.4.b. Emergencies and Absences
Supervisors establish and communicate to supervisees procedures for contacting them or, in their absence, alternative on-call supervisors to assist in handling crises.

F.4.c. Standards for Supervisees
Supervisors make their supervisees aware of professional and ethical standards and legal responsibilities. Supervisors of postdegree counselors encourage these counselors to adhere to professional standards of practice. (See C.1.)

F.4.d. Termination of the Supervisory Relationship
Supervisors or supervisees have the right to terminate the supervisory relationship with adequate notice. Reasons for withdrawal are provided to the other party. When cultural, clinical, or professional issues are crucial to the viability of the supervisory relationship, both parties make efforts to resolve differences. When termination is warranted, supervisors make appropriate referrals to possible alternative supervisors.

F.5. Counseling Supervision Evaluation, Remediation, and Endorsement
F.5.a. Evaluation
Supervisors document and provide supervisees with ongoing performance appraisal and evaluation feedback and schedule periodic formal evaluative sessions throughout the supervisory relationship.

F.5.b. Limitations
Through ongoing evaluation and appraisal, supervisors are aware of the limitations of supervisees that might impede performance. Supervisors assist supervisees in securing remedial assistance when needed. They recommend dismissal from training programs, applied counseling settings, or state or voluntary professional credentialing processes when those supervisees are unable to provide competent professional services. Supervisors seek consultation and document their decisions to dismiss or refer supervisees for assistance. They ensure that supervisees are aware of options available to them to address such decisions. (See C.2.g.)

F.5.c. Counseling for Supervisees
If supervisees request counseling, supervisors provide them with acceptable referrals. Counselors do not provide counseling services to supervisees.

F.5.d. Endorsement
Supervisors endorse supervisees for certification, licensure, employment, or completion of an academic or training program only when they believe supervisees are qualified for the endorsement. Regardless of qualifications, supervisors do not endorse supervisees whom they believe to be impaired in any way that would interfere with the performance of the duties associated with the endorsement.
F.6. Responsibilities of Counselor Educators

F.6.a. Counselor Educators
Counselor educators who are responsible for developing, implementing, and supervising educational programs are skilled as teachers and practitioners. They are knowledgeable regarding the ethical, legal, and regulatory aspects of the profession, skilled in applying that knowledge, and make students and supervisees aware of their responsibilities. Counselor educators conduct counselor education and training programs in an ethical manner and serve as role models for professional behavior. (See C.1., C.2.a., C.2.c.)

F.6.b. Infusing Multicultural Issues/Diversity
Counselor educators infuse material related to multiculturalism/diversity into all courses and workshops for the development of professional counselor educators.

F.6.c. Integration of Study and Practice
Counselor educators establish education and training programs that integrate academic study and supervised practice.

F.6.d. Teaching Ethics
Counselor educators make students and supervisees aware of the ethical responsibilities and standards of the profession and the ethical responsibilities of students to the profession. Counselor educators infuse ethical considerations throughout the curriculum. (See C.1.)

F.6.e. Peer Relationships
Counselor educators make every effort to ensure that the rights of peers are not compromised when students or supervisees lead counseling groups or provide clinical supervision. Counselor educators take steps to ensure that students and supervisees understand they have the same ethical obligations as counselor educators, trainers, and supervisors.

F.6.f. Innovative Theories and Techniques
When counselor educators teach counseling techniques/procedures that are innovative, without an empirical foundation, or without a well-grounded theoretical foundation, they define the counseling techniques/procedures as “unproven” or “developing” and explain to students the potential risks and ethical considerations of using such techniques/procedures.

F.6.g. Field Placements
Counselor educators develop clear policies within their training programs regarding field placement and other clinical experiences. Counselor educators provide clearly stated roles and responsibilities for the student or supervisee, the site supervisor, and the program supervisor. They confirm that site supervisors are qualified to provide supervision and inform site supervisors of their professional and ethical responsibilities in this role.

F.6.h. Professional Disclosure
Before initiating counseling services, counselors-in-training disclose their status as students and explain how this status affects the limits of confidentiality. Counselor educators ensure that the clients at field placements are aware of the services rendered and the qualifications of the students and supervisees rendering those services. Students and supervisees obtain client permission before they use any information concerning the counseling relationship in the training process. (See A.2.b.)

F.7. Student Welfare

F.7.a. Orientation
Counselor educators recognize that orientation is a developmental process that continues throughout the educational and clinical training of students. Counseling faculty provide prospective students with information about the counseling education program’s expectations:

1. the type and level of skill and knowledge acquisition required for successful completion of the training;
2. program training goals, objectives, and mission, and subject matter to be covered;
3. bases for evaluation;
4. training components that encourage self-growth or self-disclosure as part of the training process;
5. the type of supervision settings and requirements of the sites for required clinical field experiences;
6. student and supervisee evaluation and dismissal policies and procedures; and
7. up-to-date employment prospects for graduates.

F.7.b. Self-Growth Experiences
Counselor education programs delineate requirements for self-disclosure or self-growth experiences in their admission and program materials. Counselor educators use professional judgment when designing training experiences they conduct that require student and supervisee self-growth or self-disclosure. Students and supervisees are made aware of the ramifications their self-disclosure may have when counselors whose primary role as teacher, trainer, or supervisor requires acting on ethical obligations to the profession. Evaluative components of experiential training experiences explicitly delineate predetermined academic standards that are separate and do not depend on the student’s level of self-disclosure. Counselor educators may require trainees to seek professional help to address any personal concerns that may be affecting their competency.

F.8. Student Responsibilities

F.8.a. Standards for Students
Counselors-in-training have a responsibility to understand and follow the ACA Code of Ethics and adhere to applicable laws, regulatory policies, and rules and policies governing professional staff behavior at the agency or placement setting. Students have the same obligation to clients as those required of professional counselors. (See A.1., H.1.)

F.8.b. Impairment
Counselors-in-training refrain from offering or providing counseling services when their physical, mental, or emotional problems are likely to harm a client or others. They are alert to the signs of impairment, seek assistance for problems, and notify their program supervisors when they are aware that they are unable to effectively provide services. In addition, they seek appropriate professional services for themselves to remediate the problems that are interfering with their ability to provide services to others. (See A.1., C.2.d., C.2.g.)

F.9. Evaluation and Remediation of Students

F.9.a. Evaluation
Counselors clearly state to students, prior to and throughout the training program, the levels of competency expected, appraisal methods, and timing of evaluations for both didactic and clinical competencies. Counselor educators provide students...
with ongoing performance appraisal and evaluation feedback throughout the training program.

F.9.b. Limitations
Counselor educators, throughout ongoing evaluation and appraisal, are aware of and address the inability of some students to achieve counseling competencies that might impede performance. Counselor educators

1. assist students in securing remedial assistance when needed,
2. seek professional consultation and document their decision to dismiss or refer students for assistance, and
3. ensure that students have recourse in a timely manner to address decisions to require them to seek assistance or to dismiss them and provide students with due process according to institutional policies and procedures. (See C.2.g.)

F.9.c. Counseling for Students
If students request counseling or if counseling services are required as part of a remediation process, counselor educators provide acceptable referrals.

F.10. Roles and Relationships Between Counselor Educators and Students

F.10.a. Sexual or Romantic Relationships
Sexual or romantic interactions or relationships with current students are prohibited.

F.10.b. Sexual Harassment
Counselor educators do not condone or subject students to sexual harassment. (See C.6.a.)

F.10.c. Relationships With Former Students
Counselor educators are aware of the power differential in the relationship between faculty and students. Faculty members foster open discussions with former students when considering engaging in a social, sexual, or other intimate relationship. Faculty members discuss with the former student how their former relationship may affect the change in relationship.

F.10.d. Nonprofessional Relationships
Counselor educators avoid nonprofessional or ongoing professional relationships with students in which there is a risk of potential harm to the student or that may compromise the training experience or grades assigned. In addition, counselor educators do not accept any form of professional services, fees, commissions, reimbursement, or remuneration from a site for student or supervisee placement.

F.10.e. Counseling Services
Counselor educators do not serve as counselors to current students unless this is a brief role associated with a training experience.

F.10.f. Potentially Beneficial Relationships
Counselor educators are aware of the power differential in the relationships between faculty and students. If they believe a nonprofessional relationship with a student may be potentially beneficial to the student, they take precautions similar to those taken by counselors when working with clients. Examples of potentially beneficial interactions or relationships include, but are not limited to, attending a formal ceremony; hospital visits; providing support during a stressful event; or mutual membership in a professional association, organization, or community. Counselor educators engage in open discussions with students when they consider entering into relationships with students outside of their roles as teachers and supervisors. They discuss with students the rationale for such interactions, the potential benefits and drawbacks, and the anticipated consequences for the student. Educators clarify the specific nature and limitations of the additional role(s) they will have with the student prior to engaging in a nonprofessional relationship. Nonprofessional relationships with students should be time-limited and initiated with student consent.

F.11. Multicultural/Diversity Competence in Counselor Education and Training Programs

F.11.a. Faculty Diversity
Counselor educators are committed to recruiting and retaining a diverse faculty.

F.11.b. Student Diversity
Counselor educators actively attempt to recruit and retain a diverse student body. Counselor educators demonstrate commitment to multicultural/diversity competence by recognizing and valuing diverse cultures and types of abilities students bring to the training experience. Counselor educators provide appropriate accommodations that enhance and support diverse student well-being and academic performance.

F.11.c. Multicultural/Diversity Competence
Counselor educators actively infuse multicultural/diversity competency in their training and supervision practices. They actively train students to gain awareness, knowledge, and skills in the competencies of multicultural practice. Counselor educators include case examples, role-plays, discussion questions, and other classroom activities that promote and represent various cultural perspectives.

Section G

Research and Publication

Introduction
Counselors who conduct research are encouraged to contribute to the knowledge base of the profession and promote a clearer understanding of the conditions that lead to a healthy and more just society. Counselors support efforts of researchers by participating fully and willingly whenever possible. Counselors minimize bias and respect diversity in designing and implementing research programs.

G.1. Research Responsibilities

G.1.a. Use of Human Research Participants
Counselors plan, design, conduct, and report research in a manner that is consistent with pertinent ethical principles, federal and state laws, institutional regulations, and scientific standards governing research with human research participants.

G.1.b. Deviation From Standard Practice
Counselors seek consultation and observe stringent safeguards to protect the rights of research participants when a research problem suggests a deviation from standard or acceptable practices.
G.1.c. Independent Researchers
When independent researchers do not have access to an Institutional Review Board (IRB), they should consult with researchers who are familiar with IRB procedures to provide appropriate safeguards.

G.1.d. Precautions to Avoid Injury
Counselors who conduct research with human participants are responsible for the welfare of participants throughout the research process and should take reasonable precautions to avoid causing injurious psychological, emotional, physical, or social effects to participants.

G.1.e. Principal Researcher Responsibility
The ultimate responsibility for ethical research practice lies with the principal researcher. All others involved in the research activities share ethical obligations and responsibility for their own actions.

G.1.g. Multicultural/Diversity Considerations in Research
When appropriate to research goals, counselors are sensitive to incorporating research procedures that take into account cultural considerations. They seek consultation when appropriate.

G.2. Rights of Research Participants
(See A.2, A.7.)

G.2.a. Informed Consent in Research
Individuals have the right to consent to become research participants. In seeking consent, counselors use language that

1. accurately explains the purpose and procedures to be followed,
2. identifies any procedures that are experimental or relatively untried,
3. describes any attendant discomforts and risks,
4. describes any benefits or changes in individuals or organizations that might be reasonably expected,
5. discloses appropriate alternative procedures that would be advantageous for participants,
6. offers to answer any inquiries concerning the procedures,
7. describes any limitations on confidentiality,
8. describes the format and potential target audiences for the dissemination of research findings, and
9. instructs participants that they are free to withdraw their consent and to discontinue participation in the project at any time without penalty.

G.2.h. Deception
Counselors do not conduct research involving deception unless alternative procedures are not feasible and the prospective value of the research justifies the deception. If such deception has the potential to cause physical or emotional harm to research participants, the research is not conducted, regardless of prospective value. When the methodological requirements of a study necessitate concealment or deception, the investigator explains the reasons for this action as soon as possible during the debriefing.

G.2.c. Student/Supervisee Participation
Researchers who involve students or supervisees in research make clear to them that the decision regarding whether or not to participate in research activities does not affect one’s academic standing or supervisory relationship. Students or supervisees who choose not to participate in educational research are provided with an appropriate alternative to fulfill their academic or clinical requirements.

G.2.d. Client Participation
Counselors conducting research involving clients make clear to them that the decision regarding whether or not to participate in research activities does not affect one’s academic standing or supervisory relationship. Students or supervisees who choose not to participate in educational research are provided with an appropriate alternative to fulfill their academic or clinical requirements.

G.2.e. Confidentiality of Information
Information obtained about research participants during the course of an investigation is confidential. When the possibility exists that others may obtain access to such information, ethical research practice requires that the possibility, together with the plans for protecting confidentiality, be explained to participants as a part of the procedure for obtaining informed consent.

G.2.f. Persons Not Capable of Giving Informed Consent
When a person is not capable of giving informed consent, counselors provide an appropriate explanation to, obtain agreement for participation from, and obtain the appropriate consent of a legally authorized person.

G.2.g. Commitments to Participants
Counselors take reasonable measures to honor all commitments to research participants. (See A.2.c.)

G.2.h. Explanations After Data Collection
After data are collected, counselors provide participants with full clarification of the nature of the study to remove any misconceptions participants might have regarding the research. Where scientific or human values justify delaying or withholding information, counselors take reasonable measures to avoid causing harm.

G.2.i. Informing Sponsors
Counselors inform sponsors, institutions, and publication channels regarding research procedures and outcomes. Counselors ensure that appropriate bodies and authorities are given pertinent information and acknowledgment.

G.2.j. Disposal of Research Documents and Records
Within a reasonable period of time following the completion of a research project or study, counselors take steps to destroy records or documents (audio, video, digital, and written) containing confidential data or information that identifies research participants. When records are of an artistic nature, researchers obtain participant consent with regard to handling of such records or documents. (See B.4.a, B.4.g.)

G.3. Relationships With Research Participants
(When Research Involves Intensive or Extended Interactions)

G.3.a. Nonprofessional Relationships
Nonprofessional relationships with research participants should be avoided.

G.3.b. Relationships With Research Participants
Sexual or romantic counselor–research participant interactions or relationships with current research participants are prohibited.

G.3.c. Sexual Harassment and Research Participants
Researchers do not condone or subject research participants to sexual harassment.
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G.3.d. Potentially Beneficial Interactions
When a nonprofessional interaction between the researcher and the research participant may be potentially beneficial, the researcher must document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the research participant. Such interactions should be initiated with appropriate consent of the research participant. Where unintentional harm occurs to the research participant due to the nonprofessional interaction, the researcher must show evidence of an attempt to remedy such harm.

G.4. Reporting Results

G.4.a. Accurate Results
Counselors plan, conduct, and report research accurately. They provide thorough discussions of the limitations of their data and alternative hypotheses. Counselors do not engage in misleading or fraudulent research, distort data, misrepresent data, or deliberately bias their results. They explicitly mention all variables and conditions known to the investigator that may have affected the outcome of a study or the interpretation of data. They describe the extent to which results are applicable for diverse populations.

G.4.b. Obligation to Report Unfavorable Results
Counselors report the results of any research of professional value. Results that reflect unfavorably on institutions, programs, services, prevailing opinions, or vested interests are not withheld.

G.4.c. Reporting Errors
If counselors discover significant errors in their published research, they take reasonable steps to correct such errors in a correction erratum, or through other appropriate publication means.

G.4.d. Identity of Participants
Counselors who supply data, aid in the research of another person, report research results, or make original data available take due care to disguise the identity of respective participants in the absence of specific authorization from the participants to do otherwise. In situations where participants self-identify their involvement in research studies, researchers take active steps to ensure that data is adapted/changed to protect the identity and welfare of all parties and that discussion of results does not cause harm to participants.

G.4.e. Replication Studies
Counselors are obligated to make available sufficient original research data to qualified professionals who may wish to replicate the study.

G.5. Publication

G.5.a. Recognizing Contributions
When conducting and reporting research, counselors are familiar with and give recognition to previous work on the topic, observe copyright laws, and give full credit to those to whom credit is due.

G.5.b. Plagiarism
Counselors do not plagiarize; that is, they do not present another person’s work as their own work.

G.5.c. Review/Republication of Data or Ideas
Counselors fully acknowledge and make editorial reviewers aware of prior publication of ideas or data where such ideas or data are submitted for review or publication.

G.5.d. Contributors
Counselors give credit through joint authorship, acknowledgment, footnote statements, or other appropriate means to those who have contributed significantly to research or concept development in accordance with such contributions. The principal contributor is listed first and minor technical or professional contributions are acknowledged in notes or introductory statements.

G.5.e. Agreement of Contributors
Counselors who conduct joint research with colleagues or students/supervisees establish agreements in advance regarding allocation of tasks, publication credit, and types of acknowledgement that will be received.

G.5.f. Student Research
For articles that are substantially based on students course papers, projects, dissertations or theses, and on which students have been the primary contributors, they are listed as principal authors.

G.5.g. Duplicate Submission
Counselors submit manuscripts for consideration to only one journal at a time. Manuscripts that are published in whole or in substantial part in another journal or published work are not submitted for publication without acknowledgment and permission from the previous publication.

G.5.h. Professional Review
Counselors who review material submitted for publication, research, or other scholarly purposes respect the confidentiality and proprietary rights of those who submitted it. Counselors use care to make publication decisions based on valid and defensible standards. Counselors review article submissions in a timely manner and based on their scope and competency in research methodologies. Counselors who serve as reviewers at the request of editors or publishers make every effort to only review materials that are within their scope of competence and use care to avoid personal biases.

Section H
Resolving Ethical Issues

Introduction
Counselors behave in a legal, ethical, and moral manner in the conduct of their professional work. They are aware that client protection and trust in the profession depend on a high level of professional conduct. They hold other counselors to the same standards and are willing to take appropriate action to ensure that these standards are upheld.

Counselors strive to resolve ethical dilemmas with direct and open communication among all parties involved and seek consultation with colleagues and supervisors when necessary. Counselors incorporate ethical practice into their daily professional work. They engage in ongoing professional development regarding current topics in ethical and legal issues in counseling.

H.1. Standards and the Law
(See E.9.a.)

H.1.a. Knowledge
Counselors understand the ACA Code of Ethics and other applicable ethics codes from other professional organizations or from certification and licensure bodies of which they are members. Lack of knowledge or misunderstanding of an ethical responsibility is not a
defense against a charge of unethical conduct.

H.1.b. Conflicts Between Ethics and Laws
If ethical responsibilities conflict with law, regulations, or other governing legal authority, counselors make known their commitment to the ACA Code of Ethics and take steps to resolve the conflict. If the conflict cannot be resolved by such means, counselors may adhere to the requirements of law, regulations, or other governing legal authority.

H.2. Suspected Violations

H.2.a. Ethical Behavior Expected
Counselors expect colleagues to adhere to the ACA Code of Ethics. When counselors possess knowledge that raises doubts as to whether another counselor is acting in an ethical manner, they take appropriate action. (See H.2.b., H.2.c.)

H.2.b. Informal Resolution
When counselors have reason to believe that another counselor is violating or has violated an ethical standard, they attempt first to resolve the issue informally with the other counselor if feasible, provided such action does not violate confidentiality rights that may be involved.

H.2.c. Reporting Ethical Violations
If an apparent violation has substantially harmed, or is likely to substantially harm a person or organization and is not appropriate for informal resolution or is not resolved properly, counselors take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when counselors have been retained to review the work of another counselor whose professional conduct is in question.

H.2.d. Consultation
When uncertain as to whether a particular situation or course of action may be in violation of the ACA Code of Ethics, counselors consult with other counselors who are knowledgeable about ethics and the ACA Code of Ethics, with colleagues, or with appropriate authorities.

H.2.e. Organizational Conflicts
If the demands of an organization with which counselors are affiliated pose a conflict with the ACA Code of Ethics, counselors specify the nature of such conflicts and express to their supervisors or other responsible officials their commitment to the ACA Code of Ethics. When possible, counselors work toward change within the organization to allow full adherence to the ACA Code of Ethics. In doing so, they address any confidentiality issues.

H.2.f. Unwarranted Complaints
Counselors do not initiate, participate in, or encourage the filing of ethics complaints that are made with reckless disregard or willful ignorance of facts that would disprove the allegation.

H.2.g. Unfair Discrimination Against Complainants and Respondents
Counselors do not deny persons employment, advancement, admission to academic or other programs, tenure, or promotion based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

H.3. Cooperation With Ethics Committees
Counselors assist in the process of enforcing the ACA Code of Ethics. Counselors cooperate with investigations, proceedings, and requirements of the ACA Ethics Committee or ethics committees of other duly constituted associations or boards having jurisdiction over those charged with a violation. Counselors are familiar with the ACA Policy and Procedures for Processing Complaints of Ethical Violations and use it as a reference for assisting in the enforcement of the ACA Code of Ethics.
Glossary of Terms

**Advocacy** – promotion of the well-being of individuals and groups, and the counseling profession within systems and organizations. Advocacy seeks to remove barriers and obstacles that inhibit access, growth, and development.

**Assent** – to demonstrate agreement, when a person is otherwise not capable or competent to give formal consent (e.g., informed consent) to a counseling service or plan.

**Client** – an individual seeking or referred to the professional services of a counselor for help with problem resolution or decision making.

**Counselor** – a professional (or a student who is a counselor-in-training) engaged in a counseling practice or other counseling-related services. Counselors fulfill many roles and responsibilities such as counselor educators, researchers, supervisors, practitioners, and consultants.

**Counselor Educator** – a professional counselor engaged primarily in developing, implementing, and supervising the educational preparation of counselors-in-training.

**Counselor Supervisor** – a professional counselor who engages in a formal relationship with a practicing counselor or counselor-in-training for the purpose of overseeing that individual’s counseling work or clinical skill development.

**Culture** – membership in a socially constructed way of living, which incorporates collective values, beliefs, norms, boundaries, and lifestyles that are cocreated with others who share similar worldviews comprising biological, psychosocial, historical, psychological, and other factors.

**Diversity** – the similarities and differences that occur within and across cultures, and the intersection of cultural and social identities.

**Documents** – any written, digital, audio, visual, or artistic recording of the work within the counseling relationship between counselor and client.

**Examinee** – a recipient of any professional counseling service that includes educational, psychological, and career appraisal utilizing qualitative or quantitative techniques.

**Forensic Evaluation** – any formal assessment conducted for court or other legal proceedings.

**Multicultural/Diversity Competence** – a capacity whereby counselors possess cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge is applied effectively in practice with clients and client groups.

**Multicultural/Diversity Counseling** – counseling that recognizes diversity and embraces approaches that support the worth, dignity, potential, and uniqueness of individuals within their historical, cultural, economic, political, and psychosocial contexts.

**Student** – an individual engaged in formal educational preparation as a counselor-in-training.

**Supervisee** – a professional counselor or counselor-in-training whose counseling work or clinical skill development is being overseen in a formal supervisory relationship by a qualified trained professional.

**Supervisor** – counselors who are trained to oversee the professional clinical work of counselors and counselors-in-training.

**Teaching** – all activities engaged in as part of a formal educational program designed to lead to a graduate degree in counseling.

**Training** – the instruction and practice of skills related to the counseling profession. Training contributes to the ongoing proficiency of students and professional counselors.
Preamble
The Board of Directors of the American Association for Marriage and Family Therapy (AAMFT) hereby promulgates, pursuant to Article 2, Section 2.01.3 of the Association's Bylaws, the Revised AAMFT Code of Ethics, effective July 1, 2012.

The AAMFT strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as described in this Code. The ethical standards define professional expectations and are enforced by the AAMFT Ethics Committee. The absence of an explicit reference to a specific behavior or situation in the Code does not mean that the behavior is ethical or unethical. The standards are not exhaustive. Marriage and family therapists who are uncertain about the ethics of a particular course of action are encouraged to seek counsel from consultants, attorneys, supervisors, colleagues, or other appropriate authorities.

Both law and ethics govern the practice of marriage and family therapy. When making decisions regarding professional behavior, marriage and family therapists must consider the AAMFT Code of Ethics and applicable laws and regulations. If the AAMFT Code of Ethics prescribes a standard higher than that required by law, marriage and family therapists must meet the higher standard of the AAMFT Code of Ethics. Marriage and family therapists comply with the mandates of law, but make known their commitment to the AAMFT Code of Ethics and take steps to resolve the conflict in a responsible manner. The AAMFT supports legal mandates for reporting of alleged unethical conduct.

The AAMFT Code of Ethics is binding on members of AAMFT in all membership categories, all AAMFT Approved Supervisors and all applicants for membership or the Approved Supervisor designation. AAMFT members have an obligation to be familiar with the AAMFT Code of Ethics and its application to their professional services. Lack of awareness or misunderstanding of an ethical standard is not a defense to a charge of unethical conduct.

The process for filing, investigating, and resolving complaints of unethical conduct is described in the current AAMFT Procedures for Handling Ethical Matters. Persons accused are considered innocent by the Ethics Committee until proven guilty, except as otherwise provided, and are entitled to due process. If an AAMFT member resigns in anticipation of, or during the course of, an ethics investigation, the Ethics Committee will complete its investigation. Any publication of action taken by the Association will include the fact that the member attempted to resign during the investigation.

Principle I
Responsibility to Clients
Marriage and family therapists advance the welfare of families and individuals. They respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately.

1.1 Non-Discrimination. Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity or relationship status.

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

1.3 Multiple Relationships. Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client’s immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken.

1.4 Sexual Intimacy with Current Clients and Others. Sexual intimacy with current clients, or their spouses or partners is prohibited. Engaging in sexual intimacy with individuals who are known to be close relatives, guardians or significant others of current clients is prohibited.

1.5 Sexual Intimacy with Former Clients and Others. Sexual intimacy with former clients, their spouses or partners, or individuals who are known to be close relatives, guardians or significant others of clients is likely to be harmful and is therefore prohibited for two years following the termination of therapy or last professional contact. After the two years following the last professional contact or termination, in an effort to avoid exploiting the trust and dependency of clients, marriage and family therapists should not engage in sexual intimacy with former clients, or their spouses or partners. If therapists engage in sexual intimacy with former clients, or their spouses or partners, more than two years after termination or last professional contact, the burden shifts to the therapist to demonstrate that there has been no exploitation or injury to the former client, or their spouse or partner.

1.6 Reports of Unethical Conduct. Marriage and family therapists comply with applicable laws regarding the reporting of alleged unethical conduct.

1.7 No Furthering of Own Interests. Marriage and family therapists do not use their professional relationships with clients to further their own interests.

1.8 Client Autonomy in Decision Making. Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions. Therapists clearly advise clients that clients have the responsibility to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, and visitation.

1.9 Relationship Beneficial to Client. Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship.

1.10 Referrals. Marriage and family therapists assist persons in obtaining other therapeutic services if the therapist is unable or unwilling, for appropriate reasons, to provide professional help.

1.11 Non-Abandonment. Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of treatment.

1.12 Written Consent to Record. Marriage and family therapists obtain written informed consent from clients before videotaping, audio recording, or permitting third-party observation.

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

1.14 Electronic Therapy. Prior to commencing therapy services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that electronic therapy is appropriate for clients, taking into account the clients’ intellectual, emotional, and physical needs; (b) inform clients of the potential risks and benefits associated with electronic therapy; (c) ensure the security of their communication medium; and (d) only commence electronic therapy after appropriate education, training, or supervised experience using the relevant technology.
Principle II
Confidentiality
Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.

2.1 Disclosing Limits of Confidentiality. Marriage and family therapists disclose to clients and other interested parties, as early as feasible in their professional contacts, the nature of confidentiality and possible limitations of the clients’ right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures.

2.2 Written Authorization to Release Client Information. Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law. When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization from each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual’s confidences to others in the client unit without the prior written permission of that individual.

2.3 Confidentiality in Non-Clinical Activities. Marriage and family therapists use client and/or clinical materials in teaching, writing, consulting, research, and public presentations only if a written waiver has been obtained in accordance with Subprinciple 2.2, or when appropriate steps have been taken to protect client identity and confidentiality.

2.4 Protection of Records. Marriage and family therapists store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards.

2.5 Preparation for Practice Changes. In preparation for moving from the area, closing a practice, or death, marriage and family therapists arrange for the storage, transfer, or disposal of client records in conformance with applicable laws and in ways that maintain confidentiality and safeguard the welfare of clients.

2.6 Confidentiality in Consultations. Marriage and family therapists, when consulting with colleagues or referral sources, do not share confidential information that could reasonably lead to the identification of a client, research participant, supervisee, or other person with whom they have a confidential relationship unless they have obtained the prior written consent of the client, research participant, supervisee, or other person with whom they have a confidential relationship. Information may be shared only to the extent necessary to achieve the purposes of the consultation.

2.7 Protection of Electronic Information. When using electronic methods for communication, billing, recordkeeping, or other elements of client care, marriage and family therapists ensure that their electronic data storage and communications are privacy protected consistent with all applicable law.

Principle III
Professional Competence and Integrity
Marriage and family therapists maintain high standards of professional competence and integrity.

3.1 Maintenance of Competency. Marriage and family therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, or supervised experience.

3.2 Knowledge of Regulatory Standards. Marriage and family therapists maintain adequate knowledge of and adhere to applicable laws, ethics, and professional standards.

3.3 Seek Assistance. Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment.
3.4 Conflicts of Interest. Marriage and family therapists do not provide services that create a conflict of interest that may impair work performance or clinical judgment.

3.5 Veracity of Scholarship. Marriage and family therapists, as presenters, teachers, supervisors, consultants and researchers, are dedicated to high standards of scholarship, present accurate information, and disclose potential conflicts of interest.

3.6 Maintenance of Records. Marriage and family therapists maintain accurate and adequate clinical and financial records in accordance with applicable law.

3.7 Development of New Skills. While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, or supervised experience.

3.8 Harassment. Marriage and family therapists do not engage in sexual or other forms of harassment of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.9 Exploitation. Marriage and family therapists do not engage in the exploitation of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.10 Gifts. Marriage and family therapists do not give to or receive from clients (a) gifts of substantial value or (b) gifts that impair the integrity or efficacy of the therapeutic relationship.

3.11 Scope of Competence. Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies.

3.12 Accurate Presentation of Findings. Marriage and family therapists make efforts to prevent the distortion or misuse of their clinical and research findings.

3.13 Public Statements. Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise special care when making public their professional recommendations and opinions through testimony or other public statements.

3.14 Separation of Custody Evaluation from Therapy. To avoid a conflict of interest, marriage and family therapists who treat minors or adults involved in custody or visitation actions may not also perform forensic evaluations for custody, residence, or visitation of the minor. Marriage and family therapists who treat minors may provide the court or mental health professional performing the evaluation with information about the minor from the marriage and family therapist’s perspective as a treating marriage and family therapist, so long as the marriage and family therapist does not violate confidentiality.

3.15 Professional Misconduct. Marriage and family therapists are in violation of this Code and subject to termination of membership or other appropriate action if they: (a) are convicted of any felony; (b) are convicted of a misdemeanor related to their qualifications or functions; (c) engage in conduct which could lead to conviction of a felony, or a misdemeanor related to their qualifications or functions; (d) are expelled from or disciplined by other professional organizations; (e) have their licenses or certificates suspended or revoked or are otherwise disciplined by regulatory bodies; (f) continue to practice marriage and family therapy while no longer competent to do so because they are impaired by physical or mental causes or the abuse of alcohol or other substances; or (g) fail to cooperate with the Association at any point from the inception of an ethical complaint through the completion of all proceedings regarding that complaint.

Principle IV
Responsibility to Students and Supervisees
Marriage and family therapists do not exploit the trust and dependency of students and supervisees.
4.1 Exploitation. Marriage and family therapists who are in a supervisory role are aware of their influential positions with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships that could impair professional objectivity or increase the risk of exploitation. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions.

4.2 Therapy with Students or Supervisees. Marriage and family therapists do not provide therapy to current students or supervisees.

4.3 Sexual Intimacy with Students or Supervisees. Marriage and family therapists do not engage in sexual intimacy with students or supervisees during the evaluative or training relationship between the therapist and student or supervisee. If a supervisor engages in sexual activity with a former supervisee, the burden of proof shifts to the supervisor to demonstrate that there has been no exploitation or injury to the supervisee.

4.4 Oversight of Supervisee Competence. Marriage and family therapists do not permit students or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience, and competence.

4.5 Oversight of Supervisee Professionalism. Marriage and family therapists take reasonable measures to ensure that services provided by supervisees are professional.

4.6 Existing Relationship with Students or Supervisees. Marriage and family therapists avoid accepting as supervisees or students those individuals with whom a prior or existing relationship could compromise the therapist’s objectivity. When such situations cannot be avoided, therapists take appropriate precautions to maintain objectivity. Examples of such relationships include, but are not limited to, those individuals with whom the therapist has a current or prior sexual, close personal, immediate familial, or therapeutic relationship.

4.7 Confidentiality with Supervisees. Marriage and family therapists do not disclose supervisee confidences except by written authorization or waiver, or when mandated or permitted by law. In educational or training settings where there are multiple supervisors, disclosures are permitted only to other professional colleagues, administrators, or employers who share responsibility for training of the supervisee. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law.

Principle V
Responsibility to Research Participants
Investigators respect the dignity and protect the welfare of research participants, and are aware of applicable laws, regulations, and professional standards governing the conduct of research.

5.1 Protection of Research Participants. Investigators are responsible for making careful examinations of ethical acceptability in planning studies. To the extent that services to research participants may be compromised by participation in research, investigators seek the ethical advice of qualified professionals not directly involved in the investigation and observe safeguards to protect the rights of research participants.

5.2 Informed Consent. Investigators requesting participant involvement in research inform participants of the aspects of the research that might reasonably be expected to influence willingness to participate. Investigators are especially sensitive to the possibility of diminished consent when participants are also receiving clinical services, or have impairments which limit understanding and/or communication, or when participants are children.

5.3 Right to Decline or Withdraw Participation. Investigators respect each participant’s freedom to decline participation in or to withdraw from a research study at any time. This obligation requires special thought and consideration when investigators or other members of the research team are in positions of authority or influence over participants. Marriage and family therapists, therefore, make every effort to avoid multiple relationships with research participants that could impair professional judgment or increase the risk of exploitation.

5.4 Confidentiality of Research Data. Information obtained about a research participant during the course of an investigation is confidential unless there is a waiver previously obtained in writing. When the possibility exists that
others, including family members, may obtain access to such information, this possibility, together with the plan for protecting confidentiality, is explained as part of the procedure for obtaining informed consent.

Principle VI
Responsibility to the Profession
Marriage and family therapists respect the rights and responsibilities of professional colleagues and participate in activities that advance the goals of the profession.

6.1 Conflicts Between Code and Organizational Policies. Marriage and family therapists remain accountable to the AAMFT Code of Ethics when acting as members or employees of organizations. If the mandates of an organization with which a marriage and family therapist is affiliated, through employment, contract or otherwise, conflict with the AAMFT Code of Ethics, marriage and family therapists make known to the organization their commitment to the AAMFT Code of Ethics and attempt to resolve the conflict in a way that allows the fullest adherence to the Code of Ethics.

6.2 Publication Authorship. Marriage and family therapists assign publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with customary professional publication practices.

6.3 Authorship of Student Work. Marriage and family therapists do not accept or require authorship credit for a publication based on research from a student’s program, unless the therapist made a substantial contribution beyond being a faculty advisor or research committee member. Co-authorship on a student thesis, dissertation, or project should be determined in accordance with principles of fairness and justice.

6.4 Plagiarism. Marriage and family therapists who are the authors of books or other materials that are published or distributed do not plagiarize or fail to cite persons to whom credit for original ideas or work is due.

6.5 Accuracy in Publication and Advertising. Marriage and family therapists who are the authors of books or other materials published or distributed by an organization take reasonable precautions to ensure that the organization promotes and advertises the materials accurately and factually.

6.6 Pro Bono. Marriage and family therapists participate in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return.

6.7 Advocacy. Marriage and family therapists are concerned with developing laws and regulations pertaining to marriage and family therapy that serve the public interest, and with altering such laws and regulations that are not in the public interest.

6.8 Public Participation. Marriage and family therapists encourage public participation in the design and delivery of professional services and in the regulation of practitioners.

Principle VII
Financial Arrangements
Marriage and family therapists make financial arrangements with clients, third-party payors, and supervisees that are reasonably understandable and conform to accepted professional practices.

7.1 Financial Integrity. Marriage and family therapists do not offer or accept kickbacks, rebates, bonuses, or other remuneration for referrals; fee-for-service arrangements are not prohibited.

7.2 Disclosure of Financial Policies. Prior to entering into the therapeutic or supervisory relationship, marriage and family therapists clearly disclose and explain to clients and supervisees: (a) all financial arrangements and fees related to professional services, including charges for canceled or missed appointments; (b) the use of collection
agencies or legal measures for nonpayment; and (c) the procedure for obtaining payment from the client, to the extent allowed by law, if payment is denied by the third-party payor. Once services have begun, therapists provide reasonable notice of any changes in fees or other charges.

7.3 Notice of Payment Recovery Procedures. Marriage and family therapists give reasonable notice to clients with unpaid balances of their intent to seek collection by agency or legal recourse. When such action is taken, therapists will not disclose clinical information.

7.4 Truthful Representation of Services. Marriage and family therapists represent facts truthfully to clients, third-party payors, and supervisees regarding services rendered.

7.5 Bartering. Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: (a) the supervisee or client requests it; (b) the relationship is not exploitative; (c) the professional relationship is not distorted; and (d) a clear written contract is established.

7.6 Withholding Records for Non-Payment. Marriage and family therapists may not withhold records under their immediate control that are requested and needed for a client’s treatment solely because payment has not been received for past services, except as otherwise provided by law.

Principle VIII
Advertising
Marriage and family therapists engage in appropriate informational activities, including those that enable the public, referral sources, or others to choose professional services on an informed basis.

8.1 Accurate Professional Representation. Marriage and family therapists accurately represent their competencies, education, training, and experience relevant to their practice of marriage and family therapy.

8.2 Promotional Materials. Marriage and family therapists ensure that advertisements and publications in any media (such as directories, announcements, business cards, newspapers, radio, television, Internet, and facsimiles) convey information that is necessary for the public to make an appropriate selection of professional services and consistent with applicable law.

8.3 Professional Affiliations. Marriage and family therapists do not use names that could mislead the public concerning the identity, responsibility, source, and status of those practicing under that name, and do not hold themselves out as being partners or associates of a firm if they are not.

8.4 Professional Identification. Marriage and family therapists do not use any professional identification (such as a business card, office sign, letterhead, Internet, or telephone or association directory listing) if it includes a statement or claim that is false, fraudulent, misleading, or deceptive.

8.5 Educational Credentials. In representing their educational qualifications, marriage and family therapists list and claim as evidence only those earned degrees: (a) from institutions accredited by regional accreditation sources; (b) from institutions recognized by states or provinces that license or certify marriage and family therapists; or (c) from equivalent foreign institutions.

8.6 Correction of Misinformation. Marriage and family therapists correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist’s qualifications, services, or products.

8.7 Employee or Supervisee Qualifications. Marriage and family therapists make certain that the qualifications of their employees or supervisees are represented in a manner that is not false, misleading, or deceptive.

8.8 Specialization. Marriage and family therapists do not represent themselves as providing specialized services unless they have the appropriate education, training, or supervised experience.
Violations of this Code should be submitted in writing to the attention of:
AAMFT Ethics Committee
112 South Alfred Street, Alexandria, VA 22314
Phone: (703) 838-9808
Fax: (703) 838-9805
email: ethics@aamft.org
American Psychiatric Association
The Principles of Medical Ethics

With Annotations Especially Applicable to Psychiatry

2009 Edition Revised
The Principles of Medical Ethics

2009 Edition Revised

American Psychiatric Association
1000 Wilson Boulevard #1825
Arlington, VA 22209
In 1973, the American Psychiatric Association (APA) published the first edition of The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. Subsequently, revisions were published as the APA Board of Trustees and the APA Assembly approved additional annotations. In July of 1980, the American Medical Association (AMA) approved a new version of the Principles of Medical Ethics (the first revision since 1957), and the APA Ethics Committee incorporated many of its annotations into the new Principles, which resulted in the 1981 edition and subsequent revisions. This version includes changes to the Principles approved by the AMA in 2001.

**Foreword**

All physicians should practice in accordance with the medical code of ethics set forth in the Principles of Medical Ethics of the American Medical Association. An up-to-date expression and elaboration of these statements is found in the Opinions and Reports of the Council on Ethical and Judicial Affairs of the American Medical Association. Psychiatrists are strongly advised to be familiar with these documents.

However, these general guidelines have sometimes been difficult to interpret for psychiatry, so further annotations to the basic principles are offered in this document. While psychiatrists have the same goals as all physicians, there are special ethical problems in psychiatric practice that differ in coloring and degree from ethical problems in other branches of medical practice, even

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1The committee included Herbert Klemmer, M.D., Chairperson, Miltiades Zaphiropoulos, M.D., Ewald Busse, M.D., John R. Saunders, M.D., and Robert McDevitt, M.D. J. Brand Brickman, M.D., William P. Camp, M.D., and Robert A. Moore, M.D., served as consultants to the APA Ethics Committee.


3Chapter 7, Section 1 of the Bylaws of the American Psychiatric Association (May 2003 edition) states, “All members of the Association shall be bound by the ethical code of the medical profession, specifically defined in the Principles of Medical Ethics of the American Medical Association and in the Association’s Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry.” In interpreting the Bylaws, it is the opinion of the APA Board of Trustees that inactive status in no way removes a physician member from responsibility to abide by the Principles of Medical Ethics.
though the basic principles are the same. The annotations are not designed as absolutes and will be revised from time to time so as to be applicable to current practices and problems.

Following are the AMA *Principles of Medical Ethics*, printed in their entirety, and then each principle printed separately along with an annotation especially applicable to psychiatry.

### Principles of Medical Ethics

**American Medical Association**

**Preamble**

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following *Principles* adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

**Section 1**

A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

**Section 2**

A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

**Section 3**

A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

**Section 4**

A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

**Section 5**

A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
Section 6
A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

Section 7
A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

Section 8
A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

Section 9
A physician shall support access to medical care for all people.

Principles With Annotations

Following are each of the AMA Principles of Medical Ethics printed separately along with annotations especially applicable to psychiatry.

Preamble
The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.4

Section 1
A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.

1. A psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor–patient relationship, and thus upon the well-being of the patient. These requirements become particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.

2. A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.

4Statements in italics are taken directly from the American Medical Association’s Principles of Medical Ethics.
3. In accord with the requirements of law and accepted medical practice, it is ethical for a physician to submit his or her work to peer review and to the ultimate authority of the medical staff executive body and the hospital administration and its governing body. In case of dispute, the ethical psychiatrist has the following steps available:

   a. Seek appeal from the medical staff decision to a joint conference committee, including members of the medical staff executive committee and the executive committee of the governing board. At this appeal, the ethical psychiatrist could request that outside opinions be considered.

   b. Appeal to the governing body itself.

   c. Appeal to state agencies regulating licensure of hospitals if, in the particular state, they concern themselves with matters of professional competency and quality of care.

   d. Attempt to educate colleagues through development of research projects and data and presentations at professional meetings and in professional journals.

   e. Seek redress in local courts, perhaps through an enjoining injunction against the governing body.

   f. Public education as carried out by an ethical psychiatrist would not utilize appeals based solely upon emotion, but would be presented in a professional way and without any potential exploitation of patients through testimonials.

4. A psychiatrist should not be a participant in a legally authorized execution.

Section 2
A physician shall uphold the standards of professionalism, be honest in all professional interactions and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.

1. The requirement that the physician conduct himself/herself with propriety in his or her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification. Further, the necessary intensity of the treatment relationship may tend to activate sexual and other needs and fantasies on the part of both patient and psychiatrist, while weakening the objectivity necessary for control. Additionally, the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical.
2. The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals.

3. A psychiatrist who regularly practices outside his or her area of professional competence should be considered unethical. Determination of professional competence should be made by peer review boards or other appropriate bodies.

4. Special consideration should be given to those psychiatrists who, because of mental illness, jeopardize the welfare of their patients and their own reputations and practices. It is ethical, even encouraged, for another psychiatrist to intercede in such situations.

5. Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement between the patient and the physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established.

6. It is ethical for the psychiatrist to make a charge for a missed appointment when this falls within the terms of the specific contractual agreement with the patient. Charging for a missed appointment or for one not canceled 24 hours in advance need not, in itself, be considered unethical if a patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration for the patient and his or her circumstances.

7. An arrangement in which a psychiatrist provides supervision or administration to other physicians or nonmedical persons for a percentage of their fees or gross income is not acceptable; this would constitute fee splitting. In a team of practitioners, or a multidisciplinary team, it is ethical for the psychiatrist to receive income for administration, research, education, or consultation. This should be based on a mutually agreed-upon and set fee or salary, open to renegotiation when a change in the time demand occurs. (See also Section 5, Annotations 2, 3, and 4.)

Section 3
A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

1. It would seem self-evident that a psychiatrist who is a law-breaker might be ethically unsuited to practice his or her profession. When such illegal activities bear directly upon his or her practice, this would obviously be the case. However, in other instances, illegal activities such as those concerning the right to protest social injustices might not bear on either the image of the psychiatrist or the ability of the specific psychiatrist to treat his or her patient ethically and well. While no committee or board could offer prior assurance that any illegal activity would not be considered unethical, it is conceivable that an individual could violate a law without being guilty
of professionally unethical behavior. Physicians lose no right of citizenship on entry into the profession of medicine.

2. Where not specifically prohibited by local laws governing medical practice, the practice of acupuncture by a psychiatrist is not unethical per se. The psychiatrist should have professional competence in the use of acupuncture. Or, if he or she is supervising the use of acupuncture by nonmedical individuals, he or she should provide proper medical supervision. (See also Section 5, Annotations 3 and 4.)

Section 4
A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

1. Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern regarding the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard. Because of the sensitive and private nature of the information with which the psychiatrist deals, he or she must be circumspect in the information that he or she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.

2. A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies, business organizations, labor unions, and insurance companies. Information gained in confidence about patients seen in student health services should not be released without the students’ explicit permission.

3. Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved.

4. The ethical responsibility of maintaining confidentiality holds equally for the consultations in which the patient may not have been present and in which the consultee was not a physician. In such instances, the physician consultant should alert the consultee to his or her duty of confidentiality.

5. Ethically, the psychiatrist may disclose only that information which is relevant to a given situation. He or she should avoid offering speculation as fact. Sensitive information such as an individual’s sexual orientation or fantasy material is usually unnecessary.
6. Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination.

7. Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parents or guardian in the treatment of a minor. At the same time, the psychiatrist must assure the minor proper confidentiality.

8. When, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient.”

9. When the psychiatrist is ordered by the court to reveal the confidences entrusted to him/her by patients, he or she may comply or he/she may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality and, by extension, unimpaired treatment should be given priority. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand.

10. With regard for the person’s dignity and privacy and with truly informed consent, it is ethical to present a patient to a scientific gathering if the confidentiality of the presentation is understood and accepted by the audience.

11. It is ethical to present a patient or former patient to a public gathering or to the news media only if the patient is fully informed of enduring loss of confidentiality, is competent, and consents in writing without coercion.

12. When involved in funded research, the ethical psychiatrist will advise human subjects of the funding source, retain his or her freedom to reveal data and results, and follow all appropriate and current guidelines relative to human subject protection.

13. Ethical considerations in medical practice preclude the psychiatric evaluation of any person charged with criminal acts prior to access to, or availability of, legal counsel. The only exception is the rendering of care to the person for the sole purpose of medical treatment.

14. Sexual involvement between a faculty member or supervisor and a trainee or student, in those situations in which an abuse of power can occur, often takes advantage of inequalities in the working relationship and may be unethical because:

   a. Any treatment of a patient being supervised may be deleteriously affected.
   b. It may damage the trust relationship between teacher and student.
   c. Teachers are important professional role models for their trainees and affect their trainees’ future professional behavior.
Section 5
A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

1. Psychiatrists are responsible for their own continuing education and should be mindful of the fact that theirs must be a lifetime of learning.

2. In the practice of his or her specialty, the psychiatrist consults, associates, collaborates, or integrates his or her work with that of many professionals, including psychologists, psychometricians, social workers, alcoholism counselors, marriage counselors, public health nurses, and the like. Furthermore, the nature of modern psychiatric practice extends his or her contacts to such people as teachers, juvenile and adult probation officers, attorneys, welfare workers, agency volunteers, and neighborhood aides. In referring patients for treatment, counseling, or rehabilitation to any of these practitioners, the psychiatrist should ensure that the allied professional or paraprofessional with whom he or she is dealing is a recognized member of his or her own discipline and is competent to carry out the therapeutic task required. The psychiatrist should have the same attitude toward members of the medical profession to whom he or she refers patients. Whenever he or she has reason to doubt the training, skill, or ethical qualifications of the allied professional, the psychiatrist should not refer cases to him/her.

3. When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he or she must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if the psychiatrist allows himself/herself to be used as a figurehead.

4. In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment.

5. The psychiatrist should agree to the request of a patient for consultation or to such a request from the family of an incompetent or minor patient. The psychiatrist may suggest possible consultants, but the patient or family should be given free choice of the consultant. If the psychiatrist disapproves of the professional qualifications of the consultant or if there is a difference of opinion that the primary therapist cannot resolve, he or she may, after suitable notice, withdraw from the case. If this disagreement occurs within an institution or agency framework, the differences should be resolved by the mediation or arbitration of higher professional authority within the institution or agency.

Section 6
A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
1. Physicians generally agree that the doctor-patient relationship is such a vital factor in effective treatment of the patient that preservation of optimal conditions for development of a sound working relationship between a doctor and his or her patient should take precedence over all other considerations. Professional courtesy may lead to poor psychiatric care for physicians and their families because of embarrassment over the lack of a complete give-and-take contract.  

2. An ethical psychiatrist may refuse to provide psychiatric treatment to a person who, in the psychiatrist’s opinion, cannot be diagnosed as having a mental illness amenable to psychiatric treatment.

Section 7  
A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

1. Psychiatrists should foster the cooperation of those legitimately concerned with the medical, psychological, social, and legal aspects of mental health and illness. Psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judiciary branches of the government. A psychiatrist should clarify whether he/ she speaks as an individual or as a representative of an organization. Furthermore, psychiatrists should avoid cloaking their public statements with the authority of the profession (e.g., “Psychiatrists know that…”).

2. Psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness. Psychiatrists should always be mindful of their separate roles as dedicated citizens and as experts in psychological medicine.

3. On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement.

4. The psychiatrist may permit his or her certification to be used for the involuntary treatment of any person only following his or her personal examination of that person. To do so, he or she must find that the person, because of mental illness, cannot form a judgment as to what is in his/ her own best interests and that, without such treatment, substantial impairment is likely to occur to the person or others.

5. Psychiatrists shall not participate in torture.
Section 8
A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

New section recently adopted by the AMA.

Section 9
A physician shall support access to medical care for all people.

New section recently adopted by the AMA.
Procedures for Handling Complaints of Unethical Conduct

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients but also to society, to other health professionals, and to self. The *Principles*, adopted by the American Medical Association, are not laws but standards of conduct that define the essentials of honorable behavior for the physician.

Complaints charging members of the American Psychiatric Association (APA) with unethical behavior or practices shall be investigated, processed, and resolved in accordance with procedures approved by the APA Assembly and the APA Board of Trustees.

If a complaint of unethical conduct against a member is sustained, the member shall receive a sanction ranging from reprimand to expulsion. Any decision to expel a member must be approved by a two-thirds (2/3) affirmative vote of all members of the APA Board of Trustees present and voting.5

PART I: INITIAL PROCEDURES

1. a. Unless the complaint may be decided solely on the basis of extrinsic evidence, all formal complaints charging a member of the APA with unethical behavior shall be made in writing, signed by the complainant, and addressed to the district branch of the charged member (“respondent”) or, if addressed to the APA, shall be referred by the APA to the respondent’s district branch for investigation6 and decision in accordance with these Procedures.7 Cases that may be decided solely on the basis of extrinsic evidence may be initiated by the forwarding of documentation supporting the complaint to the district branch or APA Ethics Chair without a formal, signed charging letter.

b. If the respondent is a member-at-large of the APA, the complaint shall be referred to an ad hoc investigating committee, as provided for in Paragraph 2 below.

c. To be considered pursuant to these Procedures, a complaint alleging unethical conduct must be received within ten (10) years of the alleged conduct8.

5 Chapter 7, Sections 1, 2, and 3, Bylaws, American Psychiatric Association, May 2005 edition.

6 As used in these Procedures, the term investigation is meant to include both an information-gathering or investigatory phase of a case and a hearing phase. This term does not apply to the process by which a district branch initially determines whether or not a complaint warrants investigation.

7 The Procedures set out minimum requirements. Each district branch should comply with any additional or more stringent requirements of state law.

8 In the case of a minor patient, the ten (10) years will not begin until the patient reaches majority.
d. Unless (i) the case will be decided solely on the basis of extrinsic evidence obtained entirely from sources other than the respondent, and/or (ii) the complaint is referred to a licensing board or similar authority for initial or final processing, without receiving information from the patient, at the time it notifies respondent of a complaint received, the district branch ethics committee shall obtain and provide the respondent with valid written authorization(s) from the patient(s) involved to provide (i) relevant medical records and other information about the patient, and, if applicable, (ii) psychotherapy notes, to the district branch for the purposes of its investigation.

2. If, after receiving a written complaint, the district branch determines that there are compelling reasons why it would not be the appropriate body to consider the complaint, the district branch shall write to the Chair of the APA Ethics Committee, requesting that it be excused, providing a detailed explanation of the reasons for its request. If the Chair of the APA Ethics Committee determines that the district branch should not be excused, the district branch shall proceed with the complaint. If the Chair of the APA Ethics Committee agrees that the district branch should be excused from considering the complaint, the Chair shall then appoint three (3) Fellows of the APA to serve as an ad hoc investigating committee to conduct the investigation and to render a decision. When possible, these Fellows shall reside in the same Area as the respondent and in no event shall any such Fellow be a member of the APA Ethics Committee or the APA Board of Trustees.

3. If the district branch finds it cannot determine that the complaint warrants investigation under the ethical standards established by The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, the district branch shall so notify the complainant, requesting additional information when appropriate. If the district branch determines that the charges do not warrant investigation, it shall notify the complainant, stating the basis for the conclusion and informing the complainant that he/she may request a review of this decision no later than sixty (60) days from the Chair of the APA Ethics Committee. If the Chair of the APA Ethics Committee determines that the complaint warrants investigation, he/she will appoint an ad hoc investigating committee as provided for in Paragraph 2 above. When an ad hoc investigating committee is appointed, the district branch shall be so notified by the Chair of the APA Ethics Committee.

9 Prior to forwarding a complaint to the licensing board, any other authority or individual, the district branch should obtain the patient’s consent to potentially involving the complainant in a procedure s/he did not wish to invoke.

10 If not provided by the patient/complainant, the district branch shall provide the patient/complainant with an authorization form or forms that comply with federal law (HIPAA) and applicable state law. If investigation reveals that medical information or records and/or psychotherapy notes of a patient who is not the complainant are relevant, the district branch must obtain the authorization of such patient before obtaining such records from a member. Whenever psychotherapy notes are relevant to the case, separate authorizations for medical records and psychotherapy notes will be provided. In extrinsic evidence cases, if the respondent wishes to provide medical information or records and/or psychotherapy notes in connection with the sanction phase of the case, appropriate authorizations shall be obtained.

11 Unless otherwise indicated, whenever these Procedures refer to activities of a district branch, the same requirements shall apply to the ad hoc investigating committee when it performs an investigation.
4. If the district branch determines that a complaint warrants investigation under the ethical standards established by *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*, the district branch shall advise the APA Secretary as well as the complainant and the respondent that it will be conducting the investigation. The district branch shall also send a copy of the complaint to the respondent, along with copies of *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* and these Procedures. If the district branch decides to consider the complaint in accordance with the procedures in Part II (Enforcement Option), the respondent shall further be informed that he/she has the right to be represented by counsel; that he/she has the right to a hearing; and that if there is a hearing, at the hearing, he/she will have the rights set out in Paragraph 9 below. The respondent will also be informed of his/her right to appeal an adverse decision to the APA Ethics Committee or, where appropriate, to the APA Ethics Appeals Board in accordance with the provisions of Paragraphs 19–23 below.

5. The district branch investigation shall be comprehensive and fair and conducted as provided herein. The district branch may decide:

   a. to conduct a formal enforcement proceeding, including where appropriate a hearing, pursuant to the Enforcement Option procedures set out in Part II, Paragraphs 6-25 below, or

   b. with the agreement of the respondent, to attempt to consider and resolve the complaint in accordance with the Educational Option procedures set out in Part III, Paragraphs 26-33 below.

In deciding which approach to use, the district branch shall consider factors including the nature and seriousness of the alleged misconduct, prior findings or allegations of unethical conduct, and guidelines developed by the APA Ethics Committee. Any attempt to resolve the matter through the Educational Option shall be without prejudice to the right of the district branch to determine at a later time that resolution pursuant to this option is not possible and to proceed to consider and resolve the complaint pursuant to the Enforcement Option procedures of Part II.

**PART II: ENFORCEMENT OPTION**

6. If the district branch pursues investigation and resolution of a complaint in accordance with the provisions in this Part, a hearing conducted in accordance with the provisions of Paragraph 9 below shall be held unless the respondent has voluntarily waived his/her right to a hearing, or the district branch, prior to the hearing, has determined that there has been no ethics violations. The respondent’s waiver of a hearing shall not prevent the district branch from meeting with, and hearing the evidence of, the complainant and other witnesses and reaching a decision in the case.

7. The respondent will be notified of the hearing by certified mail or overnight delivery (signature required) at least thirty (30) days in advance of the hearing. The notice will include the following:
a. The date, time, and place of the hearing;

b. A list of witnesses expected to testify;

c. Notification of the respondent’s right to representation by legal counsel or another individual of his/her choice;

d. Notification of the respondent’s right to appeal any adverse decision to the APA Ethics Committee; and

e. The names of the members of the ethics committee or panel which will conduct the hearing.

8. The initial, information-gathering stages of the investigation, which may include preliminary interviews of the complainant and the respondent, may be conducted by any single member of or a subcommittee of the ethics committee. In all cases in which there may be a decision adverse to the respondent, unless the respondent has waived his/her right to a hearing, there must be a hearing before the district branch ethics committee or a specially constituted panel of at least three (3) members, at least one (1) of whom must be a member of the district branch ethics committee.

9. The hearing shall provide fairness and respect for both the respondent and the complainant. The following procedures shall apply:

a. The respondent may be represented by counsel or other person. The counsel or other person may answer questions addressed to him/her, advise his/her client, introduce evidence, examine and cross-examine witnesses, and make opening and closing statements. Counsel’s participation is subject to the continuing direction and control of the Chair. The Chair shall exercise its discretion so as to prevent the intimidation or harassment of the complainant and/or other witnesses and with regard to the peer review nature of the proceedings. Questions addressed by members of the committee or panel to the respondent shall be answered by the respondent.

b. Except when the district branch concludes that it is prepared to proceed solely on the basis of extrinsic evidence, the complainant must be present at the hearing unless excused by the committee or panel Chair. The complainant will be excused only when he/she has so requested and, in the judgment of the Chair, participation would be harmful to him/her.

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12 For these purposes, “extrinsic evidence” shall mean documents whose validity and accuracy appear to be clear on their face and which do not rely on the assertions or opinions of the complainant and/or his/her witnesses. Examples of such evidence include admissions by the respondent, formal judicial or administrative reports, sworn deposition or trial testimony that was subject to cross-examination, photographs, medical or hospital records, hotel or credit card receipts, and so forth. When the district branch decides to rely solely on such extrinsic evidence, it should take appropriate steps to ensure that members of the hearing panel do not take into account any information from the complainant or other witnesses and base their decision solely on the available extrinsic evidence. Additional information on extrinsic evidence is available from the APA.
c. Except when the district branch concludes that it is prepared to proceed solely on the basis of extrinsic evidence or the complainant is excused pursuant to Paragraph 9(b) above, the complainant shall testify regarding his/her charges.

d. The respondent or his/her attorney may challenge material presented by the complainant or the complainant’s witnesses: (i) by appropriate direct challenge through cross-examination; or (ii) if the complainant asked to be excused from such direct challenge and the Chair determined that such direct challenge will be harmful to the complainant, by written questions submitted by the respondent and posed to the complainant by the Chair, with answers to be provided orally or in writing as the Chair in his/her discretion determines is appropriate.

e. The respondent may choose not to be present at the hearing and to present his/her defense through other witnesses and counsel.

f. The respondent may testify on his/her own behalf, call and examine supporting witnesses, and introduce relevant evidence in support of his/her case. Evidence may not be excluded solely on the grounds that it would be inadmissible in a court of law.

g. Members of the hearing panel may ask pertinent questions during the hearing.

h. A stenographic or tape record shall be made of the proceedings, and a copy shall subsequently be made available to the respondent at a reasonable charge.

i. The respondent may make an oral statement and/or submit a written statement at the close of the hearing.

10. All ethics committee or panel recommendations shall be in writing and shall include a statement of the basis for the recommendation. If the investigation has been conducted by a panel, the panel shall make a recommendation only as to whether there has been an ethics violation, and the district branch ethics committee shall review this recommendation and add its recommendation as to sanction, if any.

11. Upon completion of the investigation and any internal review procedures required by the district branch’s governing documents, the district branch shall render a decision—

   a. that the respondent did not act unethically;

   b. that the case should be concluded without a finding; or

   c. that the respondent acted unethically, and what sanction is appropriate.

If the investigation has been conducted by an ad hoc investigating committee, the ad hoc investigating committee shall make the decision. The district branch decision shall be in writing and shall include a statement of the basis of the decision. In all cases, the district branch shall seek to reach a decision as expeditiously as possible. This should usually be within nine (9) months from the time that the complaint was received. All district branch
decisions must be reviewed by the APA Ethics Committee in accordance with Paragraph 15 below.

12. The three (3) sanctions in order of severity are as follows:

a. reprimand;

b. suspension (for a period not to exceed five [5] years);\textsuperscript{13}

c. expulsion.

13. If the district branch renders a decision that the case should be concluded without a finding, it may issue a letter of concern to the member, which can include suggestions for education. The letter of concern will be signed by the president of the district branch after a draft has been reviewed by the APA Ethics Committee. The APA Ethics Committee must agree that the complaint resulted in an investigation that was comprehensive and fair, and in accordance with the procedures in Paragraphs 6–9 above. In addition to the three (3) sanctions noted in Paragraph 12, the district branch may also, but is not required to, impose certain conditions, such as educational or supervisory requirements, on a suspended member.\textsuperscript{14} When such conditions are imposed, the following procedures shall apply:

a. If the district branch imposes conditions, it shall monitor compliance.

b. If the ad hoc investigating committee imposes conditions, the Chair of the APA Ethics Committee shall establish a means for monitoring compliance.

c. If a member fails to satisfy the conditions, the district branch or the APA monitoring body established by the Chair of the APA Ethics Committee may decide to expel the member.

d. If it is determined that a member should be expelled for noncompliance with conditions, the member may appeal pursuant to the provisions set forth in Paragraphs 19–23 below.

e. If a member expelled for noncompliance with conditions does not appeal, the APA Board of Trustees shall review the expulsion in accordance with the provisions of Paragraph 18 below.

\textsuperscript{13} A suspended member will be required to pay dues and will be eligible for APA benefits, except that such a member will lose his/her rights to hold office, vote, nominate candidates, propose referenda or amendments to the Bylaws, and serve on any APA committee or component, including the APA Board of Trustees and the APA Assembly. If the suspended member is a Fellow or Life Fellow, the Fellowship will be suspended for the same period of time. Each district branch shall decide which, if any, district branch privileges and benefits shall be denied during the period of suspension.

\textsuperscript{14} Personal treatment may be recommended, but not required, and any such recommendation shall be carried out in accordance with the ethical requirements governing confidentiality as set forth in The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. In appropriate cases, the district branch may in addition refer the psychiatrist in question to a component responsible for considering impaired or physically ill physicians.
14. After the district branch completes its investigation and arrives at its decision, the decision and any pertinent information concerning the procedures followed or relating to the action taken shall be forwarded to the APA Ethics Committee for review in accordance with the provisions of Paragraphs 15-17 below. If the Chair of the APA Ethics Committee determines that these review functions are best carried out instead by a subcommittee, he/she shall designate such a subcommittee (or subcommittees) that shall include at least three (3) voting members of the APA Ethics Committee and that shall be authorized to undertake these review functions on behalf of the full APA Ethics Committee.

15. In all cases, including those where the district branch finds that an ethics violation has not occurred or that the case should be concluded without a finding, the APA Ethics Committee shall review the information submitted by the district branch to assure that the complaint received an investigation that was comprehensive and fair and in accordance with the procedures in Paragraphs 6–9 above. If the APA Ethics Committee concludes that these requirements were not satisfied, it shall so advise the district branch, and the district branch shall remedy the deficiencies and shall make further reports to the APA Ethics Committee until such time as the APA Ethics Committee is satisfied that these requirements have been met. If, in the view of the APA Ethics Committee, the district branch is either unwilling or unable to complete the investigation in a satisfactory manner, the Chair of the APA Ethics Committee may appoint an ad hoc investigating committee to conduct the investigation and render a decision.

16. In cases where the district branch has found that an ethics violation has occurred, the APA Ethics Committee or subcommittee, after ascertaining that the investigation was comprehensive and fair and in accordance with these procedures, shall consider the appropriateness of the sanction imposed. If the APA Ethics Committee or subcommittee concludes that the sanction is appropriate, it shall so notify the district branch. If the APA Ethics Committee or subcommittee concludes that the sanction should be reconsidered by the district branch, it shall provide a statement of reasons explaining the basis for its opinion, and the district branch shall reconsider the sanction. After reconsideration, the decision of the district branch shall stand, even if the district branch decides to adhere to the original sanction, except that the sanction may be modified as provided for in Paragraphs 18, 22 or 24 below.

17. After the APA Ethics Committee or subcommittee completes the review process, the district branch shall notify the respondent of the decision and sanction, if any, by certified mail or overnight mail (signature required). The respondent shall be provided copies of the district branch ethics committee and/or panel recommendation(s) and the district branch decision. If the decision is that no ethics violation has occurred, the case shall be terminated, and the district branch shall also notify the complainant of this decision. If the decision is that an ethics violation has occurred, the respondent shall be advised that he/she has thirty (30) days to file a written letter of appeal with the Chair of the APA Ethics Committee. In such circumstances, the complainant shall not be advised of any action until after the appeal has been completed or until the APA notifies the district branch that no appeal has been taken or that the procedures provided for in Paragraph 18 below have been completed.

18. If, after review by the APA Ethics Committee or upon a finding of noncompliance with conditions as provided for in Paragraph 13(c) above, the decision is to expel a respondent, and the respondent fails to appeal the decision, the APA Board of Trustees at its next meeting shall...
review the expulsion on the basis of a presentation by the Chair of the APA Ethics Committee and the documentary record in the case. A decision to affirm an expulsion must be by a vote of two-thirds (2/3) of those Trustees present and voting. A decision to impose a lesser sanction shall be by a majority vote. If necessary, the APA Board of Trustees may request further information from the district branch before voting on the decision to expel.

19. a. All appeals in cases in which the complaint was received by the district branch after January 1, 2003 shall be considered and decided by a panel of three (3) members of the APA Ethics Committee who have not been involved in a review of the case pursuant to Paragraphs 14-17. The Chair of the APA Ethics Committee may appoint a replacement if there are not three members of the Committee who have not been involved in the case who are able to serve.

b. In cases in which the complaint was received by the district branch prior to January 1, 2003, the APA Ethics Committee shall decide whether it is appropriate under the circumstances for the appeal to be heard by a panel of the Ethics Committee or by the APA Ethics Appeal Board pursuant to procedures in effect prior to January 1, 2003. In making this decision, the APA Ethics Committee shall consider the availability of an Ethics Committee panel which has not reviewed the case, whether the respondent was notified of his/her right to appeal to the Ethics Appeals Board and whether a respondent informed of an appeal to the Appeals Board will agree to an appeal to a panel of the Ethics Committee.

20. All appeals shall be based on one (1) or more of the following grounds:

   a. that there have been significant procedural irregularities or deficiencies in the case;

   b. that The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry has been improperly applied;

   c. that the findings of or sanction imposed by the district branch are not supported by substantial evidence;

   d. that substantial new evidence has called into question the findings and conclusions of the district branch.

21. a. The respondent’s request for an appeal must be received within 30 days of the date the respondent is notified of the district branch decision. Upon receipt of the respondent’s request for an appeal, the APA Ethics Committee or Ethics Appeals Board shall request a copy of the district branch file, which shall be made available to the respondent upon request and compliance with any conditions set by the Committee or Appeals Board.

b. In appeals heard by an Ethics Committee appeals panel, the panel will review, and decide the appeal solely on the basis of, the district branch’s documentary record of its investigation and decision and any written appeal statements filed by the respondent and the district branch. The respondent’s statement will be provided to the district branch, which may file a written response. Any district branch response will be forwarded to the respondent, who will have the opportunity to respond in writing prior
to the Ethics Committee’s consideration of the appeal. Filing deadlines and other procedures governing the appeal shall be established by the APA Ethics Committee.

c. In appeals heard by the Ethics Appeals Board,\textsuperscript{15} the respondent shall be entitled to file a written statement with the Appeals Board and may appear before the Board alone or accompanied by counsel. The Appeals Board shall request a representative of the district branch, accompanied by counsel if the district branch so requests, to participate in the appeal by speaker phone. In addition, the Appeals Board may request any information from the district branch and may also request the complainant, accompanied by counsel if he/she so requests, to attend the appeal. The APA counsel and other necessary APA staff may also attend if the Appeals Board so requests. Time limits and other procedures governing the appeal shall be established by the Appeals Board.

22. After reviewing all documents and hearing any oral presentation, the APA Ethics Committee appeals panel or the APA Ethics Appeals Board may take any of the following actions:

a. affirm the decision, including the sanction imposed by the district branch;

b. affirm the decision, but alter the sanction imposed by the district branch;

c. reverse the decision of the district branch and terminate the case;

d. remand the case to the district branch with specific instructions as to what further information or action is necessary.\textsuperscript{16} After the district branch or panel has completed remand proceedings, the case shall be handled in accordance with procedures in Paragraphs 14 through 22.

23. After the APA Ethics Committee appeals panel or Ethics Appeals Board reaches a decision as set forth in Paragraph 22, if the decision is anything other than to expel a member, the Chair of the APA Ethics Committee shall notify the district branch and the respondent simultaneously of the decision and that it is final.

24. If the decision is to expel a member, the APA Board of Trustees at its next meeting shall review the action solely on the basis of the presentation of the APA Secretary (or his/her designee) or the APA Ethics Committee Chair (or designee) and the documentary record in the case. The APA Board of Trustees may affirm the sanction, impose a lesser sanction, or remand

\textsuperscript{15} The Ethics Appeals Board shall be chaired by the APA Secretary and shall include two past Presidents of the APA, a past Speaker of the APA Assembly, the Chair of the APA Ethics Committee and a current chair of a district branch ethics committee. The Secretary and Chair of the APA Ethics Committee shall serve during their respective terms of office. All other members of the Ethics Appeals Board shall be appointed by the President for a three-year term. All members of the Ethics Appeals Board, including the chair, shall be entitled to one vote on all matters. If any of the above cannot serve, the President is authorized to appoint a replacement.

\textsuperscript{16} Remands will be employed only in rare cases, such as when new information has been presented on appeal or when there is an indication that important information is available and has not been considered.
to the APA Ethics Committee appeals panel or the Ethics Appeals Board for further action or consideration. A decision to affirm an expulsion must be by a vote of two-thirds (2/3) of those Trustees present and voting. All other actions shall be by majority vote. Members of the APA Board of Trustees who participated as members of the APA Ethics Committee appeals panel or the Ethics Appeals Board shall not vote when the APA Board of Trustees considers the case. Once the APA Board of Trustees has acted or, in a case of a remand, has approved the action taken on remand, the APA Secretary shall notify the district branch of the decision and that it is final.

25. Once a final decision is reached, the district branch shall notify the complainant and the respondent by certified mail or by overnight mail (signature required).

PART III: EDUCATIONAL OPTION

26. If the district branch decides to attempt to resolve the complaint pursuant to the Educational Option procedures in this Part III ( Paragraphs 26-33), it shall proceed only after (a) the respondent has been informed (i) that the district branch wishes to proceed in this manner but that he/she is entitled to proceed under Part II enforcement procedures, and (ii) that the district branch reserves the right to begin the investigation again and use formal enforcement procedures in Part II if in its sole discretion it determines that the respondent has not satisfactorily cooperated, (b) the respondent agrees to proceed under Part III rather than Part II, and (c) the complainant has been notified that the district branch has decided to proceed in this manner and has been provided a copy of the Procedures.

27. The district branch’s consideration of an ethics complaint under this Part shall provide both the complainant and the respondent the opportunity to address the district branch. The district branch shall determine the procedures to be used, including whether to meet separately or together with the complainant and the respondent, whether to permit the respondent to be accompanied by a person of his or her own choosing, the size and composition of the group(s) meeting with the parties, and other matters involving the form and details of the district branch’s consideration of the complaint. However, in determining the procedure it will use, the district branch shall seek to provide a format that will facilitate the respondent’s understanding of the ethical issues raised by the complaint, including the reasons for or sources of the complainant’s concern, and to permit the district branch to assess the respondent’s understanding of these matters.

28. In proceedings under this Part, the district branch shall make no determination as to whether the respondent has violated the Principles or otherwise committed an ethics violation.

29. After its consideration of the complaint pursuant to Paragraph 27, the district branch may identify a specific educational program including courses, reading and consultation for the respondent to complete within a specified period. The respondent and the APA Ethics Committee will be notified of the required steps, the time frame in which they must be completed, and that failure to complete them as required will be grounds for being dropped from membership in the APA and the district branch for failure to satisfy educational requirements.
(see Bylaws, Section 2.5 or for further proceedings pursuant to Part II of these Procedures. The district branch will monitor the respondent’s compliance with any such educational requirements.

30. The district branch shall retain records of complaints considered pursuant to this Part and of any education thereafter required of a respondent. The district branch may consider such information in connection with a decision as to how to handle any later complaints involving the respondent.

31. If the district branch at any time determines that the respondent has not cooperated with the district branch’s consideration of the complaint, has not otherwise participated in a manner that permits an adequate educational experience or has not satisfied any educational requirements it has imposed, the district branch may so notify the respondent and inform him/her (a) that the complaint will be returned to the district branch ethics committee for its consideration and resolution pursuant to the procedures set out in Part II, above, or (b) that the respondent’s name will be presented to the Board of Trustees at its next meeting and the member dropped from membership unless the Board acts to exempt the respondent from the educational requirements. The decision as to whether to proceed under Part II or to recommend that the respondent be dropped from membership in the APA and the district branch will be in the district branch’s discretion.

32. If the district branch decides to return the complaint for consideration and resolution pursuant to Part II of the Procedures, any subsequent investigation and hearing under Part II shall be conducted by district branch members who did not conduct the proceedings pursuant to the Educational Option in Part III.

33. If the district branch decides and notifies the respondent that his/her name will be presented to the Board of Trustees for purposes of being dropped from membership, the district branch shall also notify the APA Ethics Committee, which will notify the Office of Membership and the Board of Trustees.

PART IV: CONFIDENTIALITY

34. Except as described in Paragraph 35 below, disclosure by APA members of the name of the respondent, the fact that a complaint has been lodged, the substance of the complaint, or the identity of any witnesses shall be limited to persons who need this information to assure the orderly and effective administration of these procedures and/or APA membership action.

35. To assure proper protection of the public, there are times when disclosure of the identity of a respondent and other information may be essential. Such disclosure is authorized in the following instances:

   a. The name of any member who is expelled from the APA for an ethics violation, along with an explanation of the nature of the violation, shall be reported in Psychiatric News

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17 State and/or federal law may impose additional reporting requirements with which district branches or the APA must comply.
and in the district branch newsletter or other usual means of communication with its membership. The name of any member who is expelled from the APA for an ethics violation, along with an explanation of the nature of the violation, shall also be reported to the medical licensing authority in all states in which the member is licensed. In addition, the name of any member who is also a member of a foreign psychiatric society or association and who is expelled shall be reported to the international society or association to which the member belongs. This Paragraph does not apply to those members who are dropped from membership for failure to satisfy educational requirements, pursuant to Paragraph 33, above.

b. The name of any member who is suspended from the APA for an ethics violation, along with an explanation of the nature of the violation, shall be reported in *Psychiatric News* and in the district branch newsletter or other usual means of communication with its membership. The name of any member who is suspended from the APA for an ethics violation, along with an explanation of the nature of the violation, shall also be reported to the medical licensing authority in all states in which the member is licensed.

c. The name of any member who resigns from the APA after an ethics complaint against him/her is received and before it is resolved shall be reported in *Psychiatric News* and in the district branch newsletter or other usual means of communication with its membership.

d. The APA Board of Trustees or, after approval by the APA Ethics Committee, any district branch’s governing council may report an ethics charge or a decision finding that a member has engaged in unethical conduct to any medical licensing authority, medical society, hospital, clinic, or other institutions or persons where such disclosure is deemed appropriate to protect the public.

Addendum 1

**Guidelines for Ethical Practice in Organized Settings**

18 Reporting shall include a press release to the media in the area in which the expelled member lives. If requested by a state licensing board to which the expulsion is reported, the APA and/or district branch may release relevant information from their files.

19 If requested by a state licensing board to whom the suspension is reported, the APA and/or district branch may release relevant information from their files.

20 Chapter 7, Sections 1, 2, and 3, Bylaws, American Psychiatric Association, May 2005 edition.
At its meeting of September 13–14, 1997, the APA Ethics Committee voted to make the “Guidelines for Ethical Practice in Organized Settings,” as approved by the Board and the Assembly, an addendum to The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, to be preceded by introductory historical comments and cross-referenced to the appropriate annotations, as follows:

This addendum to The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry was approved by the Board of Trustees in March 1997 and by the Assembly in May 1997. This addendum contains specific guidelines regarding ethical psychiatric practice in organized settings and is intended to clarify existing ethical standards contained in Sections 1–9.

Addendum

Psychiatrists have a long and valued tradition of being essential participants in organizations that deliver health care. Such organizations can enhance medical effectiveness and protect the standards and values of the psychiatric profession by fostering competent, compassionate medical care in a setting in which informed consent and confidentiality are rigorously preserved, conditions essential for the successful treatment of mental illness. However, some organizations may place the psychiatrist in a position where the clinical needs of the patient, the demands of the community and larger society, and even the professional role of the psychiatrist are in conflict with the interests of the organization.

The psychiatrist must consider the consequences of such role conflicts with respect to patients in his/her care, and strive to resolve these conflicts in a manner that is likely to be of greatest benefit to the patient. Whether during treatment or a review process, a psychiatrist shall respect the autonomy, privacy, and dignity of the patient and his/her family.

These guidelines are intended to clarify existing standards. They are intended to promote the interests of the patient and should not be construed to interfere with the ability of a psychiatrist to practice in an organized setting. The Principles and Annotations noted in this communication conform to the statement in the preamble to the Principles of Medical Ethics. These are not laws but standards of conduct, which define the essentials of honorable behavior for the physician.

1. Appropriateness of Treatment and Treatment Options
   a. A psychiatrist shall not withhold information that the patient needs or reasonably could use to make informed treatment decisions, including options for treatment not provided by the psychiatrist. [Section 1, Annotation 1 (APA); Section 2, Annotation 4 (APA)]
b. A psychiatrist’s treatment plan shall be based upon clinical, scientific, or generally accepted standards of treatment. This applies to the treating and the reviewing psychiatrist. [Section 1, Annotation 1 (APA); Section 2 (APA); Section 4 (APA)]

c. A psychiatrist shall strive to provide beneficial treatment that shall not be limited to minimum criteria of medical necessity. [Section 1, Annotation 1 (APA)]

2. Financial Arrangements

When a psychiatrist is aware of financial incentives or penalties that limit the provision of appropriate treatment for that patient, the psychiatrist shall inform the patient and/or designated guardian. [Section 1, Annotation 1 (APA); Section 2 (APA)]

3. Review Process

A psychiatrist shall not conduct reviews or participate in reviews in a manner likely to demean the dignity of the patient by asking for highly personal material not necessary for the conduct of the review. A reviewing psychiatrist shall strive as hard for a patient he or she reviews as for one he or she treats to prevent the disclosure of sensitive patient material to anyone other than for clear, clinical necessity. [Section 1, Annotations 1 and 2 (APA); Section 4, Annotations 1, 2, 4, and 5 (APA)]
Questions & Answers About Procedures for Handling Complaints of Unethical Conduct

The APA Ethics Committee receives frequent requests for opinions on the Procedures for Handling Complaints of Unethical Conduct (following the Annotations in this edition of the Principles; referred to in this Addendum as the Procedures). The questions and answers that follow have been received and developed since 1973.

1. **Question:** Ethics proceedings sometimes involve serious unethical conduct. Under what circumstances should information about ethics cases be disclosed to the membership, government authorities, or other interested organizations and persons?

**Answer:** APA ethics cases are conducted in secrecy. As a general matter, the complainant’s charges, the identity of the respondent, and other information are made available only to persons participating directly in the proceedings. Even within the APA and the district branches, information should not be passed on to other components. (October 1976; November 1977)

However, there are times when disclosure of information about an ethics case is necessary to assure proper protection of the public. For example, many states now require reporting to government agencies concerning members who have been found to have engaged in unethical conduct. The timing of such required reports, the amount and specificity of information to be disclosed, and other matters will vary from state to state. District branches should consult applicable state statutes to assure that these requirements are adhered to. The National Practitioner Data Bank requires that the APA report suspensions and expulsions. (March 1985; November 1989)

The Procedures outline in detail the public reporting that is now authorized, including releasing the names of members who are expelled or suspended, reporting to medical licensing authorities, reporting members who resign after an ethics complaint is received, and so forth. It is important to carefully review Paragraph 35 of the Procedures to ensure that you understand what is required. (July 1993)

Apart from these specific guidelines, public safety considerations may justify reporting before completion of formal proceedings. If a complainant, deemed highly credible, alleges unethical conduct on the part of a member that would pose a serious danger to the safety of patients, the district branch could report the allegations to an appropriate state agency, following consultation with legal counsel. (October 1977; March 1985)
2. **Question:** Does an Inactive Member have the responsibility to abide by the *Principles of Medical Ethics*?

**Answer:** These Principles apply to all categories of members living in the United States and in Canada. International Members and Fellows should abide by the ethics of the countries in which they live. (May 2003)

3. **Question:** For the sake of educating members and showing diligence to the public, should the results of ethics hearings be made public? Such results could be printed in the district branch newsletter or in *Psychiatric News*.

**Answer:** Undoubtedly, such publication would accomplish the above goals; but, it might also discourage complainants and district branch ethics committees from proceeding. However, if the penalty is expulsion or suspension, the name is to be published with the offense specified. If a member resigns during an ethics investigation, the name will be published. (See Question and Answer 1 above.) (March 1974; March 1985)

For educational purposes, we also encourage district branch ethics committees to extract the lessons from ethics hearings to illustrate the tensions between ethics principles and member behavior and their resolution. The purpose is to alert members to possible vulnerability to allegations of unethical conduct. (September 1979)

In addition, the APA may publish disguised ethics cases in *Psychiatric News* in order to educate members and the public as to what matters are being reported and how they are being handled. (APA Board of Trustees, December 1981)

4. **Question:** Aren’t APA members who participate in ethics hearings or who bring complaints taking a risk of being sued?

**Answer:** Local laws vary, and one should check with local attorneys. In general, if procedures are followed properly and all involved act without malice, there should be no serious risk. In many states, specific immunity has been granted by laws. In fact, the public expects professional organizations to police themselves, and courts have held that professional peers are best qualified to judge the actions of each other. The most a respondent could sue for would be a rehearing, not damages, unless the member can prove malice on the part of those who judged him or her. It should be understood that anyone can file a suit at any time. To date, there has never been a successful suit against the APA and/or its district branches. (April 1976; March 1985)

5. **Question:** What does a complainant have to gain except potential embarrassment and harassment?

**Answer:** Patient complainants may be seeking vindication or revenge. Occasionally they see an ethics procedure as a route to financial reward. There have been complainants who demonstrate a sincere desire to obtain help for the respondent. Colleague complainants are usually seeking to protect the reputation of the profession. As a general statement, the only gain a complainant can expect is the realization that he or she has brought to our profession’s attention a possible break...
in our ethical standards. From then on, it is up to us. Local laws vary, but in most jurisdictions complainants who bring ethics charges without malice receive legal protection. (June 1976; March 1985)

6. **Question:** In an ethics hearing, should the complainant and respondent be heard together?

**Answer:** The Procedures require that the complainant and the respondent be heard together under most circumstances. Exceptions include cases in which the member has waived his/her right to a hearing, cases in which the committee or panel chair has determined that requiring the complainant and the respondent to appear together would be harmful to the complainant, and cases in which the respondent decides not to appear but to present his/her case through legal counsel and other witnesses. (November 1989)

If the district branch determines that an ethics complaint will be handled under the Educational Option (see Paragraph 27 of the Procedures), both the complainant and the respondent shall have the opportunity to address the district branch. The district branch shall determine the procedures to be used, including whether to meet separately or together with the complainant and the respondent. (May 2003)

7. **Question:** Can various specialty groups within psychiatry develop their own code of ethics?

**Answer:** Because we are members of the medical profession first, we are responsible to the Principles of Medical Ethics, formulated by the American Medical Association. The APA added “With Annotations Especially Applicable to Psychiatry.” These annotations were additive, and in no case did they subtract from or change any elements of the Principles of Medical Ethics.

Nothing precludes another psychiatric society from developing a code that addresses the special needs of that group as long as it is additive to The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry and does not subtract or change any elements of the above. To allow anything else would be to create much confusion for our membership and the public and would lead to legal challenges. (July 1976)

8. **Question:** To whom at the district branch should formal complaints be directed?

**Answer:** That is to be determined by each district branch. We recommend complaints be directed to the president of the district branch. We prefer the president to be the initial recipient because of his/her elected status and because there is frequent turnover in the office. Occasionally a chair of an ethics committee remains in that position for several years, and it would be unwise for him or her to be not only the initial recipient of complaints but also the recipient of charges of member harassment or complaint suppression. (October 1976)

9. **Question:** Should a district branch provide an appeal mechanism?

**Answer:** There are ample appeal mechanisms available under the Procedures. Nothing prevents a district branch from setting up an appeal to its local membership as long as the district branch
follows its own procedures as well as those of the APA. We do not recommend it. (January 1977; March 1977)

10. **Question:** Can a former member dropped for ethical reasons be readmitted to membership?

**Answer:** Yes, if he or she demonstrates a return to ethical conduct. We should strongly encourage and reward efforts toward rehabilitation. (March 1977)

11. **Question:** If a member is undergoing legal investigation for an alleged crime or is involved in a malpractice suit and a formal complaint has been received by the district branch, should its ethics committee proceed?

**Answer:** If the ethics committee decides to proceed, the member may object because he or she might fear that information produced at the ethics hearing could be subpoenaed for the trial, although the district branch would be advised to use all legal means to resist the subpoena. For this reason, or others, the district branch might determine it was more prudent to defer the investigation for the time being. However, it is incumbent upon the ethics committee to monitor the investigation and trial so that an ethics hearing can be conducted as soon after their completion as possible. (April 1977; August 1977; November 1977; January 1978; September 1979)

12. **Question:** If a district branch covers a large area, can one of its chapters act on an ethics complaint?

**Answer:** The Procedures would allow the executive council of the district branch to appoint a special hearing body composed of chapter members that would investigate the complaint and make recommendations to the council as long as at least one member of the hearing panel is a member of the district branch ethics committee. However, only the council can make an official decision on the merits of the complaint. (April 1977; October 1989)

13. **Question:** What are the expectations of a complainant in an ethics hearing?

**Answer:** The complainant should be heard, and the complaint be taken seriously even though it may eventually be found to be without merit. While the complainant can be accompanied by an attorney to the hearing and can ask the attorney for advice, the attorney should not be allowed to argue the client’s complaint or cross-examine the respondent or his/her witnesses. The complainant can gain nothing from the procedure of a tangible nature. He or she can gain only appreciation for assisting us in maintaining the integrity of our profession. (June 1977)

14. **Question:** What are the “rights” of a member against whom a formal complaint has been filed?

**Answer:** A member complained against has the right to be informed of the complaint, to be notified in advance of any hearing or investigation, to have legal counsel, to bring witnesses in his/her defense, to be allowed to present his/her defense in detail, to expect the hearing panel and
the decision-making body to make a decision that is fair and without malice, and to be notified of the decision and the avenue of appeal. The respondent and/or the respondent’s attorney have a right, in most cases, to confront his/her accusers and to cross-examine those accusers and other witnesses against him or her. There is a significant issue here—the member’s right of confrontation versus the concern as to the harm this might do to a complainant—so each hearing chairperson will decide the form the cross-examination will take, whether by direct questioning or by written inquiry. (June 1977; October 1989)

If the district branch decides to attempt to resolve the complaint using the Educational Option, the respondent must be informed that the district branch wishes to proceed in this manner, that the respondent is entitled to proceed instead under the Enforcement Option, among other requirements. (See Procedures, Paragraphs 26-33) (May 2003)

15. **Question:** If a component committee, council, or task force of the APA comes across evidence of unethical behavior of a member, should the component make a formal ethics complaint as a matter of routine?

**Answer:** Yes, with one exception. If the component was gathering confidential information for another purpose and had advised the member of this confidentiality, the component should not make a formal complaint unless the unethical behavior is of such magnitude as to constitute a severe and immediate risk to the public or other members. (September 1977)

16. **Question:** Do APA Fellows and Members and International Members and Fellows (who live in other countries) have to follow the ethics principles of the APA?

**Answer:** Yes. The Bylaws make no exception in the requirement to abide by the *Principles of Medical Ethics*. However, the APA is not able to enforce the provisions of itsAnnotations to the *Principles of Medical Ethics* beyond the geographic boundaries of its district branches (in the United States and Canada). International Fellows and Members, and other Fellows and Members living in other countries are expected to follow the ethics codes of the country where they live or practice. (October 1977; July 1999, APA Board of Trustees)

17. **Question:** Does a patient-complainant have to give permission to a respondent to reveal information about the treatment relationship?

**Answer:** No. To bring a complaint is to consent to an investigation. In such a circumstance, the psychiatrist may ethically reveal only that information relevant to the hearing of the complaint. (November 1977) Although the complainant (patient) may not have to give an informed consent to the respondent to discuss the respondent-complainant’s relationship, the complainant does have to sign an informed consent that may be provided to the respondent (if the respondent is the holder of the medical records) to release records for review by the ethics committee. (September 2003)

18. **Question:** If the public press reports the conviction of a member psychiatrist of a crime or the loss of a malpractice suit that raises a very serious question about moral competency to practice, what is the responsibility of the district branch?
Answer: If no other member of the district branch nor anyone else makes a formal complaint, it
would be appropriate for an officer of the district branch to do so. (January 1978; January 1979)

19. Question: Can the district branch send to the APA a code number rather than the name of
the respondent? If the member has been found innocent, can the district branch expunge its
records of the complaint?

Answer: The APA believes that the use of code numbers and initials presents serious
administrative problems. This information is kept in a secure place at APA headquarters, so fear
of loss of confidentiality is unwarranted. A file is created after the original material is destroyed
so that we can maintain a history of ethics issues involving our profession. The district branch
can expunge its record if it chooses, but might also wish to maintain such history. (April 1978;
June 1978)

20. Question: When a member transfers from our district branch to another, can information
about a finding of unethical conduct be sent to the second district branch?

Answer: With the written permission of the transferring member, the transferring district branch
can send information about an ethical charge and the results of the investigation to the new
district branch executive council as confidential correspondence. Unless the member is suspend-
ed or expelled, he or she remains an APA member and does not lose the right to transfer.
However, the receiving district branch has a right to challenge the transfer. (May 1978)

21. Question: Our district branch ethics committee is investigating an ethics complaint
against one of our members. The member is moving to another district branch. Do we drop the
investigation or pass the information on to the new district branch?

Answer: This question presents problems. The member might use moving and transferring as a
way of avoiding the investigation and possible censure by peers. To pass the information on to
the new district branch for continued investigation would create a very difficult problem for the
new district branch, the complainant, and witnesses. Further, at this time, the information the
first district branch received is to be considered confidential. (April 1978) Therefore, the APA
Board of Trustees has made the following addition to the Operations Manual:
A transfer from one district branch to another will be delayed until resolution of any charge of
unethical conduct. (May 1978)

22. Question: Should a member who is mentally ill and, as a result, has behaved unethically
be suspended or expelled?

Answer: We would recommend the member be placed on Inactive Status and encouraged to
seek treatment under the “impaired physician” act adopted in many states. Because he or she
may also have had his or her medical license suspended or revoked, return to active membership
would require that the local licensing body had returned his or her medical license. The district
branch would want to assure itself that the member had recovered and was again capable of
ethical practice. The ultimate goal of such proceedings is rehabilitation of our colleague. The APA Board of Trustees has made the following addition to the *Operations Manual*:

When a member has had a license suspended or revoked because of physical or mental illness or substance abuse, he or she will not be dropped from membership in the APA, but may be placed on Inactive Status until recovery. This will be handled administratively in the APA Central Office, with the concurrence of the district branch and the Chair of the APA Membership Committee. (May 1978; July 1999)

23. **Question**: What should the composition of a district branch ethics committee be?

**Answer**: That is up to the district branch to decide. The committee should consist of members whose judgment is respected, obviously, but there are no specific requirements. Some district branches use their executive council, but it is more common to establish a standing committee. The APA Ethics Committee membership is defined in the Operations Manual as follows: six members, appointed for 3 years, with one to be a Past President of the APA. (August 1978; May 2003)

24. **Question**: If a complainant refuses to participate in a formal hearing, should the complaint be dropped?

**Answer**: Not necessarily. While not willing to participate in a formal hearing, the complainant might present written information sufficient to proceed or point the way to other evidence that would be relevant. The role of the complainant is not that of a prosecutor but that of a person bringing a potential problem to our attention (see Questions 5, 6, 13, and 14). (February 1979)

25. **Question**: When a member is suspended from membership in the district branch and in the APA, what privileges does he or she lose?

**Answer**: A suspended member will lose privileges cited in the Bylaws. He or she will lose the right to vote, to nominate candidates for office, to propose referenda and amendments to the Bylaws, and to serve on components, including the APA Board of Trustees and the APA Assembly. He or she may not hold elected office and may not initiate referenda to change actions of the Board of Trustees. If the suspended member is a Fellow or Life Fellow, the Fellowship will be suspended for the same period of time. The suspended member will be expected to pay dues and assessments and will remain eligible for the other benefits of membership. Suspension may also result in the loss of other district branch privileges. (September 1981; March 1985; July 1993; May 2003)

26. **Question (Part A)**: On occasion, a member charged with unethical behavior may settle out of court with the complainant in a parallel civil suit. Part of the settlement requires the complainant not to pursue the ethical charge. Should the APA establish a rule that participation by a member in such agreements is unethical in itself?

**Answer**: This “back door exit” from ethical complaints concerns us and, if used to stifle a bona fide complaint, is unethical.
26. **Question (Part B):** Even though the complainant drops the charge, can the process be continued?

**Answer:** If the alleged behavior is known to others, such as district branch officers, and from sources other than that provided by the original complainant, another complaint may be brought by whoever has that information. Obviously, the original complainant would not be available to provide information or to appear at a hearing. (March 1988)

27. **Question (Part A):** For an ethics charge, is there a time limit between the alleged behavior and complaint beyond which the complaint cannot be accepted?

**Answer:** In 2002, the APA Board of Trustees and the APA Assembly adopted a “statute of limitations” for an ethics complaint. The following appears in the Procedures: To be considered, a complaint alleging unethical conduct must be received within ten (10) years of the alleged conduct. In the case of a minor patient, the ten (10) years will not begin until the patient reaches age of majority.) (November 2002)

27. **Question (Part B):** If the district branch determines that the alleged complaint occurred prior to the ten (10) year statute of limitations, can a complainant ask that the APA review this decision?

**Answer:** Yes. However, the review is only to determine that the statute of limitations was applied appropriately. Such a review will be done by the APA Secretary. (November 2002)

28. **Question:** What is the effect of a respondent’s refusal to participate in the investigation or hearing? Is that, in itself, unethical?

**Answer:** The investigation and hearing can proceed with the evidence at hand and reach its conclusion in the absence of the respondent’s participation, although the right of appeal is not lost. A charge of unethical conduct upon this action itself would not be sufficient to constitute a sustainable complaint. (October 1977)

29. **Question:** We have learned from the Board of Medical Examiners that a member has been found guilty of sexual misconduct with a patient. The Board revoked his license, stayed the revocation, suspended his license for 6 months, and gave him 7 years of probation. Can the district branch suspend him without going through all the repetitive procedures?

**Answer:** APA policy does not allow automatic suspension at the time of license suspension, but requires an investigation. Thus, while a fair procedure must be followed, it is likely this will not have to be exhaustive under the circumstances. (January 1988)

30. **Question:** A serious ethical allegation about a member was received shortly after he resigned from our district branch and the APA, presumably because he was aware of the impending complaint. Should we publish that he resigned while under investigation?
Answer: The name of any member who resigns from the APA after an ethics complaint against him or her is received shall be reported in *Psychiatric News* and in the district branch newsletter or other usual means of communication with its membership. (July 1993)

31. **Question:** Do you go forward with a complaint alleging unethical behavior by a psychiatrist before he or she was an APA member?  (September 2003)

**Answer:** No.

32. **Question:** Our district branch is quite large and has a heavy volume of complaints. Thus, we have divided the ethics committee into several hearing panels, all of whose members belong to the ethics committee. Paragraph 10 of the Procedures gives to a panel only the responsibility to determine if there has been a violation, and the recommendation of the ethics committee is required for the penalty. This would overburden us. Can you clarify?

**Answer:** This requirement for a panel to recommend only the finding of unethical conduct but not the penalty was meant for panels not entirely comprised of ethics committee members. If all of the panel members are on the ethics committee, they may recommend the sanction, too. (April 1990)

33. **Question:** Although we found a member not to have behaved unethically, we feel he is impaired. Can the district branch ethics committee refer him to an impaired physician committee?

**Answer:** While the rules protecting confidentiality in the processing of ethical complaints do not address this, we believe a discreet referral to an impaired physician committee is permissible. (June 1990)

34. **Question:** Should our district branch executive council discuss matters from the ethics committee in executive session? Should minutes be kept and, if so, how complete?

**Answer:** Discussion should be in executive session and complete minutes should be kept, including the reasoning leading to the decision and the vote to reach a decision. (January 1991)

35. **Question:** Are there circumstances in which a reprimand can be published?

**Answer:** No. Publication is limited to suspension or expulsion (see Paragraph 35 of the Procedures). If you feel publication is indicated, you may wish to review your sanction. (February 1991)

36. **Question:** What material should be retained in the district branch file at the conclusion of a case?

**Answer:** The district branch file is the formal record of its investigation, hearing, and/or resolution of a complaint. The file will be produced if the member appeals the decision as well as if there is litigation. As such it should include the following:
a. the final district branch decision and report of the case;
b. any other final reports of the ethics committee, the district branch council, investigators, etc.;
c. all correspondence to and from the respondent (and legal counsel), the complainant (and his/her legal counsel), other witnesses and/or potential witnesses, and from the APA;
d. all other documents and other evidence submitted by the parties or obtained by the ethics committee; and
e. audio tapes, minutes, or other formal records of interviews or district branch committee or council meetings.

37. Question (Part A): There has been a great deal of discussion recently about using “extrinsic evidence” in processing ethics complaints. Could you clarify what this is?

Answer: Extrinsic evidence is really just information, often written, but also perhaps photographs. It is carefully defined in the Procedures (see Footnote 10); all aspects of this definition are crucial. First, the information must be “extrinsic” to the ethics proceeding; that is, it comes from some source or exists due to some purpose entirely unrelated to the ethics proceeding. Examples include an independent court or administrative (board) hearing, a medical record or a report from a state licensing board. Written reports made in the course of an ethics investigation are part of the proceeding, and thus, are not extrinsic to it.

Second, validity and accuracy must be clear; the information cannot be merely someone’s assertions. A determination by a court or a licensing board would generally be considered valid and accurate. Sworn testimony subject to cross-examination, receipts, photographs, or medical records also generally meet this requirement. A newspaper article, however, alleging that a member has done certain things, would be “extrinsic,” but is not presumptively valid and accurate, so it could not be used as extrinsic evidence (although it might actually stimulate some inquiry by the district branch). (March 2000)

37. Question (Part B): A district branch has a complaint and information that meets the requirements to be considered “extrinsic evidence.” How might this be helpful to the work of the district branch ethics committee?

Answer: Extrinsic evidence can be used in two ways. It may be just one more piece of information to be considered with others in the course of a full hearing (photographs, receipts, and medical records are often used in this way); or more importantly, it may be sufficient to eliminate the need for the district branch to conduct a full hearing on whether an ethics violation has occurred. If the document meets all criteria to be extrinsic evidence and, standing alone, it is sufficient to make a determination on whether there has been a violation and the nature of the violation, then a full hearing is not required.

When a district branch decides to reply on extrinsic evidence alone, care must be taken that this is the only information considered in determining whether there has been a violation and which
of the *Principles* has been violated. This most commonly occurs when the district branch has detailed information from a court or licensing board. Notice to the respondent and other procedural requirements still apply: the respondent is notified that rather than a hearing, the district branch will consider certain identified extrinsic evidence. The respondent must still be given an opportunity to be heard regarding any sanction but would not be allowed to speak or present any evidence as to whether or not there was a violation of ethics. If the district branch feels that information in addition to the extrinsic evidence is needed in determining the occurrence of a violation, then the district branch should convene a full hearing under all of the requirements listed in the Procedures. (March 2000)

38 (Part A). **Question:** How does the district branch determine that it will proceed using the Educational Option?

**Answer:** The district branch should consider several factors, namely the nature and seriousness of the alleged misconduct, and whether or not there have been previous findings of misconduct. Certainly the Educational Option may be considered for less seriousness instances of ethical misconduct, where the respondent is clearly receptive to education, and where there is a likelihood that education would lead to rehabilitation. If this option is chosen, it must be with the agreement of the respondent. In addition, this does not preclude the district branch from determining at a later date to resolve the complaint using the Enforcement Procedures. (September 2003)

38 (Part B). **Question:** When would a district branch choose the Enforcement Option?

**Answer:** The Enforcement Option should be used when there is egregious behavior, when there has been harm to the patient or to the profession; or when the respondent’s behavior manifests a pattern of misconduct. (September 2003)
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Principles of ethics and professionalism in psychiatry

Section 1. Introduction

Mental illness affects millions of persons throughout the world, regardless of age, gender, class, or nationality. One in five people will suffer a significant episode of mental illness over the course of their lives, with neuropsychiatric disorders comprising the leading cause of disease burden in countries with established market economies and the third leading cause of disease burden across the globe. The immense suffering associated with mental illness is greatly increased by stigma, societal disadvantage, and coexisting conditions.

Psychiatrists are physicians with specialized knowledge of mental illness and its treatment. Psychiatrists share the same ethical ideals as all physicians and are committed to compassion, fidelity, beneficence, trustworthiness, fairness, integrity, scientific and clinical excellence, social responsibility, and respect for persons. Psychiatrists endeavor to embody these principles in their diverse roles as diagnosticians, treating physicians, therapists, teachers, scientists, consultants, and colleagues.

The daily work of psychiatrists poses distinct ethical challenges. Mental illnesses directly affect thoughts, feelings, intentions, behaviors, and relationships – those attributes that help define people as individuals and as persons. The therapeutic alliance between psychiatrists and patients struggling with mental illness thus has a special ethical nature. Moreover, because of their unique clinical expertise psychiatrists are entrusted with a heightened professional obligation: to prevent patients from causing harm to themselves or others. Psychiatrists may consequently be required to treat patients against their wishes and breach the usual expectations of confidentiality. Psychiatrists may also be called upon to assume duties of importance to society, such as legal or organizational consultation, that are beyond the scope of usual clinical activities. These features of psychiatric practice may therefore create greater asymmetry in interpersonal power than in other professional relationships and introduce ethical issues of broad social relevance. For all these reasons, psychiatrists are called upon to be especially attentive to the ethical aspects of their work and to act with great professionalism.

Psychiatrists are entrusted to serve in a special role in the lives of ill persons and in society as a whole. Psychiatrists’ ability to serve in this special role is predicated on the fulfillment of the ethical principles that ground the field. This is the cardinal feature of a profession: professionals apply specialized knowledge in the service of others, and are part of a distinct group that affirms a code of ethics and engages in self-governance. Members of the profession, by definition, must exercise strong self-discipline and accept responsibility for their actions. They must seek to adhere to a specific set of standards. As a consequence, there are many who have a stake in the ethical commitments and conduct of psychiatric practitioners. This is most apparent for patients and their families, but it is also true for colleagues, students, members of the profession of medicine as a whole, and society at large. All count on the profession’s integrity in embodying the principles of ethical practice.

Ethical conduct by psychiatrists goes beyond mere knowledge of ethics principles. It also requires certain moral skills and habits. These assure that ethically sound judgment and the actions that follow fall within accepted ethical bounds. Examples of skills of importance to the ethical practice of psychiatry include: 1) the ability to recognize ethical aspects of a professional situation; 2) the ability to reflect on one’s role, motives, potential “blind spots”, and competing or conflicting interests; 3) the ability to seek out, critically appraise, and make use of additional knowledge and valuable resources, e.g., clinical, ethical, or legal information; 4) the ability to apply a formal decisionmaking model in evaluating the ethical aspects of a professional situation and in identifying possible courses of action; and 5) the ability to create appropriate safeguards in an ethically complex situation. Routine behaviors or habits of the ethical practitioner include obtaining additional data, seeking appropriate consultation or supervision, maintaining clear professional boundaries, and separating roles that may pose conflicts. Together these skills and habits support ethical decision-making and minimize the likelihood of ethical breaches.

A statement of ethics principles affirmed by the profession is an important resource for aligning ethical knowledge with professional behavior. Such a document can provide guiding principles to assist practitioners in identifying and resolving ethical dilemmas. Ethics principles can also help define the boundaries of acceptable behavior, proscribing certain behaviors while supporting and encouraging others. Consequently, ethical principles are valuable in assessing the professional conduct of colleagues. Ethics principles are likewise an important tool for the educators who introduce
students to the ethical foundations of the field.

To help fulfill these aims, this document has been organized into five sections.

Section 1 introduces the scope, spirit, and structure of the document.

Section 2 presents the Principles of Medical Ethics of the American Medical Association. These nine principles serve as the foundation for ethics and professionalism in the field of medicine, including the specialty of psychiatry. The American Psychiatric Association conforms to these AMA principles in its Constitution and Bylaws.

Section 3 articulates ethics principles as applied to the morally complex aspects of psychiatric work. These aspects of professional practice are organized into four domains: the ethical basis of the physician-patient relationship; ethically important practices in psychiatric care; the ethical basis of relationships with colleagues; and other ethically important topics in psychiatric practice. Each domain covers several topics, such as dual agency, honesty and trust, confidentiality, informed consent, conflict of interest, small community issues, among others. For each topic, we provide a description of important ethics concepts, and seek to demonstrate their special relevance to psychiatric practice.

Section 4 provides a discussion of the uses of the document to educational, clinical, professional compliance, and related areas.

Section 5 outlines selected additional resources that may be of value to readers.

This document differs in two respects from prior APA codes of professional ethics (the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry). It is oriented toward educational more than regulatory purposes. It is for this reason that the document gives attention to the philosophical basis of ethical psychiatric practice, the concepts and terms of importance to ethics and professionalism, and the skills and habits of ethical professionals. Moreover, the document seeks to encompass more completely the multiplicity of roles and activities of psychiatrists, the diverse populations they serve, and the array of settings in which they work. It is our hope that this document will become a valuable resource for our profession.

Section 2. Principles of Medical Ethics of the American Medical Association

Preamble. The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician will uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements, which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people. *Adopted June 1957; revised June 1980; revised June 2001*

Section 3. **Ethical principles in the professional practices of psychiatrists**

In this section, we illustrate how ethical principles find expression in the professional practice of psychiatrists in their various roles and activities. We have focused on four domains:

3.1 The ethical basis of the physician-patient relationship

3.2 Ethically important practices in psychiatric care

3.3 The ethical basis of relationships with colleagues

3.4 Other ethically important topics in psychiatric practice

Each domain has several topics that correspond to everyday practice issues. In section 3.2, for example, this document addresses the topics of confidentiality, honesty and trust, non-participation in fraud, informed consent, decisionmaking capacity, involuntary psychiatric treatment, and therapeutic boundary-keeping. Within each topic, we define relevant ethics concepts and explain how they relate to the professional activities of psychiatrists. We also provide examples and, when appropriate, exceptions or special applications of these ideas within the profession of psychiatry.

This document highlights domains and topics that have apparent significance and salience in the practice of psychiatry at the present time. We could not address the full universe of ethically important issues in our field, and we could not anticipate the issues that will accompany future innovation and change in psychiatry. We have thus selected the domains and topics that will, we hope, help clarify and illuminate the fundamental ethical commitments of our profession.

We believe that ethical conduct is informed by knowledge of ethical principles and expectations but is best assured through the acquisition of ethically important skills and behaviors. These skills and behaviors – the “habits” of an ethical professional – will allow a psychiatrist to respond to complex and novel situations with an understanding of their ethical implications and the ethically-sound decisions that may be undertaken.

**Practice Domain 3.1**

**The ethical and professional basis of the physician-patient relationship**

**Topic 3.1.1 The physician-patient relationship**

The physician-patient relationship is the foundation of medicine. It is at the heart of psychiatric practice. Many ethical principles have bearing on this relationship, including respect for persons, beneficence, autonomy, honesty, confidentiality, and fidelity. The physician-patient relationship generally begins when a physician has a face-to-face interaction with a patient in which the physician is entrusted with the responsibility of applying his or her knowledge and clinical skills on behalf of the health and well-being of the patient. In our society, the relationship has been conceptualized as a consensual agreement between two autonomous individuals who are free to enter, sustain, or discontinue the relationship unconstrained by discrimination, coercion, or fear of physician abandonment.

In psychiatric practice, as in other areas of medicine, however, the patient may seek care because of distress from significant mental and physical symptoms. This need for clinical care, especially in cases of severe illness, creates an asymmetry or disparity in the relationship: patients are relatively less empowered than physicians. This disparity creates a special ethical obligation for physicians who must place the unique needs of the patient above their own professional or
personal interests. Physicians, furthermore, must be vigilant for situations that can reasonably be expected to cause physical, sexual, psychological, or financial harm to the patient. For psychiatrists, ethical obligations to the patient arise from a special sensitivity to the trust and dependence created, in part, by the communication of highly personal information.

At times, the nature and specific obligations of the physician-patient relationship can vary because of a patient's age or cognitive capacity. For example, when the patient is a child, the process of informed consent will typically extend to the child's parent or guardian. Similarly, when a seriously ill patient's cognitive capacity is compromised, the process of informed consent may include the next of kin or a legally recognized substitute decision-maker.

Third party obligations and the clinical context may also influence the ethical expectations of the physician-patient relationship. For instance, a psychiatrist providing psychoanalytic treatment to a long-term patient should not, under ordinary circumstances, disclose key aspects of the treatment to anyone else. On the other hand, a psychiatrist who serves as a consultant in providing a psychosomatic medicine evaluation undertakes different clinical duties, will have different responsibilities in the patient's care, and may have different ethical obligations in comparison with the long-time psychotherapist. The consulting physician retains the fundamental responsibility to serve the well-being and interests of the patient, but will naturally share clinical information, diagnostic impression, and treatment plan recommendations with appropriate clinical staff members. Similarly, in forensic, employment, or military settings, the physician's obligation to preserve a patient's confidentiality may be limited or redefined because of obligations to a third party.

Because of the complex variations in physician-patient relationships, the reasonably anticipated duties and limits of these different relationships should, when possible, be discussed with the patient. For example, in treating an adolescent in psychotherapy, it will be important to talk with him or her about the kinds of issues that can be "kept private" in their discussions, and which kinds of issues require informing others (e.g., parents, state officials, referral physicians, clinical staff, etc). In a health care system where patients are transferred from one physician to another (e.g., from an inpatient "hospitalist" to an outpatient psychiatrist), the patient should receive appropriate clinical information, such as the reasons for subsequent treatment, the consequences of foregoing treatment and the reasons for transitioning the patient's care to another clinician.

Topic 3.1.2 Professional competence

Competent care of the patient is the cornerstone of ethical psychiatric practice and is the primary basis of patient trust. Professional competence is the ability to apply the accepted standards of clinical practice to patient care. It is an absolute requirement of ethical psychiatric practice.

In a rapidly evolving and diverse field such as psychiatry, competent practice is influenced by advances in behavioral and biological sciences and by complex social and economic contexts of practice. Obtaining, maintaining, and practicing within the bounds of professional competence consequently requires attention throughout a psychiatrist's career; life-long learning must be a habit of professional competence.

From an ethical perspective, it is expected that psychiatrists will maintain a sufficient level of professional competence through continuing education, supervision, consultation, or study. It is also expected that psychiatrists will practice within the bounds of their competence. This is predicated on their training, education, professional experience, supervised experience, or consultation. It is further expected that psychiatrists will make referrals or delegate care only to persons who are, in the psychiatrist's best judgment, competent to deliver the necessary treatment. Finally, it is expected that psychiatrists will obtain the relevant education, training, and supervised experience to implement new treatments with proven effectiveness or treat conditions that are new to their practice.

In an underserved context, if a patient care situation falls outside of a psychiatrist's usual scope of practice and areas of professional competence, he or she may justifiably provide care if: a) the psychiatrist has closely related training and experience; b) the psychiatrist possesses the most readily available expertise; and c) the patient's clinical needs warrant evaluation and intervention (e.g., because of severity, urgency).

Topic 3.1.3 Dual agency and overlapping roles

The terms "dual agency", "dual roles", "overlapping roles", and "double agency" refer to the competing allegiances and obligations a psychiatrist may have in an interaction with a patient. Because of their special expertise, psychiatrists sometimes use their training to serve specific social institutions (e.g., employers, the judicial system, the military). Under a variety of circumstances, a psychiatrist may have competing duties to an institution and an individual patient, for
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Specific examples of dual roles that may give rise to role conflicts include the obligation to assure security in the correctional setting and the provision of an adequate fighting force in the military. In these circumstances the traditional patient-physician relationship is in tension with allegiance to a social institution and concerns of social order, stewardship of community resources, or justice. In these situations, the psychiatrist must always uphold the ethical principle of respect for persons, but honesty (e.g., through accurate and truthful documentation of the findings of an evaluation) may be the greater obligation than beneficence, which typically shapes physician-patient interactions. In other words, psychiatrists may be unable to serve patients exclusively because of appropriate ethical obligations to community safety, social order, or other fundamental societal interests.

A vital ethical skill for psychiatrists who serve in various roles is to recognize the different professional obligations that exist in dual or overlapping role situations. Sometimes it is possible, and advisable, to try to reduce or completely eliminate dual roles. In a correctional setting, for instance, separating the role of clinician from the role of institutional or administrative representative permits the caregiving psychiatrist to safeguard the relationship with the patient. This approach recognizes the differing obligations imposed by the two roles and the confusion that may occur for both the patient and the social institution.

Treatling psychiatrists should also generally avoid serving as expert witnesses for their patients or performing evaluations of their own patients for legal purposes. This form of dual agency can damage the therapeutic relationship and confound the accuracy and utility of the evaluation. However, there may sometimes be difficulty in separating psychiatrists’ functions within a complex set of interactions. In Worker’s Compensation, guardianship, or civil commitment hearings, for example, it may not be realistic or even possible (because of legal requirements) to achieve the formal separation of roles. Recognizing the vulnerability of the individual in conflict with a social institution, a permissible alternative to complete role separation is maintaining primary, although not total, allegiance to the individual. Such an approach would allow recognizable thresholds for breaking confidentiality similar to the responsibility for reporting harm to self or others.

When dual or overlapping roles cannot be minimized (e.g., clinical research situations, employee health centers, correctional settings, school-based mental health programs) it is especially important to inform the patient about the role issues and conflicting ethical obligations. Informed consent “cautions” or “warnings” about overlapping roles should be commonplace in these settings. Attention should be paid to subtle changes in the patient’s view of the relationship; cautions and reminders should be repeated if potentially harmful self-disclosures are anticipated. Further, psychiatrists reporting to social institutions must also make clear whether they have personally interviewed an evaluee or formed an opinion based on other data. Language must be clear on any limitations of the professional opinion, using terms and phrasing that describe the appropriate level of uncertainty (e.g., “the records support the presence of..., reports are consistent with..., the data appears to....” etc.) Through such efforts, institutions and patients -- or individuals undergoing evaluations -- are reminded that the psychiatrist fulfills two roles, and that disclosures may be used in ways that are not therapeutic.

There is one role that, despite its basis in medical knowledge, is absolutely prohibited in all fields of medicine. Physicians may not ethically participate in any manner that supports, facilitates, or enacts human torture or the development and implementation of interrogation techniques that involve torture.

Practice Domain 3.2

Central ethical and professional practices in psychiatric care

Topic 3.2.1 Confidentiality

Confidentiality is the obligation not to reveal a patient’s personal information without his or her explicit permission. Information may be derived either from the patient’s direct disclosure or the physician’s observations. The special nature of confidentiality derives from a long and cherished history that predates modern medicine and privacy laws, and is part of the foundation of the physician-patient relationship. It is important to distinguish between the ethical duty to keep confidences (an obligation created by and owed to the patient) from the legal duty that governs the handling of private medical information (an obligation created by the state). Recognizing this difference maintains the psychiatrist’s focus on the patient’s interest rather than on mere compliance with privacy regulations.

Respecting patients’ confidentiality is especially important for psychiatrists because patients entrust them with highly personal and often sensitive information. Patients’ willingness to make painful, stigmatizing, or embarrassing disclosures
depends on their trust in the physician-patient relationship and its expectation of confidentiality. Beyond this therapeutic rationale, there are ethical duties that arise from principles of fidelity (i.e., promise-keeping), beneficence (i.e., doing good, seeking benefit), and non-maleficence (i.e., avoiding harm).

The exchange of patient information with families and others should occur with the patient’s explicit informed consent (or with implied consent in emergencies, see section 3.2.4) and when it is consistent with the psychiatrist’s best clinical judgment. The psychiatrist’s goal when involving families in a patient’s treatment is to facilitate the coordination of care, the gathering of data, and the management of expectations. Although family members may have been excluded from treatment discussions in the past, evolved conceptualizations of patient autonomy now recognize the importance of the patient’s relationships more fully. Thus, the absolute—even routine--exclusion of families and significant others may not be ethically or clinically justified.

Explicit permission is important for the ethical disclosure of patient information by psychiatrists to family members, teachers, or others. However, psychiatrists may accept or receive information under many circumstances. Psychiatrists should be sensitive to the feelings this kind of information disclosure may raise for patients and maintain communication with them when it occurs.

Several important considerations guide the confidentiality of medical information:

i. Patients should be told of the limits to confidentiality at the beginning of the physician-patient relationship and as events arise that create potential revelations.

ii. Disclosure of confidential information should occur only if informed consent has been given by the patient or if it is necessary to protect the patient or third parties from imminent harm, in a manner consistent with relevant legal statutes.

iii. Disclosure of patient information should always be limited to the requirements of the situation. This limitation is particularly relevant when state or federal privacy rules provide a lower standard of protection.

iv. In their progress notes, psychiatrists should record only the information necessary for continued patient care.

v. Psychotherapy notes may afford further, although not absolute, protection of patient information when kept separate from other components of the medical record. Psychotherapy process comments, therapist formulations and hypotheses, details of patient’s dreams and wishes, and intimate personal details of patients or related individuals should be recorded in these psychotherapy notes rather than the medical record.

vi. Electronic patient records require appropriate, additional safeguards and precautions. (See also Professional Use of the Internet, Topic 3.4.6).

Topic 3.2.2 Honesty and Trust

Honesty and trust are elemental values of a profession. Honesty entails the “positive” duty to tell the truth as well as the “negative” duty not to lie or intentionally mislead someone. Derived from core principles of trustworthiness, integrity, and respect for persons, honesty and trust are fundamental expectations for the patient seeking psychiatric care.

Discussions and interactions in psychiatric practice often deal with highly sensitive and personal information. Psychiatrists may be occasionally tempted to skirt or “soften” the truth in order to avoid harm to a patient. In general, omission (intentional failure to disclose) and evasion (avoidance of telling the truth) will undermine a trusting and constructive relationship between physician and patient and is not appropriate. In addition, releasing inaccurate or misleading clinical information to insurers or employers is a specific example of dishonesty and may constitute fraud. Such behavior undermines trust in the profession as a whole and in third-party interactions in particular. At the same time, out of respect for patient privacy, the ethical physician should reveal only the minimum information necessary for third party review.

Protecting patients from harmful disclosures (i.e., withholding information), as in very acute situations, in therapy with fragile or minor patients, or in end-of-life decision-making -- when deemed essential -- must occur with the strictest concern for patient values and autonomy. This protective measure should be temporary, and ideally will occur with prior discussions with appropriate persons who are in accord with such an approach.
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Topic 3.2.3 Non-participation in fraud

Fraud is an action that is intended to deceive, and ordinarily arises in the context of behavior that seeks to secure unfair or unlawful gain. It is illegal, which violates a fundamental ethical principle for the profession of medicine (see Section 2). Moreover, because honest dealings are essential to the physician-patient relationship, any act of deception or misrepresentation compromises the psychiatrist’s ability to provide care.

Psychiatrists communicate with numerous agencies and individuals during patient treatment. They are responsible for the usual physicianly contact with funding and reimbursement agencies, families, employers, and other third parties. However, because of their expertise in human behavior, psychiatrists are often asked, formally and informally, for information justifying or excusing patient actions. This offers numerous opportunities for ethical mis-steps.

Ideally, principles of trustworthiness and integrity will over-ride inappropriate attempts to benefit an individual patient or psychiatrist. Deceptive conduct of any kind cannot be generalized as a model for others, and, when it becomes known, undermines patient trust in the profession as a whole.

Specific examples of fraud in psychiatric practice include making false or intentionally misleading statements to patients, falsifying medical records, research, or reports, submitting false bills or claims for service, lying about credentials or qualifications, supporting inappropriate exemptions from work or school, practicing outside one’s area of professional competence or beyond one’s authorized scope, providing unnecessary treatment, and taking credit for another’s work. Further illustrations of overt (and legally actionable) dishonesty include writing a prescription for a patient in a family member’s name, or writing prescriptions for a larger number of pills than necessary in order to reduce insurance co-payments. These actions are not ethically acceptable in the practice of psychiatry.

Topic 3.2.4 Informed Consent

Informed consent is an ethically and legally important process that involves information-sharing (e.g., about the nature of an illness and a recommended treatment) and knowledgeable and authentic decision-making about the individual’s health (e.g., by a patient or authorized surrogate). Informed consent for assessment or treatment is obtained if adequate information is disclosed, the patient is capable to make a decision, and does so voluntarily.

The doctrine of informed consent has evolved largely since the 1950’s. The legal standard for information disclosure, for example, continues to evolve and still varies by jurisdiction. Many states apply the “professional standard,” in which the amount and content of disclosure is determined by what most physicians traditionally disclose. Another standard, more consistent with an increasing emphasis on patient autonomy, is the “reasonable person standard.” This standard requires that physicians disclose what a reasonable person would want to know. Typically these standards include an accurate description of the proposed treatment, its potential risks and benefits, any relevant alternatives and their risks and benefits, and the risks and benefits of no treatment at all.

The field of psychiatry as a whole is attentive to the use of language and the interpersonal aspects of obtaining informed consent. The manner in which information is presented, the choice of facts that are included or omitted, and the selection of alternatives that are offered have distinct effects on patient choices. Distorting influences on the consent process may consequently arise from the simplest patient interactions. These include telephone conversations, cross-coverage, and curbside encounters in the clinical setting. Even language used in informal interactions with patients can carry the weight of professional opinion and is colored by the vulnerabilities of knowledge and power inherent to the patient role. When seeking consent, psychiatrists thus must be careful not to influence the patient unduly.

Adults are presumed capable of making their own decisions, with the clinical and legal burden of proof falling on those who wish to prove otherwise. Assessments of decision-making capacity should follow clinical models of assessment and the legal standards of the jurisdiction. (See also Decision-making Capacity, Section 3.2e)

Physicians maintain the highest standards of informed consent when they become familiar with, and endeavor to honor, the specific authentic and enduring personal values of their individual patients. The requirement of voluntariness in informed consent thus affirms the autonomous and values-shaped decisionmaking of the individual and it prohibits coercive pressures in the consent process. In the practice of psychiatry, these issues may be particularly salient because some symptoms of certain mental illnesses (e.g., amotivation, alexithymia, a sense of diminished self-worth, negative cognitive distortions) can prevent an individual from discerning, expressing, and enacting his or her specific authentic and enduring personal values in some circumstances. Furthermore, the experience of dependence, societal marginalization, and insufficient access to clinical care may create a situation of desperation that may interfere with
voluntary decisionmaking. It is important to note that these vulnerabilities need not confer incapacity. Nonetheless, they should be explored in order to optimize a patient's decision-making. This is particularly important in psychiatry where, even if patients are decisionally capable, both internal and external factors (e.g., the patient's illness, stigma, lack of resources) can make them vulnerable to coercive influences.

Important exceptions to informed consent exist:

i. Genuine emergencies do not require informed consent. Emergency care occurs in the framework of implied or presumed consent. That is, in emergency situations in which reasonable persons would want the intervention it is ethical to proceed as if consent exists.

ii. Care for children or incompetent patients requires consent from parents or legally recognized surrogates. Assent of incompetent individuals (i.e., acquiescence as opposed to informed consent) is obtained whenever possible.

iii. Patients may also waive their right to informed consent. This exception, however, presumes competence to do so.

iv. Finally, the doctrine of therapeutic privilege allows a physician to withhold information if it is truly damaging to the patient. But such an exception should be rare. Withholding information about side effects, for example, in the hope of increasing compliance is not acceptable.

Because the concepts of autonomy and informed consent have a legal basis, they may cast the clinical situation in an adversarial light. This view is antithetical to ethical practice. Although the ultimate choice to consent is made by an individual patient, autonomous choice does not take place in a vacuum; it must be nurtured by continued dialogue. Ultimately, the ideal understanding of informed consent is clinical, an important reminder of respect for the strengths of patients and the need for transparent, collaborative, and enduring alliances. Psychiatrists who strive to develop these relationships with their patients will easily exceed the requirements of ethics and law.

**Topic 3.2.5 Decision-making capacity**

Decision-making capacity is the ability of an individual to reach an informed, reasoned, and free choice, when making a specific decision. Among patients and research participants, capacity is a consideration in psychiatric and non-psychiatric conditions that affect mentation, cognition, or emotional regulation.

Common assessment standards expressed in ethics and law include evidencing a choice, understanding relevant information, manipulating information rationally, and appreciating the situation and its consequences. Elements of each standard are often necessary to a competent decision and apply to the specific task at hand.

Psychiatrists in particular have special preparation with respect to the mental status examination and certain cognitive evaluation procedures. Rather than screen all individuals, psychiatrists may use capacity assessments in a targeted fashion when patient decisions or discussions raise concerns. Psychiatrists may be asked to perform capacity assessments when patients or research participants exhibit cognitive deficits, appear to lose decision-making capacity, or manifest atypical behaviors and decisions. Although any physician may conduct the assessment, psychiatrists are specially trained to identify the vulnerabilities of persons with mental retardation, delirium, or hopeless outlook as well as to identify cognitive strengths of even severely ill persons. Psychiatrists recognize that deficits in decision-making capacity may be overcome by targeted educational and clinical interventions. These often include part-by-part and repeated information disclosures, or use of a single trusted clinician to communicate information. Interventions to reduce anxiety, diminish psychotic symptoms, or reduce sedating side effects are equally valuable in overcoming incapacity. Other interventions may include videotape, written, or group education sessions.

Psychiatrists may apply assessment standards on a "sliding scale", with more stringent assessments and higher thresholds of capacity required for decisions that are more consequential, complex, or risky. When incapacity persists surrogate decision makers may be invoked in accordance with local law. Surrogate decision-makers themselves should also be held to appropriate standards of decision-making capacity.

Capacity assessment is particularly relevant for determining the wishes of patients who want treatment or research.
procedures after they become incapacitated. In such circumstances capacity assessment tools or independent interviewers may be helpful in maintaining standards of surrogate decision-making and adherence to patient wishes. Reminding patients of their earlier preferences can also serve to enhance their decision-making. These techniques, however, do not, overcome the clinician or investigator’s primary obligation to provide appropriate information and assessment.

**Topic 3.2.6 Involuntary psychiatric treatment**

Involuntary psychiatric treatment most commonly comprises psychiatric hospitalization or court-ordered outpatient treatment. Mandated treatment generally uses the state’s enforcement apparatus to place individuals into medical care, and is justified by the doctrines of police power and of *parens patriae* (i.e., the state as “parent”).

For psychiatrists, mandated treatment creates inherent ethical tensions. It requires great sensitivity to principles of respect for persons and social responsibility because psychiatrists are contributing to decisions directly controlling patient choices. This kind of power -- in which a patient’s personal freedoms are limited and treatment decisions are being made -- is generally exercised by careful balancing of principles that value both the individual and the community.

Involuntary hospitalization is usually justified by patients’ imminent dangerousness to themselves or others, or their inability to meet basic needs. To meet these criteria, dangerousness must be likely in the near future, and related to a major mental illness. In acknowledgement of the seriousness of depriving a patient of freedom, involuntary commitment usually requires judicial review, access to legal counsel, and consideration of the least restrictive alternative to hospitalization.

Separate authorization is often required for treatment with psychiatric medications. In collaboration with the patient (and/or surrogate decision-makers) ethical psychiatrists discuss those treatments that are most likely to restore the patient’s freedom -- if necessary, in incremental fashion. This requires sensitivity to the coercive nature of commitment, the informed consent process, and the patient’s decision-making capacity. When there is a treatment refusal, and efforts to engage in collaborative decision-making have been insufficient to prevent harm, administrative or legal appeals may be available to review treatment and may require a showing of impaired capacity.

Historically, prior to the ascendancy of dangerousness-based statutes in the 1970s, treatability was the most common legal criterion for involuntary psychiatric hospitalization. The APA has taken a view that combines the two. The APA’s model law for civil commitment embodies a standard that adds treatment rationales to commitments using dangerousness criteria. The APA’s model law requires that:

i. the person is suffering from a severe mental disorder; and

ii. there is reasonable prospect that his disorder is treatable at or through the facility to which he is to be committed and such commitment would be consistent with the least restrictive alternative principle; and

iii. the person either refuses or is unable to consent to voluntary admission for treatment; and

iv. the person lacks capacity to make an informed decision concerning treatment; and

v. as the result of the severe disorder, the person is a) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or b) likely to cause harm to others.

Another common form of involuntary care is mandatory outpatient treatment. Although many states retain the same criteria for outpatient commitment as inpatient commitment, the focus is increasingly on repeated deteriorations that require hospitalization. The likelihood of continued deterioration without intervention, a treatment plan that holds the prospect of stabilization, and involvement of the community treatment team are important ethical requirements.

Outpatient commitment should be informed by concern for patient values, past clinical history, and decision-making capacity. Specific procedures that address non-adherence to recommended treatment should be clear to patients and clinicians, from mandated emergency evaluations to court hearings.

Expectations for taking psychotropic medications should be clearly stated in a formal treatment plan. Forced medication,
however, remains a matter of some legal controversy. The ethical problem, as in inpatient settings, remains one of creating a class of persons for whom psychiatrists are required to care, yet who they are unable to treat.

Ethical obligations to patients committed in the community may require psychiatrists to advocate for greater resources, community-based services, and parity with other forms of medical care. Active outreach and intensive service coordination are among the means for meeting these obligations and ending the suffering of people living with mental illness who may not receive adequate care without such intensive efforts.

Psychiatric commitment of children by parents or guardians requires even greater attention to the effects of confinement and loss of liberty. In such cases psychiatrists endeavor to assure a balance between the fewest obstacles to treatment and the greatest protections from unnecessary institutionalization. The ethical ideal is one of the child’s best interest, appropriate high quality care, and psychiatric participation.

**Topic 3.2.7 Therapeutic Boundary-keeping**

Boundaries may be described as defining the limits of a profession. They connote a professional distance and respect that ensure an atmosphere of safety and predictability. Appropriate therapeutic boundaries are also necessary for therapeutic efficacy. Psychiatrists are trained to examine and appreciate the significant psychological and social overtones of the treatment relationship. Their expertise consequently gives rise to specific rules that govern the bounds of ethical practice.

Physicians must never exploit or otherwise take advantage of patients. The unique position of power afforded by the psychotherapeutic relationship can be used in ways that are unrelated to treatment. Physicians must therefore limit the relationship with patients to the therapeutic context. This boundary requires that physicians avoid patient interactions that are aimed at gratifying the physician’s needs and impulses.

Professional boundaries limit both sexual and non-sexual behavior. Even the possibility of a future sexual or romantic relationship may contaminate current therapy. Thus sexual activity, not only with current but also with former patients, is unethical. Likewise, any occasion in which the physician interacts with a current or former patient in ways that may be a prelude to an intimate, non-professional relationship (e.g. as a date, intimate friend etc.) should be avoided.

Inappropriate physical contact is perhaps the most obvious form of boundary violation, but other behaviors can transgress, undermine or cross therapeutic boundaries. These cause harm by exploiting the patient’s dependence on the physician or by exploiting the inherent power differential between them.

Examples of non-therapeutic interactions within the treatment relationship that should be avoided include, but are not limited to: financial and business dealings, employer-employee relationships, or trustee and guardianship roles. These boundary violations, as with inappropriate physical contact, have the potential to compromise the physician’s exclusive focus on the patient’s well-being, to impair the physician’s judgment, and to diminish the effectiveness of care.

The rules guiding professional boundaries are context-sensitive. For example, social or business interactions with a patient may be unavoidable in a rural setting. Because of this, it is important to distinguish boundary violations from boundary crossings. Boundary violations are transgressions that are immediately harmful, are likely to cause future harm, or are exploitive of the patient. Boundary crossings are deviations from customary behavior, but do not harm the patient, and may allow for flexibility within the therapy.

Psychiatrists recognize that not all therapeutic boundary issues may be resolved satisfactorily. Although psychiatrists are encouraged to address boundary issues with the patient in therapy and to seek consultation with colleagues, certain problems may only be resolved by termination of the therapeutic relationship. These include instances when the physician’s subjective reaction to the patient interferes with therapy or the patient’s intentional intrusion into the physician's personal life makes it difficult to assure intact treatment boundaries.

Specific applications of boundaries in psychotherapy include:

i. **Time and Place** – The therapeutic relationship is bounded by constraints on the appointment itself. A set time to begin and end a session should be agreed upon and adhered to. Although variations may, on occasion, be helpful (e.g. visiting a patient with a severe physical illness at home) psychiatric sessions should take place in dedicated office space.
ii. Money – Psychiatric fees exemplify the business nature of the therapeutic relationship.

Reduced, waived, or unpaid fees should be considered carefully and discussed with the patient because they may adversely affect therapy. In most health care systems such as academic medical centers, practices that may be identified as non-equitable may place psychiatrists' institutions at risk for violations of federal regulations. Barter (i.e., allowing the patient to trade or work for the therapist in order to pay for treatment) is at best confusing and ill-advised. Barter in some jurisdictions is illegal.

iii. Gifts – Small gifts from patients, especially small handmade gifts, are acceptable. Their meaning and symbolism are appropriate for discussion in therapy. Psychiatrists must also be aware that the meaning of gifts varies across cultures. Large personal gifts should be avoided. Philanthropic donations to finance or support a psychiatrist’s position or research (e.g., an endowed chair) should be channeled through proper administrative venues. The appropriateness of accepting such gifts should be determined in consultation with colleagues or ethics committees. Thus acceptance of philanthropic gifts, in psychiatry as in other fields of medicine, may be ethically acceptable if there is sufficient role separation and if appropriate safeguards are in place to prevent exploitation of the patient. The restrictions on receiving gifts from industry (e.g., pharmaceutical companies), are well defined in the AMA Council on Ethical and Judicial Affairs (CEJA) code. In general, gifts from industry should benefit patients, relate to the physician’s work, and be of minimal value. (See also Financial Conflicts of Interest, 3.4d).

iv. Self-disclosure – Self-disclosure from the therapist is not, in general, conducive to the therapeutic relationship and should be avoided. Therapists should not burden patients with their own personal issues, and they should not use the opportunity of the therapeutic relationship to influence the patient in any way not directly relevant to the treatment goals. Exploring common interests such as sports and movies, while likely boundary crossings, may on occasion be useful in the therapeutic process. The disclosures required by general standards of truth and honesty are expected (e.g., fees, vacation schedules, conflicts of interest, etc.) (See also Honesty and Trust, 3.2b).

v. Physical contact – Sexual activity with current and former patients is unethical. Non-sexual physical contact, other than a handshake, is best avoided. Patients may interpret touch differently than the psychiatrist intends. Therapy with children does allow contact appropriate to the patient’s development and clinical condition (e.g., a hug).

vi. Language choice – Boundary violations may stem from the therapist’s choice of language. The title or name the therapist and patient call each other is an important and sensitive issue that should be discussed in therapy. Use of the patient’s first name, for example, may imply an intimacy that is not intended, and may add to the power difference, especially if the therapist is referred to as “Doctor.” By the same token, the use of last names may be experienced as distant and aloof. The choice of language by the psychiatrist should be motivated by therapeutic aims. The use of expletives and off-color language may be experienced as verbal assault and should be avoided.

vii. Appearance – One’s manner of dress also requires professional boundaries. Psychiatrists should follow common professional office standards and avoid dressing provocatively.

viii. Influence – The psychiatrist’s influence in the professional relationship should be closely monitored. Psychiatrists should not use their unique position of power in the therapeutic relationship to influence the patient in any way unrelated to treatment, (e.g., by focusing on political views, direct solicitation of donations to a hospital, or recruitment to a personal cause or organization).

ix. Behavior with family and other patient intimates – Personal relationships between the therapist and the patient’s family (or individuals intimately associated with the patient) should be avoided during the course of therapy and usually even after it ends.

**Practice Domain 3.3**

**The ethical and professional basis of the relationship with colleagues**

**Topic 3.3.1 Seeking professional consultation**

An important aspect of psychiatric practice is the ability to recognize when one needs consultation. Professional competence itself entails recognizing the limits of one’s clinical skills. Consultation in the analysis of ethical dilemmas is
encouraged as well.

Psychiatrists treat difficult illnesses, and psychiatric illnesses are influenced by complex social and cultural contexts, co-morbid conditions, and stigma. Because of this complexity, psychiatrists should carefully consider the need for consultation when patients are not doing well.

If psychiatrists receive referrals for conditions that are outside their expertise and more competent psychiatrists are available, they should make the referral to the more competent clinician. However, psychiatrists should not delegate care that requires the exercise of professional medical judgment to non-physicians.

Psychiatrists should agree to patient requests for consultation (or to the requests of family/guardian for minor or incompetent patients). Psychiatrists may suggest a choice among consultants, but the patient or family should make the final decision. If psychiatrists disapprove of the professional qualifications of the consultant, or have a difference of opinion with the findings, they may withdraw from the case after suitable notice.

**Topic 3.3.2 Relations with non-psychiatrists/collaboration on multidisciplinary teams**

The primary goal in multidisciplinary treatment, as in all psychiatry, is the highest standard of care. This derives from recognizable ethical standards of beneficence and fidelity to patients, and draws on the expertise and ethics of professionals who are similarly devoted to mental health. The treatment of patients, especially those who are chronically ill, is enhanced by multidisciplinary coordination (e.g., with psychology, social work, and nursing).

When psychiatrists assume a collaborative role with other mental health clinicians, however, they must assure that they are fully engaged and not merely used as “figureheads”. Decision-making in collaborative treatment approaches must occur in a manner that enhances the care of the patient.

One type of collaboration occurs with independent practitioners. For instance, a psychiatrist in private practice may treat a patient with medication, while an independent psychologist or social worker provides psychotherapy. Although the practitioners work independently, they coordinate their care and assume shared responsibility for the patient. The psychiatrist and the collaborating clinician must communicate with their common patient the unique roles of each clinician. For example, it should be clear which clinician is to be called when the patient becomes suicidal.

In some multidisciplinary teams, the psychiatrist is the only physician involved in the patient’s care and thereby bears special ethical and legal responsibilities. Because of the specialized knowledge and level of accountability of physicians, psychiatrists should not accede to a decision which may be detrimental to sound principles of psychiatric patient care.

**Topic 3.3.3 Responsibilities in teaching and in supervising psychiatrists-in-training**

The training of the next generation of psychiatrists is an important duty based in scientific and clinical excellence, social responsibility, and respect for persons. Psychiatrists should strive to take part in the training of young psychiatrists, as well as in the education of new physicians on the psychiatric aspects of medicine.

As teachers and supervisors, psychiatrists must model not only clinical expertise but also a high standard of professional ethics. Psychiatrists should remain committed to fostering a positive, respectful learning environment for trainees. Psychiatrists must be mindful of the asymmetry in power between themselves and their trainees; this asymmetry places important fiduciary responsibilities on the teacher (for example, avoidance of sexual involvement with trainees) that take into account the vulnerabilities of trainees and their development as professionals.

**Topic 3.3.4 Responding to the unethical conduct of colleagues**

All physicians have an obligation to recognize and report the unethical behavior of colleagues. Unethical conduct includes a variety of behaviors that violate professional standards. These may include exploitation of a patient, dishonesty, fraud, or behavior meant to demean or humiliate others.

The duty to report unethical conduct is an essential part of a profession’s self-regulation. It is the members of a profession who are in the best position to recognize unethical behavior from their colleagues. When unethical psychiatrists continue to practice, they not only harm patients, but also damage the profession as a whole. They also
harm future patients who may become reluctant to seek care.

Physicians who engage in unethical behavior may be unaware of the ethical standards they are expected to observe. Alternatively, they may engage in unethical conduct because they believe the rules do not apply to their situation or believe they are “an exception”. Finally, misconduct may occur because physicians intentionally choose not to abide by the rules and expectations of the profession. Irrespective of the reasons behind misconduct, however, psychiatrists have ethical obligations to learn and follow their profession’s standards. Colleagues are obliged to follow the reporting requirements of their jurisdiction. In some instances reporting is mandated by law.

In the clinical setting in particular there should be special protections (e.g., opportunities for consultation, supervision) against any behavior that could reasonably be expected to exploit a patient.

Unethical behavior which does not fit into the category of impairment or incompetence should be reported in the following manner:

i. Unethical conduct which threatens patient safety or welfare should be reported to the appropriate authority of the clinical setting, (e.g., to the chief of a particular service, or the hospital chief of staff).

ii. Unethical behavior which violates the provisions of the state licensing board should be reported to the state licensing board.

iii. Unethical behavior which violates criminal statutes should be reported to the appropriate law enforcement authorities.

iv. Examples of unethical conduct which do not fall into the previous three categories, or which has not been addressed specifically by other institutional policies, should be reported to the local district branch of the APA, or to the county medical society.

*Topic 3.3.5 Responding to impaired colleagues*

Impairment among psychiatrists arises from physical, mental, or substance-related disorders that compromise their professional competence. An impaired physician not only fails the ethical duty of providing professionally competent care, but also risks direct harm to patients. The effect of impairment is also heightened because psychiatrists often work with seriously ill persons who may not recognize impaired behavior. Some patients may consequently be unable to advocate for themselves or seek alternative treatment.

Moreover, an impaired physician fails the community of psychiatrists and its standards. Because psychiatrists are uniquely trained to identify impairment from mental illness or substance abuse, they have a special ethical responsibility to monitor their own health. Psychiatrists also have an ethical obligation to be familiar with the relevant legal and institutional policies that address physician impairment. It is likewise important to be aware of the resources that can assist impaired colleagues. When psychiatrists observe evidence of impairment, they share in the obligation of all physicians to abide by the law and to assure patient safety by reporting it.

**Domain 3.4**

*Other ethically important topics in psychiatric practice*

*Topic 3.4.1 Working within organized systems of care*

Managed care systems include those that prospectively, concurrently, or retrospectively review treatment in order to contain costs. Such systems may emphasize preventive or primary care services, require specific approvals for specialty procedures or referral, encourage use of specific treatment guidelines, or create economies of scale to streamline care within large systems.

The fundamental tension of psychiatrists working in this setting is addressed by maintaining the primacy of patient benefit while recognizing the importance of resource stewardship. Psychiatrists practicing within such systems must be honest
about treatment restrictions, assure reasonable access to care within the system, and help identify alternatives available outside it.

Use of appropriate standards of care and evidence-based practices, when available, are part of this obligation and support efforts to maintain the primacy of patient care. In the roles of policy-maker, administrator, or reviewer, psychiatrists must live up to the general standards of fairness in the profession and to clinical standards of care. Persistent concern for patient welfare must remain the paramount principle in decisionmaking. Fiduciary obligations to use resources wisely and assure access to care should be guided by rationally synthesized, evidence-based practices and transparent communication to enrollees regarding what is covered and what is not.

In keeping with the professional principles of fairness, respect for persons, and fidelity, psychiatrists ensure that significant injustices of benefit coverage or availability are remedied by identifiable and accessible appeal mechanisms. This includes advocacy for parity of care and non-discrimination for psychiatric and other medical conditions.

Because patients do not necessarily yield any of their expectations of privacy in the managed care setting, both psychiatrists and reviewers retain strong obligations to maintain the confidentiality of the medical record.

Psychiatrists should keep themselves abreast of specific cost-containment strategies that are unethical, including gag clauses, hold harmless clauses, proprietary definitions that restrict care, and other emerging practices.

Topic 3.4.2 Clinically Innovative Practices

Evidence-based practice is a cornerstone of professional competence. However, clinical decision-making in situations where there is not yet an established literature is not uncommon. In such situations, patient care should still be guided by informed clinical judgments drawing on sound theoretical reasoning, the best available research, and mainstream clinical experience. When usual treatments have failed, psychiatrists retain the authority to offer non-standard or novel interventions using a shared decision-making approach grounded in the patient’s informed consent and a thorough discussion of how the treatment is being chosen and the uncertainties surrounding it.

The advancement of psychiatric diagnosis and treatment requires formal research but it can often be sparked by the clinical innovation that precedes it. Clinical innovation, however, must be clearly distinguished from human research in its theoretical and practical foundations, and should not be confused with scientific inquiry that seeks to produce generalizable knowledge. The reader is referred to the APA Task Force Report on Research Ethics for elucidation of the principles and recommendations offered for psychiatric research.

Topic 3.4.3 Psychiatric issues in end-of-life care

End-of-life care is a collaborative decision-making process that should begin early in the physician-patient relationship. Preparation for conditions that may require palliative care, withholding or withdrawal of treatment, or general trade-offs of longevity for quality of life involves familiarity with patient values and exploration of common scenarios that arise in the medical setting.

Psychiatrists can have a critical role to play in end-of-life discussions because of their experience in dealing with sensitive and difficult discussions with patients. Psychiatrists can also identify and treat common neuropsychiatric symptoms at the end of life. Finally, psychiatrists may be well-positioned to address the psychological suffering that accompanies the stigmatization and marginalization of those nearing the end of life.

Appropriate approaches to end-of-life care often combine treatment–specific information with values histories. Such approaches allow physicians to balance information regarding end-of-life care with accurate knowledge of patient sensibilities. Patients must be provided sufficient information for making decisions and their wishes documented and monitored over time. Ongoing discussions with care-givers can be an invaluable source of information. Use of the full range of tools for improving end-of-life care – including advance directives, treatment vignettes, and values histories – can begin to overcome the barriers to treatment faced by persons requiring end-of-life care.

Where there is doubt regarding the authenticity or stability of decisions, psychiatrists have special expertise in focused capacity assessments. In addition, specific assurances that patients will not be abandoned can overcome feelings of hopelessness. Information on the likely course of an illness and means for managing symptoms can also bring hope. Improved communication is critical for addressing common feelings of dread and despair, identifying and treating depression, addressing medication side effects or related neuropsychiatric symptoms, and supporting families in
resisting psychosocial stressors.

**Topic 3.4.4 Financial Conflicts of Interest in Relations with Pharmaceutical Manufacturers**

The practice of psychiatry and the roles assumed by psychiatrists may bring competing values into conflict (See Section 3.1.3, “Dual agency and overlapping roles”). The mere existence of a conflict of interest is common, expected, and does not by itself imply any wrongdoing or compromise in the integrity of the professional. Whether and how a conflict of interest is recognized and addressed, however, does raise important ethical questions. Failure to recognize and actively manage conflicts of interest does constitute a serious compromise of professional integrity. Without active efforts, conflicts of interest may create pressures that may shape physician decisions or actions in ways that are detrimental to patients and to the profession.

The APA endorses the codes of conduct outlined in recent documents of the American Medical Association (see Section 5). The ethics of managing financial conflicts of interest must go beyond the mere following of rules and instead embrace their spirit.

It is also possible, and indeed quite common, for an activity primarily intended for marketing to meet the minimal regulatory requirements of “education,” thus escaping FDA scrutiny. The FDA sets minimal standards because it expects objective, independent physicians—motivated by the welfare of their patients and an allegiance to academic integrity—to exercise their own scrutiny. Therefore integrity and true professional self-regulation require that the standards be set at a higher level than mere regulatory compliance. Such integrity cannot be externally imposed; it should be the aspiration of individual practitioners as well as of professional societies.

Some useful questions for self-appraisal of conflicts of interest include: What would my patients think about this arrangement? What would the public think? How would I feel if the relationship were disclosed by the media? What is the purpose of the industry offer? What would I think if my own physician accepted this offer?

Finally, it is important to recall that disclosure does not eliminate a conflict. It only shifts the responsibility for managing negative consequences to the recipient of the disclosure. Routine disclosures of broad conflicts of interest have a de-sensitizing effect that diminishes the gravity of the profession’s ethical responsibility. Routine disclosures may consequently lull the profession into failing to recognize real conflicts when they arise.

Financial conflicts of interest (especially in interactions with the pharmaceutical industry) pose a danger to the practitioner’s independence. Rules, although important, serve only as minimal standards of conduct. Disclosure, a common institutional rule, merely shifts the responsibility for the conflict to others without addressing the potential dangers to integrity and objectivity. Therefore, avoiding persistent conflicts of interest remains an important ethical obligation for the psychiatric practitioner.

**Topic 3.4.5 Ethical issues in small communities**

Small communities pose special ethical challenges to psychiatrists because of the interdependence of the members in the community. Many small communities face great limitations of health care resources, and heightened barriers to care arising from weather, geography, or lack of transportation. Psychiatrists who serve small communities treat patients who may be long-time neighbors, members of their extended family, local officials, or civic leaders. Consequently, the ethical standard of separating personal and professional relationships may be difficult to achieve.

Psychiatrists in small communities may experience greater difficulty in protecting the health information of their patients. When patients describe their own health-related experiences, they may indirectly disclose information about family or community members who may be well-known to the clinician. The consequences of confidentiality breaches may be serious and enduring, particularly given the stigma associated with mental illness. Certain communities may also require sensitivity to cultural practices that are unique to the group. Practices, rituals, and conceptualizations of fundamental medical principles (e.g., familial rather than individual consent) may require psychiatrists to obtain consultation or education on their role in these interactions. Respecting values that may be prioritized differently can be useful in improving the relationship with the patient as well as the entire community. Finally, small community physicians may themselves be isolated, experiencing fewer opportunities for supervision, consultation, expert review, and continuing education.
These features of small communities may therefore create situations where patient needs cannot be met completely. In psychiatric emergencies in remote and frontier areas, for example, it may not be possible to refer the patient to another clinician in a timely manner or to provide the consultation or referral available in urban areas. Some of these concerns are also relevant for the occupational health psychiatrist who cares for members of a circumscribed workplace community or to the student health psychiatrist who cares for members of a college or medical school community.

Psychiatrists in small communities may consequently provide care of broader scope than psychiatrists in larger communities, and may find it necessary to provide care where professional and personal roles overlap. Psychiatrists in these communities should make special efforts and adopt specific practices to assure that their patients are provided appropriate care to the full extent possible. Examples of such practices include additional training for staff on the importance of confidentiality protections, development of reciprocal referrals and ethics consultation resources in neighboring communities, and additional efforts to obtain supervision, consultation, expert review, and continuing education.

Topic 3.4.6 Professional Use of the Internet

Use of electronic media to improve knowledge, communication, patient assessment and care brings great power to the practicing psychiatrist. The greater reach of communication and access, however, brings greater responsibility for patient safety as well. Because psychiatry depends so heavily on the written and spoken word – perhaps more so than other specialties – it is tempting to use electronic media to facilitate communication. This potential benefit, however, must be sought carefully and guarded from a number of potential pitfalls.

It is important to recognize the clinical limitations of electronic communication. Face-to-face evaluation and an ongoing physician-patient relationship cannot be replaced by electronic media. Failure to recognize this limit may create unanticipated consequences for psychiatrists who may extend their practice beyond recognizable limitations. However, there may be circumstances in which the use of two-way audio-visual “telepsychiatry” is the only method that permits patients in remote areas access to psychiatrists. The potential threat to patient privacy must also be recognized. Lastly, the Internet makes it possible to propagate misinformation rapidly, widely, and irreversibly. Inaccurate information may consequently have broad adverse consequences. Any public representations of psychiatric practice, including statements on psychiatrists’ websites, must be based on sound scientific information.

The practicing psychiatrist should ensure the confidentiality of medical records. At the same time, it is important to distinguish the mandates of privacy law with the traditional ethical obligations of confidentiality. Even when the standards of privacy law are met, duties arising from professional ethics may remain (see section 3.2.1 on confidentiality).

Topic 3.4.7 Public statements and the media

Public statements to journalists and other members of the media are part of the mission of the profession to provide public education on mental illness. They are important for addressing social stigma and issues of fairness such as the lack of parity between insurance coverage for psychiatric and other medical conditions. In this activity, psychiatrists are governed with particular force by the ethical principles of scientific excellence, trustworthiness, and social responsibility. Without this emphasis the integrity of the professional and the profession are undermined.

From an ethical perspective, psychiatrists are on firmest footing when commenting on mental illness in general, basing their statements on well-established medical literature. This is an important function for a profession that consistently seeks to decrease stigma associated with mental illness and to diminish the adverse impact of misinformation. Thus, when psychiatrists are asked to comment on a specific individual in the public eye, they may, in accordance with their expertise, comment on the general health issue involved.

In general, it is not ethically acceptable to offer professional opinions about specific individuals in public settings without an appropriate examination and an appropriate formal authorization for the public statement. However, these restrictions may not apply to psychiatrists whose intellectual scholarship focuses on studying the relevance of mental illness in the lives and actions of public or historical figures. In these circumstances, this intellectual work must be subject to the scrutiny and standards of the appropriate scholarly field. The psychiatrist must accurately indicate the scope of collateral sources used in the analysis.

Psychiatrists’ use of language in public statements and comments to the media should make clear the limitations of their
data or of the certainty of their opinion. Minority or evolving viewpoints should be described appropriately, and psychiatrists should be careful not to represent their views as those of the entire profession.

When referring to specific individuals, as in the presentation of case material for scientific audiences, in teaching settings, at public gatherings, or in interactions with the media, it is essential that the psychiatrist either obtain written permission or vigorously and sufficiently disguise the case material.

**Topic 3.4.8 Civil disobedience**

Civil disobedience is the nonviolent and principled refusal to obey the dictates of government. Civil disobedience may occur when a psychiatrist’s ethical obligation to a patient conflicts with the law. Such a conflict may occur, for example, when, in the psychiatrist’s opinion, the state’s request for patient information jeopardizes the patient’s well-being. Psychiatrists should clearly state their ethical obligation in such cases, when options within the law have been exhausted. Psychiatrists may consequently agree to comply with the mandate or not. While physicians have an ethical responsibility to respect the law (see Section 2), it is conceivable that a practitioner could violate the law without violating professional ethics. If psychiatrists refuse to comply with the law, however, they should be aware of the legal consequences of their action and obtain legal counsel.

**Section 4. Uses of this document**

The overarching aim of the Principles of Ethics and Professionalism in Psychiatry is to serve as an informational document for the field. It is relevant to the many types of activities that psychiatrists undertake, the diverse populations they serve, and the array of settings in which they work. This document is clinically-oriented, but has relevance for other psychiatric endeavors such as research, consultation, leadership, and education. Its primary purpose is to help individual psychiatrists gain a sense of the accepted bounds of professional conduct.

Psychiatrists may find it helpful to read the revised Principles in their entirety, gaining an appreciation for the richness of thought and language that frames ethical dilemmas. This approach can offer a basis for understanding how common ethical principles are applied. Since it is impossible to anticipate every ethical dilemma, this kind of reading can provide the reader with a framework that can be applied to novel situations.

This document is also intended as a reference manual. The index allows the reader to locate specific topics of interest. In addition, the resources section provides assistance in identifying critical documents for further reading and study on particular ethical issues.

This document is written as a resource for psychiatrists who serve in many roles. It may be of particular value to individual psychiatric practitioners in their clinical activities. It may also be helpful to teachers and academic psychiatrists as they convey expectations regarding ethical conduct to the next generation of physicians. In addition, as with previous versions of this document, this set of principles can serve to facilitate fair and systematic peer-review when a concern arises about the conduct of a colleague. The document may also be of assistance to administrators and institutional leaders in establishing expectations for the conduct of psychiatrist employees and faculty members.

This document is not a “rule book”. It is a tool, and its value and impact will depend on the ways it is used. It is not intended to cover all ethically important situations and novel ethical questions that psychiatrists may encounter in the course of their careers. Accordingly, it will have limitations. For instance it may not be relevant for the resolution of courtroom disputes which apply legal rather than clinical standards and values, nor is it intended to undermine ethical practitioners serving in communities with scarce mental health resources (e.g., by applying urban standards to rural settings). Furthermore, it cannot fully capture all of the circumstances that alter the ethical nature of a particular decision or action. Indeed, people may do the “right thing” for the “wrong reasons”; or they may do the “wrong thing” for the “right reasons”. Consequently, the ways in which people understand ethical aspects of their work, and the values influencing the ethical commitments of the profession of medicine naturally evolve. Clarifications, reiteration, and re-application of principles to emerging issues are accepted elements of this evolution.

For these reasons, this document emphasizes the importance of ethical skills as well as knowledge of ethical principles and their application to psychiatric practice. It is our hope that this work will help assure greater clarity and rigor in approaching, implementing, and evaluating ethically important decisions and actions. In the end, however, an ethics resource is only as good as the integrity and judgment of those who use it.
Section 5. Additional Resources: Policy statements, ethics guidelines, and related
resource documents of the American Psychiatric Association

Acad Psychiatry Law, Bloomfield CT

assn.org/ama/pub/article/4001-4236.html

AMA CEJA Opinion. E- Addendum II: Council on Ethical and Judicial Affairs Clarification of Gifts to Physicians from


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Ethical Principles of Psychologists and Code of Conduct  
2010 Amendments

Introduction and Applicability

The American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, five General Principles, and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

This Ethics Code applies only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, internet, and other electronic transmissions. These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.

Membership in the APA commits members and student affiliates to comply with the standards of the APA Ethics Code and to the rules and procedures used to enforce them. Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct.

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. APA may impose sanctions on its members for violations of the standards of the Ethics Code, including termination of APA membership, and may notify other bodies and individuals of its actions. Actions that violate the standards of the Ethics Code may also lead to the imposition of sanctions on psychologists or students whether or not they are APA members by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and payors for health services. In addition, APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure. When the sanction to be imposed by APA
is less than expulsion, the 2001 Rules and Procedures do not guarantee an opportunity for an in-person hearing, but generally provide that complaints will be resolved only on the basis of a submitted record.

The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.

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

In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner in keeping with basic principles of human rights.

**Preamble**

Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.
This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

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

**General Principles**

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

**Principle A: Beneficence and Nonmaleficence**

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

**Principle B: Fidelity and Responsibility**

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

**Principle C: Integrity**

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat,
Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

**Principle D: Justice**
Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

**Principle E: Respect for People's Rights and Dignity**
Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

**Standard 1: Resolving Ethical Issues**

1.01 Misuse of Psychologists' Work
If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority
If psychologists’ ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands
If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the
Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.04 Informal Resolution of Ethical Violations
When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)

1.05 Reporting Ethical Violations
If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)

1.06 Cooperating with Ethics Committees
Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.07 Improper Complaints
Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.08 Unfair Discrimination Against Complainants and Respondents
Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

Standard 2: Competence

2.01 Boundaries of Competence
(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.
(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.02 Providing Services in Emergencies
In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

2.03 Maintaining Competence
Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 Bases for Scientific and Professional Judgments
Psychologists’ work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.05 Delegation of Work to Others
Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to
(1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)

2.06 Personal Problems and Conflicts
(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy.)

Standard 3: Human Relations

3.01 Unfair Discrimination
In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

3.02 Sexual Harassment
Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants and Respondents.)

3.03 Other Harassment
Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.04 Avoiding Harm
Psychologists take reasonable steps to avoid harming their clients/patients, students,
supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

3.05 Multiple Relationships
(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

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

3.07 Third-Party Requests for Services
When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality. (See also
Standards 3.05, Multiple relationships, and 4.02, Discussing the Limits of Confidentiality.)

3.08 Exploitative Relationships
Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05, Barter with Clients/Patients; 7.07, Sexual Relationships with Students and Supervisees; 10.05, Sexual Intimacies with Current Therapy Clients/Patients; 10.06, Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy with Former Sexual Partners; and 10.08, Sexual Intimacies with Former Therapy Clients/Patients.)

3.09 Cooperation with Other Professionals
When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard 4.05, Disclosures.)

3.10 Informed Consent
(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

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

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

3.12 Interruption of Psychological Services
Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.)

Standard 4: Privacy and Confidentiality

4.01 Maintaining Confidentiality
Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 Discussing the Limits of Confidentiality
(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

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

4.03 Recording
Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See
also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing with Informed Consent for Research; and 8.07, Deception in Research.)

4.04 Minimizing Intrusions on Privacy
(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures
(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)

4.06 Consultations
When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)

4.07 Use of Confidential Information for Didactic or Other Purposes
Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

Standard 5: Advertising and Other Public Statements

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

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

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

5.02 Statements by Others
(a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item. (See also Standard 1.01, Misuse of Psychologists’ Work.)

(c) A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.

5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs
To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

5.04 Media Presentations
When psychologists provide public advice or comment via print, Internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)
5.05 Testimonials
Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.06 In-Person Solicitation
Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

Standard 6: Record Keeping and Fees

6.01 Documentation of Professional and Scientific Work and Maintenance of Records
Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work
(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records.)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)

6.03 Withholding Records for Nonpayment
Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.
6.04 Fees and Financial Arrangements
(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists' fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)

6.05 Barter with Clients/Patients
Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)

6.06 Accuracy in Reports to Payors and Funding Sources
In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)

6.07 Referrals and Fees
When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation with Other Professionals.)

Standard 7: Education and Training

7.01 Design of Education and Training Programs
Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for
which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)

7.02 Descriptions of Education and Training Programs
Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching
(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)

(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)

7.04 Student Disclosure of Personal Information
Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 Mandatory Individual or Group Therapy
(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs.)

(b) Faculty who are or are likely to be responsible for evaluating students' academic performance do not themselves provide that therapy. (See also Standard 3.05, Multiple Relationships.)
7.06 Assessing Student and Supervisee Performance
(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.07 Sexual Relationships with Students and Supervisees
Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)

Standard 8: Research and Publication

8.01 Institutional Approval
When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.02 Informed Consent to Research
(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing with Informed Consent for Research; and 8.07, Deception in Research.)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent to Research.)

8.03 Informed Consent for Recording Voices and Images in Research
Psychologists obtain informed consent from research participants prior to recording their
voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research.)

8.04 Client/Patient, Student, and Subordinate Research Participants
(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 Dispensing with Informed Consent for Research
Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants' employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 Offering Inducements for Research Participation
(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter with Clients/Patients.)

8.07 Deception in Research
(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.

(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the
conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)

8.08 Debriefing
(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.

(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 Humane Care and Use of Animals in Research
(a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.

(b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.

(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)

(d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.

(e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.

(g) When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results
(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)
(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 Plagiarism
Psychologists do not present portions of another's work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit
(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

8.13 Duplicate Publication of Data
Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 Sharing Research Data for Verification
(a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.

(b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers
Psychologists who review material submitted for presentation, publication, grant, or
research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

**Standard 9: Assessment**

**9.01 Bases for Assessments**
(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

**9.02 Use of Assessments**
(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

(c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

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

(b) Psychologists inform persons with questionable capacity to consent or for whom
testing is mandated by law or governmental regulations about the nature and purpose of
the proposed assessment services, using language that is reasonably understandable to the
person being assessed.

(c) Psychologists using the services of an interpreter obtain informed consent from the
client/patient to use that interpreter, ensure that confidentiality of test results and test
security are maintained, and include in their recommendations, reports, and diagnostic or
evaluative statements, including forensic testimony, discussion of any limitations on the
data obtained. (See also Standards 2.05, Delegation of Work to Others; 4.01, Maintaining
Confidentiality; 9.01, Bases for Assessments; 9.06, Interpreting Assessment Results; and
9.07, Assessment by Unqualified Persons.)

9.04 Release of Test Data
(a) The term test data refers to raw and scaled scores, client/patient responses to test
questions or stimuli, and psychologists' notes and recordings concerning client/patient
statements and behavior during an examination. Those portions of test materials that
include client/patient responses are included in the definition of test data. Pursuant to a
client/patient release, psychologists provide test data to the client/patient or other persons
identified in the release. Psychologists may refrain from releasing test data to protect a
client/patient or others from substantial harm or misuse or misrepresentation of the data
or the test, recognizing that in many instances release of confidential information under
these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test
Security.)

(b) In the absence of a client/patient release, psychologists provide test data only as
required by law or court order.

9.05 Test Construction
Psychologists who develop tests and other assessment techniques use appropriate
psychometric procedures and current scientific or professional knowledge for test design,
standardization, validation, reduction or elimination of bias, and recommendations for
use.

9.06 Interpreting Assessment Results
When interpreting assessment results, including automated interpretations, psychologists
take into account the purpose of the assessment as well as the various test factors, test-
taking abilities, and other characteristics of the person being assessed, such as situational,
personal, linguistic, and cultural differences, that might affect psychologists' judgments
or reduce the accuracy of their interpretations. They indicate any significant limitations of
their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and
3.01, Unfair Discrimination.)
9.07 Assessment by Unqualified Persons
Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard 2.05, Delegation of Work to Others.)

9.08 Obsolete Tests and Outdated Test Results
(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.09 Test Scoring and Interpretation Services
(a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)

(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 Explaining Assessment Results
Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11 Maintaining Test Security
The term test materials refers to manuals, instruments, protocols, and test questions or stimuli and does not include test data as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

Standard 10: Therapy

10.01 Informed Consent to Therapy
(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed
Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 Therapy Involving Couples or Families
(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

10.03 Group Therapy
When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

10.04 Providing Therapy to Those Served by Others
In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client's/patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.05 Sexual Intimacies with Current Therapy Clients/Patients
Psychologists do not engage in sexual intimacies with current therapy clients/patients.
10.06 Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients
Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.07 Therapy with Former Sexual Partners
Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 Sexual Intimacies with Former Therapy Clients/Patients
(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.

(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)

10.09 Interruption of Therapy
When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)

10.10 Terminating Therapy
(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.
History and Effective Date

The American Psychological Association’s Council of Representatives adopted this version of the APA Ethics Code during its meeting on August 21, 2002. The Code became effective on June 1, 2003. The Council of Representatives amended this version of the Ethics Code on February 20, 2010. The amendments became effective on June 1, 2010. Inquiries concerning the substance or interpretation of the APA Ethics Code should be addressed to the Director, Office of Ethics, American Psychological Association, 750 First St. NE, Washington, DC 20002-4242. The standards in this Ethics Code will be used to adjudicate complaints brought concerning alleged conduct occurring on or after the effective date. Complaints will be adjudicated on the basis of the version of the Ethics Code that was in effect at the time the conduct occurred.

The APA has previously published its Ethics Code as follows:


Introduction and Applicability
If psychologists’ ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing authority in keeping with basic principles of human rights.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority
If psychologists’ ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority. Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands
If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.
Record Keeping Guidelines

American Psychological Association

Introduction

These guidelines are designed to educate psychologists and provide a framework for making decisions regarding professional record keeping. State and federal laws, as well as the American Psychological Association’s (APA, 2002b) “Ethical Principles of Psychologists and Code of Conduct” (hereafter referred to as the Ethics Code), generally require maintenance of appropriate records of psychological services. The nature and extent of the record will vary depending upon the purpose, setting, and context of the psychological services. Psychologists should be familiar with legal and ethical requirements for record keeping in their specific professional contexts and jurisdictions. These guidelines are not intended to describe these requirements fully or to provide legal advice.

Records benefit both the client1 and the psychologist through documentation of treatment plans, services provided, and client progress. Record keeping documents the psychologist’s planning and implementation of an appropriate course of services, allowing the psychologist to monitor his or her work. Records may be especially important when there are significant periods of time between contacts or when the client seeks services from another professional. Appropriate records can also help protect both the client and the psychologist in the event of legal or ethical proceedings. Adequate records are generally a requirement for third-party reimbursement for psychological services.

The process of keeping records involves consideration of legal requirements, ethical standards, and other external constraints, as well as the demands of the particular professional context. In some situations, one set of considerations may suggest a different course of action than another, and it is up to the psychologist to balance them appropriately. These guidelines are intended to assist psychologists in making such decisions.

Guidelines and Use of Language

Psychological practice entails applications in a wide range of settings for a variety of potential clients. This document was written to provide broad guidance to providers of services (e.g., assessment, diagnosis, prevention, treatment, psychotherapy, consultation). Extension of the guidelines to some areas of practice (e.g., industrial/ organizational, consulting psychology) may likely call for modifications, although some of the same general principles may be useful.

The term guidelines refers to statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help facilitate a high level of practice by psychologists. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists.

These guidelines are intended to provide psychologists with a general framework for considering appropriate courses of action or practice in relation to record keeping. Record keeping procedures are directed, to some extent, by the Ethics Code and legal and regulatory requirements. Within these guidelines, more directive language has been used when a particular guideline is based specifically on mandatory provisions of the Ethics Code or law. However, some areas are not addressed in those enforceable standards and regulations. In these areas, more aspirational language has been used. This document aims to elaborate and provide assistance to psychologists as they attempt to establish their own record keeping policies and procedures.

This revision of the 1993 “Record Keeping Guidelines” was completed by the Board of Professional Affairs (BPA) Committee on Professional Practice and Standards (COPPS). Members of COPPS during the development of this document were Eric Y. Drogin (Chair, 2007), Mary A. Connell (Chair, 2006), William E. Foote (Chair, 2005), Cynthia A. Sturm (Chair, 2004), Kristin A. Hancock (Chair, 2003), Armand R. Cerbone, Victor de la Cancela, Michele Galietta, Larry C. James (BPA liaison, 2004–2006), Leigh W. Jerome (BPA liaison, 2003), Sara J. Knight, Stephen Lally, Gary D. Lovejoy, Bonnie J. Spring, Carolyn M. West, and Philip H. Witt. COPPS is grateful for the support and guidance of the BPA, particularly to BPA Chairs Kristin A. Hancock (2006), Rosie Phillips Bingham (2005), and Julie A. Tucker (2004). COPPS also acknowledges the consultation of Lisa R. Grossman, Stephen Behnke, Lindsay Childress-Beatty, Billie Hinnefeld, and Alan Nessman. COPPS extends its appreciation to the APA staff members who facilitated the work of COPPS: Lynn F. Bufka, Mary G. Hardiman, Laura Kay-Roth, Ernestine Penniman, Geoffrey M. Reed, and Omar Rehman.

Correspondence concerning this article should be addressed to the Practice Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242.

1 The term client is used throughout this document to refer to the child, adolescent, adult, older adult, family, group, organization, community, or other population receiving psychological services. Although it is recognized that the client and the recipient of services may not necessarily be the same entity (APA Ethics Code, Standard 3.07), for economy the term client is used in place of service recipient.
avoiding ethical and legal pitfalls in mental health practice

Bob Stinson, Psy.D., J.D., ABPP

It should also be noted that APA policy generally requires substantial review of the relevant empirical literature as a basis for establishing the need for guidelines and for providing justification for the guidelines’ statements themselves (APA, 2005). There is relatively little empirical literature, however, that bears specifically on record keeping. Therefore, these guidelines are based primarily on previous APA policy, professional consensus as determined by the APA Board of Professional Affairs (BPA) Committee on Professional Practice and Standards (COPPS), the review and comment process used in developing this document, and, where possible, existing ethical and legal requirements.

interaction with state and federal laws

Specific state and federal laws and regulations govern psychological record keeping. To the extent possible, this document attempts to provide guidelines that are generally consistent with these laws and regulations. In the event of a conflict between these guidelines and any state or federal law or regulation, the law or regulation in question supersedes these guidelines. It is anticipated that psychologists will use their education, skills, and training to identify the relevant issues and attempt to resolve conflicts in a way that conforms to both law and ethical practice.

HIPAA

Psychologists who are subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) should be aware of certain record keeping requirements and considerations under HIPAA’s Security Rule and Privacy Rule (see HIPAA Administrative Simplification, Regulation Text, 45 CFR Parts 160, 162 and 164; U.S. Department of Health and Human Services, Office for Civil Rights, 2006). These guidelines indicate some key areas in which HIPAA requirements or considerations impact record keeping. However, detailed coverage of the requirements for HIPAA compliance is beyond the scope of this document, and the rules related to HIPAA and their interpretation may change over the lifetime of these guidelines. Accordingly, consultation with other sources of information regarding the implications of HIPAA for psychologists is recommended.2

expiration

These guidelines are scheduled to expire 10 years from February 16, 2007 (the date of adoption by the APA Council of Representatives). After this date, users are encouraged to contact the APA Practice Directorate to determine whether this document remains in effect.

background

In 1988, APA’s Board of Professional Affairs (BPA) requested that its Committee on Professional Practice and Standards (COPPS) examine the possible usefulness of guidelines on record keeping for psychologists. Interviews with psychologists indicated that such guidance would indeed be useful. COPPS also surveyed state laws and regulations related to record keeping by psychologists and found them to be vague and to vary substantially across jurisdictions. Based on these findings, BPA directed COPPS to undertake the development of “Record Keeping Guidelines” (APA, Committee on Professional Practice and Standards, 1993), which were subsequently adopted as APA policy.

As part of a process of reviewing guidelines over time to ensure their continued relevance and applicability, BPA noted that the guidelines did not account for new questions raised by rapidly changing technology, particularly electronic communications and electronic media. Further, it was clear that HIPAA had important implications for record keeping by psychologists. In particular, HIPAA’s Privacy Rule and Security Rule have implications for the development, maintenance, retention, and security of medical and mental health records. In light of these developments, BPA directed COPPS to revise the “Record Keeping Guidelines.”

COPPS began with an assessment of APA member experience with the current guidelines. The 1993 “Record Keeping Guidelines” were posted on the APA Web site for member and public comment in the light of a possible revision. A call for comments was published in the APA Monitor and circulated to state, provincial, and territorial psychological associations and to APA divisions. COPPS also surveyed current professional literature on record keeping. Relevant provisions of the Ethics Code (APA, 2002b), which had been extensively revised since the development of the 1993 “Record Keeping Guidelines,” were examined in detail, as were the ethics codes and relevant policies of several other mental health professions. COPPS also considered the implications of current federal and state laws and regulations, including HIPAA. COPPS reviewed the questions received from members by the APA Practice Directorate Legal and Regulatory Affairs Office and the APA Ethics Office about record keeping practices. Most commonly, these questions concerned the content of records, management and maintenance of records, electronic records, retention of records, and compliance with rapidly changing state and federal requirements for record keeping. Finally, other APA practice guidelines were examined to ensure internal consistency of APA policies.

After drafting a proposed revision, COPPS sought feedback and incorporated suggestions from the APA Ethics and Legal offices. BPA reviewed and approved the draft for release for a Call for Comments. In the Call for Comments, input was sought from all APA divisions and individual members. COPPS presented the draft to APA Con-

2 Resources regarding HIPAA, and HIPAA compliance for psychologists, are available at the U.S. Department of Health and Human Services, Office for Civil Rights Web site (www.hhs.gov/ocr/hipaa/) and in documents prepared by the APA Practice Organization (2003, 2005), solely or in collaboration with the APA Insurance Trust (APA Practice Organization & APA Insurance Trust, 2002).
Guideline 2—Content of Records: A psychologist strives to maintain accurate, current, and pertinent records of professional services as appropriate to the circumstances and as may be required by the psychologist’s jurisdiction. Records include information such as the nature, delivery, progress, and results of psychological services, and related fees.

Rationale

The Ethics Code (Standard 6.01) sets forth reasons why psychologists create and maintain records. Based on various provisions in the Ethics Code, in decision making about content of records, a psychologist may determine what is necessary in order to (a) provide good care; (b) assist collaborating professionals in delivery of care; (c) ensure continuity of professional services in case of the psychologist’s injury, disability, or death or with a change of provider; (d) provide for supervision or training if relevant; (e) provide documentation required for reimbursement or required administratively under contracts or laws; (f) effectively document any decision making, especially in high-risk situations; and (g) allow the psychologist to effectively answer a legal or regulatory complaint.

Application

In making decisions about the content of records, the psychologist takes into account factors such as the nature of the psychological services, the source of the information recorded, the intended use of the records, and his or her professional obligations. Some hospitals, clinics, prisons, or research organizations mandate record format, specific data to be gathered and recorded, and time frames within which the records are to be created. A psychologist endeavors to include only information germane to the purposes for the service provided (Ethics Code, Standard 4.04). Additionally, consistent with the Ethics Code (Principle A), psychologists are sensitive to the potential impact of the language used in the record (e.g., derogatory terms, pathologizing language) on the client.

Considerations Regarding the Level of Detail of the Record

A psychologist makes choices about the level of detail in which the case is documented. Psychologists balance client care with legal and ethical requirements and risks. Information written in vague or broad terms may not be sufficient if more documentation is needed (e.g., for continuity of care, mounting an adequate defense against criminal, malpractice, or state licensing board complaints). However, some clients may express a desire for the psychologist to keep a minimal record in order to provide maximum protection and privacy. Although there may be advantages to keeping minimal records, for example, in light of risk management concerns or concerns about unintended disclosure, there are, alternately, legitimate arguments for keeping a highly detailed record. Those may include such
factors as improved opportunities for the treatment provider to identify trends or patterns in the therapeutic interaction, enhanced capacity to reconstruct the details of treatment for litigation purposes, and more effective opportunities to use supervision and consultation. The following issues may provide a guide to assist the psychologist in wrestling with these tensions:

The client’s wishes. For a variety of reasons, clients may express a wish that limited records of treatment be maintained. In some situations, the client may require limited record keeping as a condition of treatment. The psychologist then considers whether treatment can be provided under this condition.

Emergency or disaster relief settings. When psychologists provide crisis intervention services to people on an emergency relief basis, the records that are created may be less substantial because of the situational demands. The psychologist may be guided by the oversight agency regarding necessary elements for the record. For example, disaster relief agencies may require only cursory identifying information, the date of service, a brief summary of the service provided, and the provider’s name. There may be limited opportunity to keep as detailed records as would be kept in a less urgent situation, particularly in the short-term or immediate crisis. In some situations, such as disaster relief following an airplane crash or a hurricane, no further intervention beyond the on-site contact may occur and, given the brevity and sheer number of services provided, highly detailed records may be impossible to construct even after the crisis.

Alteration or destruction of records. Many statutes, regulations, and rules of evidence prohibit the alteration or removal of information once a record has been made. In the context of litigation, addition or removal of information from a record that has been subpoenaed or requested by court order may create liability for the psychologist. Psychologists may wish to seek consultation regarding relevant state and federal law before changing an existing record. It is recommended that later additions made to a record be documented as such.

Legal/regulatory. Some statutes and regulations mandate inclusion or prohibit exclusion of particular information. For example, an institutional rule for record keeping may prohibit reference to sealed juvenile records or to HIV test results, or a statute may govern disclosure of information about treatment for chemical dependency. The psychologist takes into account the statutes and regulations that govern practice and heeds mandates in making decisions about record detail.

Agency/setting. Psychologists providing psychological services within an institution consider institutional policies and procedures in making decisions about the level of detail in the record (See Guideline 10).

Third-party contracts. The psychologist considers whether the decision to maintain less detailed records deviates from contracts between the psychologist and third-party payers. Many third-party payers’ contracts require specific information to be included within the record. Psychologists who sign but do not abide by contracts with such payers will potentially experience a number of adverse consequences (e.g., required reimbursement of previously received funds, legal actions).

The record of psychological services may include information of three kinds.

Information in the client’s file:

- identifying data (e.g., name, client ID number);
- contact information (e.g., phone number, address, next of kin);
- fees and billing information;
- where appropriate, guardianship or conservatorship status;
- documentation of informed consent or assent for treatment (Ethics Code, Standard 3.10);
- documentation of waivers of confidentiality and authorization or consent for release of information (Ethics Code, Standard 4.05);
- documentation of any mandated disclosure of confidential information (e.g., report of child abuse, release secondary to a court order);
- presenting complaint, diagnosis, or basis for request for services;
- plan for services, updated as appropriate (e.g., treatment plan, supervision plan, intervention schedule, community interventions, consultation contracts);
- health and developmental history.

For each substantive contact with a client:

- date of service and duration of session;
- types of services (e.g., consultation, assessment, treatment, training);
- nature of professional intervention or contact (e.g., treatment modalities, referral, letters, e-mail, phone contacts);
- formal or informal assessment of client status.

The record may also include other specific information, depending upon the circumstances:

- client responses or reactions to professional interventions;
- current risk factors in relation to dangerousness to self or others;
- other treatment modalities employed, such as medication or biofeedback treatment;
- emergency interventions (e.g., specially scheduled sessions, hospitalizations);
- plans for future interventions;
- information describing the qualitative aspects of the professional–client interaction;
- prognosis;
- assessment or summary data (e.g., psychological testing, structured interviews, behavioral ratings, client behavior logs);
- consultations with or referrals to other professionals;
- case-related telephone, mail, and e-mail contacts;
- relevant cultural and sociopolitical factors.
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Guideline 3—Confidentiality of Records: The psychologist takes reasonable steps to establish and maintain the confidentiality of information arising from service delivery.

Rationale
Confidentiality of records is mandated by law, regulation, and ethical standards (Ethics Code, Standards 4.01 and 6.02). The assurance of confidentiality is critical for the provision of many psychological services. Maintenance of confidentiality preserves the privacy of clients and promotes trust in the profession of psychology.

Application
The psychologist maintains records in such a way as to preserve their confidentiality. The psychologist develops procedures to protect the physical and electronic record from inadvertent or unauthorized disclosure (see Guideline 5). Psychologists are familiar with the ethical standards regarding confidentiality, as well as state and federal regulations and statutes (e.g., HIPAA, licensing laws, mandated reporting of abuse). Psychologists strive to be aware of the legal and regulatory requirements governing the release of information (e.g., some jurisdictions prohibit the re-release of mental health records, records of sexually transmitted diseases, or chemical dependency treatment records). When the psychologist employs clerical or testing personnel, he or she is required by the Ethics Code (Standard 2.05) to take reasonable steps to ensure that the employee’s work is done competently. Therefore, the psychologist strives to educate employees about confidentiality requirements and to implement processes that support the protection of records and the disclosure of confidential information only with proper consent or under other required circumstances (e.g., mandated reporting, court order).

The manner in which records are maintained may not immediately appear who should have access to records. For example, children in treatment following marital dissolution may be brought for services by one parent who wishes the record to be kept confidential from the other parent, or an adolescent who is near but has not quite reached the age of majority may request that records be kept confidential from the parent/guardian. A minor may have the legal prerogative to consent to treatment (e.g., for reproductive matters), but the parent may nevertheless press for access to the record. The psychologist is guided by the Ethics Code (providing that psychologists may disclose information to a legally authorized person on behalf of the client/patient unless prohibited by law; Ethics Code, Standard 4.05) as well as by state and federal regulations in these matters. Following marital dissolution, a psychologist may be uncertain whether to release records to one of the parents, particularly when the release is not wanted by the other parent. In such a situation, the psychologist recognizes that the relevant court overseeing the marital dissolution may have already specified who has access to the child’s treatment records.

Guideline 4—Disclosure of Record Keeping Procedures: When appropriate, psychologists inform clients of the nature and extent of record keeping procedures (including a statement on the limitations of confidentiality of the records; Ethics Code, Standard 4.02).

Rationale
Informed consent is part of the ethical and legal basis of professional psychology procedures (Ethics Code, Standards 3.10, 8.02, 9.03, and 10.01), and disclosure of record keeping procedures may be a part of this process.

Application
Consistent with the APA’s Ethics Code, psychologists obtain and document informed consent appropriate to the circumstances at the beginning of the professional relationship. In some circumstances, when it is anticipated that the client might want or need to know how records will be maintained, this process may include the disclosure of record keeping procedures. This may be especially relevant when record keeping procedures are likely to have an impact upon confidentiality or when the client’s expressed expectations regarding record keeping differ from the required procedures.

The manner in which records are maintained may potentially affect the client in ways that may be unanticipated by the client. Psychologists are encouraged to inform the client about these situations. For example, in some medical settings, client records may become part of an electronic file that is accessible by a broad range of institutional staff (see Guideline 10). In some educational settings, institutional, state, and federal regulations dictate record keeping procedures that may expand the range of individuals who have access to the records of a school psychologist.

When a psychologist releases client records, with proper authorization to release information, they may be further distributed without the psychologist’s or the client’s consent. The psychologist may wish to alert the client of this potential at the outset of services or before consent for release is given. For example, after release in a litigation context, records may be placed in the public domain and be accessible to any member of the public. Another example of unwanted re-release may occur when records are sent, at the client’s request, to another treating professional, whose handling of those records is then beyond the control of the psychologist who sent them.

Guideline 5—Maintenance of Records: The psychologist strives to organize and maintain records to ensure their accuracy and to facilitate their use by the psychologist and others with legitimate access to them.

Rationale
The usefulness of psychological service records often depends on the records being systematically updated and
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For instance, when a psychologist is responding to a subpoena or compelled testimony, the client’s wishes, along with the situational demands, must be considered. A psychologist may also consider, for purposes of convenience and organization, an additional section to include material generated by the client or by third parties, such as the client’s family members, or from prior treatment providers. This might include, among other things, behavioral ratings or logs, diaries, journals, letters from the client’s children, pictures or videos, or greeting cards. Psychological test data, because it may bear more care than other records, may constitute a section. A psychologist may also consider, for purposes of convenience and organization, an additional section to include material generated by the client or by third parties, such as the client’s family members, or from prior treatment providers. This might include, among other things, behavioral ratings or logs, diaries, journals, letters from the client’s children, pictures or videos, or greeting cards. Psychological test data, because it may bear more care than other records, may constitute a section.

Guideline 6—Security: The psychologist takes appropriate steps to protect records from unauthorized access, damage, and destruction.

Rationale

Psychologists proceed with respect for the rights of individuals to privacy and confidentiality (Ethics Code, Principle E). Appropriate security procedures protect against the loss of or unauthorized access to the record, which could have serious consequences for both the client and psychologist. Access to the records is limited in order to safeguard against physical and electronic breaches of the confidentiality of the information. Advances in technology, especially in electronic record keeping, may create new challenges for psychologists in their efforts to maintain the security of their records (see Guideline 9).

Application

The psychologist strives to protect the security of the paper and electronic records he or she keeps and is encouraged to develop a plan to ensure that these materials are secure. In the security plan, two elements to be considered are the medium on which the records are stored and access to the records.

Maintenance. Psychologists are encouraged to keep paper records in a secure manner in safe locations where they may be protected from damage and destruction (e.g., fire, water, mold, insects). Condensed records may be copied and kept in separate locations so as to preserve a copy from natural or other disasters. Similarly, electronic records stored on magnetic and other electronic media may require protection from damage (e.g., electric fields or mechanical insult; power surges or outage; and attack from viruses, worms, or other destructive programs). Psychologists may plan for archiving of electronic data including file and system backups and off-site storage of data (See Guideline 9).

Access. Control of access to paper records may be accomplished by storing files in locked cabinets or other containers housed in locked offices or storage rooms. Psychologists protect electronic records from unauthorized access through security procedures (e.g., passwords, firewalls, data encryption and authentication). Consistent with legal and regulatory requirements and ethical standards (e.g., Ethics Code, Standard 6.02; HIPAA Privacy Rule and Security Rule), psychologists employ procedures to limit access of records to appropriately trained professionals and others with legitimate need to see the records.

3 See the HIPAA Privacy Rule (Standards for Privacy of Individually Identifiable Health Information, 2002).
4 See “Strategies for Private Practitioners Coping With Subpoenas or Compelled Testimony for Client Records or Test Data” (APA, Committee on Legal Issues, 2006, or http://content.apa.org/journals/pro/37/2/215.pdf).
5 For psychologists who are subject to HIPAA and maintain electronic records, the HIPAA Security Rule requires a detailed analysis of the risk of loss of, or unauthorized access to, electronic records and detailed policies and procedures to address those risks (for more details regarding the Security Rule, see Health Insurance Reform: Security Standards, 2003). 6 If the psychologist is subject to HIPAA and maintains electronic records, the HIPAA Security Rule will generally require the development of security policies and procedures for those records (for more details regarding the Security Rule, see Health Insurance Reform: Security Standards, 2003).
Guideline 7—Retention of Records: The psychologist strives to be aware of applicable laws and regulations and to retain records for the period required by legal, regulatory, institutional, and ethical requirements.

Rationale
A variety of circumstances (e.g., requests from clients or treatment providers, legal proceedings) may require release of client records after the psychologist’s termination of contact with the client. Additionally, it is beneficial for the psychologist to retain information concerning the specific nature, quality, and rationale for services provided. The retention of records may serve not only the interests of the client and the psychologist but also society’s interests in a fair and effective legal dispute resolution and administration of justice, when those records are sought to illuminate some legal issue such as the nature of the treatment provided or the psychological condition of the client at the time of services.

Application
In the absence of a superseding requirement, psychologists may consider retaining full records until 7 years after the last date of service delivery for adults or until 3 years after a minor reaches the age of majority, whichever is later. In some circumstances, the psychologist may wish to keep records for a longer period, weighing the risks associated with obsolete or outdated information, or privacy loss, versus the potential benefits associated with preserving the records (See Guideline 8).

There are inherent tensions associated with decisions to retain or dispose of records. Associated with these decisions are both costs and benefits for the recipient of psychological services and for the psychologist. A variety of circumstances can trigger requests for records even beyond 7 years after the psychologist’s last contact with the client. For example, an earlier record of symptoms of a mental disorder might be useful in later diagnosis and treatment. In contrast, the client may be served by the disposal of the record as soon as allowed. For example, the client may have engaged in behavior as a minor that, if later disclosed, might prove demeaning or embarrassing. Also, retaining records over long intervals can be logistically challenging and expensive for the psychologist. The psychologist is encouraged to carefully weigh these matters in making decisions to retain or dispose of records.

Guideline 8—Preserving the Context of Records: The psychologist strives to be attentive to the situational context in which records are created and how that context may influence the content of those records.

Rationale
Records may have a significant impact on the lives of clients (and prior clients). At times, information in a client’s record is specific to a given temporal or situational context (e.g., the time frame and situation in which the services were delivered and the record was created). When that context changes over time, the relevance and meaning of the information may also change. Preserving the context of the record protects the client from the misuse or misinterpretation of those data in a way that could prejudice or harm the client.

Application
When documenting treatment or evaluation, the psychologist is attentive to situational factors that may affect the client’s psychological status. The psychologist is often asked to assess or treat individuals who are in crisis or under great external stress. Those stresses may affect the client’s functioning in that setting, so that the client’s behavior in that situation may not represent the client’s enduring psychological characteristics. For example, a child subjected to severe physical abuse may produce low scores in a cognitive assessment that may not accurately predict the child’s future functioning. Or a psychologist writing a case summary regarding a client who had only been violent in the midst of a psychotic episode is careful to record the context in which the behavior occurred. The psychologist strives to create and maintain records in such a way as to preserve relevant information about the context in which the records were created.

Guideline 9—Electronic Records: Electronic records, like paper records, should be created and maintained in a way that is designed to protect their security, integrity, confidentiality, and appropriate access, as well as their compliance with applicable legal and ethical requirements.

Rationale
The use of electronic methods and media compels psychologists to become aware of the unique aspects of electronic record keeping in their particular practice settings. These aspects include limitations to the confidentiality of these records, methods to keep these records secure, measures necessary to maintain the integrity of the records, and the unique challenges of disposing of these records. In many cases, psychologists who maintain electronic records will be subject to the HIPAA Security Rule, which requires a detailed analysis of the risks associated with electronic records. Conducting that risk analysis may be advisable even for psychologists who are not technically subject to HIPAA. The HIPAA Privacy Rules and Security Standards provide assistance to the practitioner in scrutinizing office practices such as assuring that personal health information is handled in a way designed to protect the privacy of...
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Organizational settings may present unique challenges in record keeping. Organizational record keeping requirements may differ substantially from procedures in other settings. Psychologists working in organizational settings may encounter conflicts between the practices of their organization and established professional guidelines, ethical standards, or legal and regulatory requirements. Additionally, record ownership and responsibility is not always clearly defined. Often, multiple service providers access and contribute to the record. This potentially affects the degree to which the psychologist may exercise control of the record and its confidentiality.

Application

Three record keeping issues arise when psychologists provide services in organizational settings: conflicts between record ownership and responsibility; conflicts between organizational and other requirements; ownership of the records, and access to the records.

The psychologist may consult with colleagues in the organization to support record keeping that serves the needs of different disciplines and while meeting acceptable record keeping requirements and guidelines. In addition, the psychologist may review local, state, and federal laws and regulations that pertain to that organization and its record keeping practices. In the event that there are conflicts between an organization’s policies and procedures and the Ethics Code, psychologists clarify the nature of the conflict, make their ethical commitments known, and to the extent feasible, resolve the conflict consistent with those commitments (Ethics Code, Standard 1.03).

Record keeping practices may depend upon the nature of the psychologist’s legal relationship with the organization. In some settings, the physical record of psychological services is owned by the organization and does not travel with the psychologist upon departure. However, in consultative relationships, record ownership and responsibility may be maintained by the psychologist. It is therefore helpful for psychologists to clarify these issues at the beginning of the relationship in order to minimize the likelihood of misunderstandings.

Often, rules for record creation and maintenance reflect requirements of all relevant disciplines, not only those related to psychological services. Treatment team involvement in service delivery may occasion wider access to records than usually exists in independent practice settings. Because others (e.g., physicians, nurses, paraprofessionals, and other service providers) may have access to and make entries into the client’s record, the psychologist has less direct control over the record. Psychologists are encouraged to participate in development and refinement of organizational policies involving record keeping.

It is important to note that multidisciplinary records may not enjoy the same level of confidentiality generally afforded psychological records. The psychologist working in these settings is encouraged to be sensitive to this wider access to the information and to record only information congruent with organizational requirements and necessary to accurately portray the services provided. In this situation, if permitted by institutional rules and legal and regulatory requirements, the psychologist may keep more sensitive information, such as therapy notes, in a separate and confidential file.10

Guideline 10—Record Keeping in Organizational Settings: Psychologists working in organizational settings (e.g., hospitals, schools, community agencies, prisons) strive to follow the record keeping policies and procedures of the organization as well as the APA Ethics Code.

Rationale

Organizational settings may present unique challenges in record keeping. Organizational record keeping requirements may differ substantially from procedures in other settings. Psychologists working in organizational settings may encounter conflicts between the practices of their organization and established professional guidelines, ethical standards, or legal and regulatory requirements. Additionally, record ownership and responsibility is not always clearly defined. Often, multiple service providers access and contribute to the record. This potentially affects the degree to which the psychologist may exercise control of the record and its confidentiality.

Application

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It is important to note that multidisciplinary records may not enjoy the same level of confidentiality generally afforded psychological records. The psychologist working in these settings is encouraged to be sensitive to this wider access to the information and to record only information congruent with organizational requirements and necessary to accurately portray the services provided. In this situation, if permitted by institutional rules and legal and regulatory requirements, the psychologist may keep more sensitive information, such as therapy notes, in a separate and confidential file.10

The reader may wish to consult the HIPAA Security Rule for further guidance on this issue.

See the HIPAA Security Rule.

In order for therapy notes to have heightened protection as “psychotherapy notes” as defined by the HIPAA Privacy Rule, the notes must be kept separate from the rest of the record. If they are psychotherapy notes, only the psychologist who took the notes can access them, absent a HIPAA complaint authorization from the client (for more details regarding the Privacy Rule, see Standards for Privacy of Individually Identifiable Health Information, 2002).
Guideline 11—Multiple Client Records: The psychologist carefully considers documentation procedures when conducting couple, family, or group therapy in order to respect the privacy and confidentiality of all parties.

Rationale

In providing services to multiple clients, issues of record keeping may become very complex. Because records may include information about more than one individual client, legitimate disclosure of information regarding one client may compromise the confidentiality of other clients.

Application

The psychologist strives to keep records in ways that facilitate authorized disclosures while protecting the privacy of clients. In services involving multiple individuals, it may be important to specify the identified client(s) (Ethics Code, Standards 10.02 and 10.03).

There are a number of further concerns regarding record keeping with multiple clients. First, the information provided to clients as part of the informed consent process at the onset of the professional relationship (Ethics Code, Standard 10.02) may include information about how the record is kept (e.g., jointly or separately) and who can authorize its release. In considering the creation of records for couple, family, or group therapy, the psychologist may first seek to clarify the identified client(s). In some situations, such as group therapy, it may make sense to create and maintain a complete and separate record for all identified clients. On the other hand, if a couple or family is the identified client, then one might keep a single record. This will vary depending upon practical concerns, ethical guidelines, and third-party reporting requirements. Upon later requests for release of records, it will be necessary to release only the portions relevant to the party covered by the release. Given this possibility, the psychologist may choose to keep separate records on each participant from the outset. The psychologist endeavors to become familiar with legal and regulatory requirements regarding the release of a record containing information about multiple clients.

Guideline 12—Financial Records: The psychologist strives to ensure accuracy of financial records.

Rationale

Accurate and complete financial record keeping helps to ensure accuracy in billing (Ethics Code, Standards 6.04 and 6.06). A fee agreement or policy, although not explicitly required for many kinds of psychological services such as preemployment screening under agency contract or emergency counseling services at a disaster site, provides a useful starting point in most service delivery contexts for documenting reimbursement of services. Accurate financial records not only assist payers in assessing the nature of the payment obligation but also provide a basis for understanding exactly which services have been billed and paid. Up-to-date record keeping can alert the psychologist and the client to accumulating balances that, left unaddressed, may adversely affect the professional relationship.

Application

Financial records may include, as appropriate, the type and duration of the service rendered, the name of the client, fees paid for the service, and agreements concerning fees, along with date, amount, and source of payment received. Special consideration may be given to fee agreements and policies, barter agreements, issues relating to adjusting balances, issues concerning copayments, and concerns about collection.

Fee agreement or fee policy. The financial record for services may begin with a fee agreement or fee policy statement that identifies the amount to be charged for service and the terms of any agreement for payment. The record may potentially include who is responsible for payment, how missed appointments will be handled, acknowledgment of any third-party payer preauthorization requirements, any agreement regarding copayment and adjustments to be made, payment schedule, interest to accrue on unpaid balance, suspension of confidentiality when collection procedures are employed, and the methods by which financial disputes may be resolved (Ethics Code, Standard 6.04).

Barter agreements and transactions. Accurately recording bartering agreements and transactions helps ensure that the record clearly reflects how the psychologist was compensated. Designation of the source, nature, and date of each financial or barter transaction facilitates clarification when needed regarding the exchange of goods for service. Because of the potential for the psychologist to have greater power in the negotiation of bartering agreements, careful documentation protects both the psychologist and the client. Such documentation may reflect the psychologist’s basis for concluding, at the onset, that the arrangement is neither exploitative nor clinically contraindicated (Ethics Code, Standard 6.05).

Adjustments to balance. It is helpful to designate the rationale for, description of, and date of any adjustments to the balance that are made as a result of agreement with a third-party payer or the client. This may reduce potential misunderstanding or perceived obligations that might affect the relationship.

Collection. Psychologists may consider including in the record information about collection efforts, including documentation of notification of the intention to use a collection service.
Guideline 13—Disposition of Records: The psychologist plans for transfer of records to ensure continuity of treatment and appropriate access to records when the psychologist is no longer in direct control, and in planning for record disposal, the psychologist endeavors to employ methods that preserve confidentiality and prevent recovery.11

Rationale

Client records are accorded special treatment in times of transition (e.g., separation from work, relocation, death). A record transfer plan is required by both the Ethics Code (Standard 6.02), and by laws and regulations governing health care practice in many jurisdictions. Such a plan provides for continuity of treatment and preservation of confidentiality. Additionally, the Ethics Code (Standards 6.01 and 6.02) requires psychologists to dispose of records in a way that preserves their confidentiality.

Application

The psychologist has two responsibilities in relation to the transfer and disposal of records. In anticipation of unexpected events, such as disability, death, or involuntary withdrawal from practice, the psychologist may wish to develop a disposition plan in which provisions are made for the control and management of the records by a trained individual or agency. In other circumstances, when the psychologist plans in advance to leave employment, close a practice, or retire, similar arrangements may be made or the psychologist may wish to retain custody and control of client records.

In some circumstances, the psychologist may consider a method for notifying clients about changes in the custody of their records. This may be especially important for those clients whose cases are open or who have recently terminated services. The psychologist may consider including in the disposition plan, in accordance with legal and regulatory requirements, a provision for providing public notice about changes in the custody of the records, such as placing a notice in the local newspaper.

Considerations of record confidentiality are critical when planning for disposal of records. For example, in transporting records to be shredded, the psychologist may take care that confidentiality of the records is maintained. Some examples of this effort might be accompanying the records through the disposal process or establishing a confidentiality agreement with those responsible for records disposal. When considering methods of record destruction, the psychologist seeks methods, such as shredding, that prevent recovery. Disposal of electronic records poses unique challenges because the psychologist may not have the technical expertise to fully delete or erase records, for example, before disposing of a computer hard drive, external back-up storage device, or other repository for electronic records. Even though efforts to delete or erase records may be undertaken, the records may nevertheless remain accessible by those with specialized expertise. The psychologist may seek consultation from technical consultants regarding adequate methods for destruction of electronic records, such as physically destroying the entire medium or wiping clean (demagnetizing) the storage device.12

Conclusion

These “Record Keeping Guidelines” provide a framework for keeping, maintaining, and providing for the disposition of records and what is contained in them. They discuss special situations: electronic records, organizational settings, and multiple clients. They are intended to benefit both the psychologist and the client by facilitating continuity and evaluation of services, preserving the client’s privacy, and protecting the psychologist and client in legal and ethical proceedings.

These guidelines do not establish rules for practice, but rather provide an overall conceptual model and strategies for resolving divergent considerations. The demands of professional settings are varied and complex. It would not be feasible to establish detailed guidelines for record creation, maintenance, and disposition that would be relevant for each setting. The current document may provide useful guidance for various professional applications. Where standards and legal and regulatory codes exist, they take precedence over these guidelines.

Record Keeping Guidelines Bibliography

The authors considered the following reference materials and relied upon those with obvious authority (for example, the APA Ethics Code and HIPAA) while also consulting those that provided relevant guidance (APA guidelines; professional publications). This is not an exhaustive list of sources that psychologists may find useful in determining the best course of action in record keeping, and it is not intended to be representative of the entire body of knowledge that can guide decision making. It does represent, however, a solid basis for consideration that, in combination with state and federal regulations, may provide an adequate framework for record keeping.

11 See the HIPAA Security Rule.

12 See the HIPAA Security Rule requirements for the disposal of electronic records.

GENERAL REFERENCES

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INTRODUCTION

In the past 50 years forensic psychological practice had expanded dramatically. The American Psychological Association has a division devoted to matters of law and psychology (APA Division 41, the American Psychology-Law Society), a number of scientific journals devoted to interactions between psychology and the law exist (e.g., Law and Human Behavior, Psychology, Public Policy and Law, Behavioral Sciences and the Law), and a number of key texts have been published and undergone multiple revisions (e.g., Grisso, 1986, 2003; Melton, Petrila, Poythress, & Slobogin, 1987, 1997; Melton, Petrila, Poythress, Slobogin, Lyons, & Otto, 2007; Rogers, 1988, 1997, 2008). In addition, training in forensic psychology is available in pre-doctoral, internship and post-doctoral settings, and the American Psychological Association recognized forensic psychology as a specialty in 2001, with subsequent re-certification in 2008.

Because the practice of forensic psychology differs in important ways from more traditional practice areas (Monahan, 1980) the Specialty Guidelines for Forensic Psychologists were developed and published in 1991 (Committee on Specialty Guidelines for Forensic Psychologists, 1991). Because of continued developments in the field in the ensuing 20 years, forensic practitioners’ ongoing need for guidance, and policy requirements of the American Psychological Association, the 1991 Specialty Guidelines for Forensic Psychologists were revised, with the intent of benefitting forensic practitioners and recipients of their services alike.

The goals of these Guidelines are to improve the quality of forensic psychological services; enhance the practice and facilitate the systematic development of forensic psychology; encourage a high level of quality in professional practice; and encourage forensic practitioners to acknowledge and respect the rights of those they serve. These Guidelines are intended for use by psychologists when engaged in the practice of forensic psychology as described below, and may also provide guidance on professional conduct to the legal system, and other organizations and professions.

For the purposes of these Guidelines, forensic psychology refers to professional practice by any psychologist working within any sub-discipline of psychology (e.g., clinical, developmental, social, cognitive) when applying the scientific, technical, or specialized knowledge of psychology to the law to assist in addressing legal, contractual, and administrative matters. Application of the Guidelines does not depend on the practitioner’s typical areas of practice or expertise, but rather on the service provided in the case at hand. These Guidelines apply in all matters in which psychologists provide expertise to judicial, administrative, and educational systems including, but not limited to, examining or treating persons in anticipation of or subsequent to legal, contractual, administrative, proceedings; offering expert opinion about psychological issues in the form of amicus briefs or testimony to judicial, legislative or administrative bodies; acting in an adjudicative capacity; serving as a trial consultant or otherwise offering expertise to attorneys, the courts, or others; conducting research in connection with, or in the anticipation of, litigation; or involvement in educational activities of a forensic nature.

Psychological practice is not considered forensic solely because the conduct takes place in, or the product is presented in, a tribunal or other judicial, legislative, or administrative forum. For example, when a party (such as a civilly or criminally detained individual) or another individual (such as a child whose parents are involved in divorce proceedings) is ordered into treatment with a practitioner, that treatment is not necessarily the practice of forensic psychology. In addition, psychological testimony that is solely based on the provision of psychotherapy and does not include psycholegal opinions is not ordinarily considered forensic practice.
For the purposes of these Guidelines, “forensic practitioner” refers to a psychologist when engaged in the practice of forensic psychology as described above. Such professional conduct is considered forensic from the time the practitioner reasonably expects to, agrees to, or is legally mandated to, provide expertise on an explicitly psycholegal issue. The provision of forensic services may include a wide variety of psycholegal roles and functions. For example, as researchers, forensic practitioners may participate in the collection and dissemination of data that are relevant to various legal issues. As advisors, forensic practitioners may provide an attorney with an informed understanding of the role that psychology can play in the case at hand. As consultants, forensic practitioners may explain the practical implications of relevant research, examination findings, and the opinions of other psycholegal experts. As examiners, forensic practitioners may assess an individual’s functioning and report findings and opinions to the attorney, a legal tribunal, an employer, an insurer, or others (American Psychological Association, 2010; American Psychological Association, 2011a). As treatment providers, forensic practitioners may provide therapeutic services tailored to the issues and context of a legal proceeding. As mediators or negotiators, forensic practitioners may serve in a third-party neutral role and assist parties in resolving disputes. As arbitrers, special masters, or case managers with decision-making authority, forensic practitioners may serve parties, attorneys, and the courts (American Psychological Association, 2011b).

These guidelines are informed by the American Psychological Association’s (APA’s) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the EPPCC; APA, 2002). The term guidelines refers to statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and facilitate a high level of practice by psychologists. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional situation. They are not definitive, and they are not intended to take precedence over the judgment of psychologists.

As such, the Guidelines are advisory in areas in which the forensic practitioner has discretion to exercise professional judgment that is not prohibited or mandated by the EPPCC or applicable law, rules, or regulations. The Guidelines neither add obligations to nor eliminate obligations from the EPPCC, but provide additional guidance for psychologists. The modifiers used in the Guidelines (e.g., reasonably, appropriate, potentially) are included in recognition of the need for professional judgment on the part of forensic practitioners; ensure applicability across the broad range of activities conducted by forensic practitioners; and reduce the likelihood of enacting an inflexible set of guidelines that might be inapplicable as forensic practice evolves. The use of these modifiers, and the recognition of the role of professional discretion and judgment, also reflects that forensic practitioners are likely to encounter facts and circumstances not anticipated by the Guidelines and they may have to act upon uncertain or incomplete evidence. The Guidelines may provide general or conceptual guidance in such circumstances. The Guidelines do not, however, exhaust the legal, professional, moral and ethical considerations that inform forensic practitioners, for no complex activity can be completely defined by legal rules, codes of conduct, and aspirational guidelines.

The Guidelines are not intended to serve as a basis for disciplinary action or civil or criminal liability. The standard of care is established by a competent authority not by the Guidelines. No ethical, licensure, or other administrative action or remedy, nor any other cause of action, should be taken solely on the basis of a forensic practitioner acting in a manner consistent or inconsistent with these Guidelines.

In cases in which a competent authority references the Guidelines when formulating standards, the authority should consider that the Guidelines attempt to identify a high level of quality in forensic practice. Competent practice is defined as the conduct of a reasonably prudent forensic practitioner engaged in similar activities in similar circumstances. Professional conduct evolves and may be viewed along a continuum of adequacy, and
“minimally competent” and “best possible” are usually different points along that continuum.

The Guidelines are designed to be national in scope and are intended to be consistent with state and federal law. In cases in which a conflict between legal and professional obligations occur, forensic practitioners make known their commitment to the EPPCC and the Guidelines and take steps to achieve an appropriate resolution consistent with the EPPCC and Guidelines.

The format of the Guidelines is different from most other practice guidelines developed under the auspices of APA. This reflects the history of the Guidelines as well as the fact that the Guidelines are considerably broader in scope than any other APA-developed guidelines. Indeed, these are the only APA-approved guidelines that address a complete specialty practice area. Despite this difference in format, the Guidelines function as all other APA guideline documents.

This document replaces the 1991 Specialty Guidelines for Forensic Psychologists which were approved by the American Psychology-Law Society, Division 41 of the American Psychological Association and the American Board of Forensic Psychology. The current revision has also been approved by the Council of Representatives of the American Psychological Association. Appendix I includes a discussion of the revision process, enactment, and current status of these Guidelines. Appendix II includes definitions and terminology as used for the purposes of these Guidelines.

1. RESPONSIBILITIES

1.01 Integrity

Forensic practitioners strive for accuracy, honesty, and truthfulness in the science, teaching, and practice of forensic psychology and they strive to resist partisan pressures to provide services in any ways that might tend to be misleading or inaccurate.

1.02 Impartiality and Fairness

When offering expert opinion to be relied upon by a decision maker, providing forensic therapeutic services, or teaching or conducting research, forensic practitioners strive for accuracy, impartiality, fairness, and independence (EPPCC Standard 2.01). Forensic practitioners recognize the adversarial nature of the legal system and strive to treat all participants and weigh all data, opinions, and rival hypotheses impartially.

When conducting forensic examinations, forensic practitioners strive to be unbiased and impartial, and avoid partisan presentation of unrepresentative, incomplete, or inaccurate evidence that might mislead finders of fact. This guideline does not preclude forceful presentation of the data and reasoning upon which a conclusion or professional product is based.

When providing educational services, forensic practitioners seek to represent alternative perspectives, including data, studies, or evidence on both sides of the question, in an accurate, fair and professional manner, and strive to weigh and present all views, facts, or opinions impartially.

When conducting research, forensic practitioners seek to represent results in a fair and impartial manner. Forensic practitioners strive to utilize research designs and scientific methods that adequately and fairly test the questions at hand, and they attempt to resist partisan pressures to develop designs or report results in ways that might be misleading or unfairly bias the results of a test, study, or evaluation.

1.03 Avoiding Conflicts of Interest

Forensic practitioners refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to impair their impartiality, competence, or effectiveness, or expose others with whom a professional relationship exists to harm (EPPCC Standard 3.06).
Forensic practitioners are encouraged to identify, make known, and address real or apparent conflicts of interest in an attempt to maintain the public confidence and trust, discharge professional obligations, and maintain responsibility, impartiality, and accountability (EPPCC Standard 3.06). Whenever possible, such conflicts are revealed to all parties as soon as they become known to the psychologist. Forensic practitioners consider whether a prudent and competent forensic practitioner engaged in similar circumstances would determine that the ability to make a proper decision is likely to become impaired under the immediate circumstances.

When a conflict of interest is determined to be manageable, continuing services are provided and documented in a way to manage the conflict, maintain accountability, and preserve the trust of relevant others (also see Section 4.02 below).

2. COMPETENCE

2.01 Scope of Competence

When determining one’s competence to provide services in a particular matter, forensic practitioners may consider a variety of factors including the relative complexity and specialized nature of the service, relevant training and experience, the preparation and study they are able to devote to the matter, and the opportunity for consultation with a professional of established competence in the subject matter in question. Even with regard to subjects in which they are expert, forensic practitioners may choose to consult with colleagues.

2.02 Gaining and Maintaining Competence

Competence can be acquired through various combinations of education, training, supervised experience, consultation, study, and professional experience. Forensic practitioners planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies that are new to them are encouraged to undertake relevant education, training, supervised experience, consultation, or study.

Forensic practitioners make ongoing efforts to develop and maintain their competencies (EPPCC Section 2.03). To maintain the requisite knowledge and skill, forensic practitioners keep abreast of developments in the fields of psychology and the law.

2.03 Representing Competencies

Consistent with the EPPCC, forensic practitioners adequately and accurately inform all recipients of their services (e.g., attorneys, tribunals) about relevant aspects of the nature and extent of their experience, training, credentials, and qualifications, and how they were obtained (EPPCC Standard 5.01).

2.04 Knowledge of the Legal System and the Legal Rights of Individuals

Forensic practitioners recognize the importance of obtaining a fundamental and reasonable level of knowledge and understanding of the legal and professional standards, laws, rules, and precedents that govern their participation in legal proceedings and that guide the impact of their services on service recipients (EPPCC Standard 2.01).

Forensic practitioners aspire to manage their professional conduct in a manner that does not threaten or impair the rights of affected individuals. They may consult with, and refer others to, legal counsel on matters of law. Although they do not provide formal legal advice or opinions, forensic practitioners may provide information about the legal process to others based on their knowledge and experience. They strive to distinguish this from legal opinions, however, and encourage consultation with attorneys as appropriate.

2.05 Knowledge of the Scientific Foundation for Opinions and Testimony

Forensic practitioners seek to provide opinions and testimony that are sufficiently based upon adequate scientific foundation, and reliable and valid principles and methods that have been applied appropriately to the facts of the case.
When providing opinions and testimony that are based on novel or emerging principles and methods, forensic practitioners seek to make known the status and limitations of these principles and methods.

2.06 Knowledge of the Scientific Foundation for Teaching and Research

Forensic practitioners engage in teaching and research activities in which they have adequate knowledge, experience, and education (EPPCC Standard 2.01), and they acknowledge relevant limitations and caveats inherent in procedures and conclusions (EPPCC Standard 5.01).

2.07 Considering the Impact of Personal Beliefs and Experience

Forensic practitioners recognize that their own cultures, attitudes, values, beliefs, opinions, or biases may affect their ability to practice in a competent and impartial manner. When such factors may diminish their ability to practice in a competent and impartial manner, forensic practitioners may take steps to correct or limit such effects, decline participation in the matter, or limit their participation in a manner that is consistent with professional obligations.

2.08 Appreciation of Individual and Group Differences

When scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, socioeconomic status, or other relevant individual and cultural differences affects implementation or use of their services or research, forensic practitioners consider the boundaries of their expertise, make an appropriate referral if indicated, or gain the necessary training, experience, consultation, or supervision (EPPCC Standard 2.01, American Psychological Association, 2003; American Psychological Association, 2004; American Psychological Association, 2011c; American Psychological Association, in press; American Psychological Association Task Force on Guidelines for Assessment and Treatment of Persons with Disabilities, 2011).

Forensic practitioners strive to understand how factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, socioeconomic status, or other relevant individual and cultural differences may affect and be related to the basis for people’s contact and involvement with the legal system.

Forensic practitioners do not engage in unfair discrimination based on such factors or on any basis proscribed by law (EPPCC Standard 3.01). They strive to take steps to correct or limit the effects of such factors on their work, decline participation in the matter, or limit their participation in a manner that is consistent with professional obligations.

2.09 Appropriate Use of Services and Products

Forensic practitioners are encouraged to make reasonable efforts to guard against misuse of their services and exercise professional discretion in addressing such misuses.

3. DILIGENCE

3.01 Provision of Services

Forensic practitioners are encouraged to seek explicit agreements that define the scope of, time-frame of, and compensation for their services. In the event that a client breaches the contract or acts in a way that would require the practitioner to violate ethical, legal or professional obligations, the forensic practitioner may terminate the relationship.

Forensic practitioners strive to act with reasonable diligence and promptness in providing agreed-upon and reasonably anticipated services. Forensic practitioners are not bound, however, to provide services not reasonably anticipated when retained, nor to provide every possible aspect or
variation of service. Instead, forensic practitioners may exercise professional discretion in determining the extent and means by which services are provided and agreements are fulfilled.

3.02 Responsiveness

Forensic practitioners seek to manage their workloads so that services can be provided thoroughly, competently, and promptly. They recognize that acting with reasonable promptness, however, does not require the forensic practitioner to acquiesce to service demands not reasonably anticipated at the time the service was requested, nor does it require the forensic practitioner to provide services if the client has not acted in a manner consistent with existing agreements, including payment of fees.

3.03 Communication

Forensic practitioners strive to keep their clients reasonably informed about the status of their services, comply with their clients’ reasonable requests for information, and consult with their clients about any substantial limitation on their conduct or performance that may arise when they reasonably believe that their clients expect a service that is not consistent with their professional obligations. Forensic practitioners attempt to keep their clients reasonably informed regarding new facts, opinions, or other potential evidence that may be relevant and applicable.

3.04 Termination of Services

The forensic practitioner seeks to carry through to conclusion all matters undertaken for a client unless the forensic practitioner-client relationship is terminated. When a forensic practitioner’s employment is limited to a specific matter, the relationship may terminate when the matter has been resolved, anticipated services have been completed, or the agreement has been violated.

4. RELATIONSHIPS

Whether a forensic practitioner-client relationship exists depends on the circumstances and is determined by a number of factors which may include the information exchanged between the potential client and the forensic practitioner prior to, or at the initiation of, any contact or service, the nature of the interaction, and the purpose of the interaction.

In their work, forensic practitioners recognize that relationships are established with those who retain their services (e.g., retaining parties, employers, insurers, the court) and those with whom they interact (e.g., examinees, collateral contacts, research participants, students). Forensic practitioners recognize that associated obligations and duties vary as a function of the nature of the relationship.

4.01 Responsibilities to Retaining Parties

Most responsibilities to the retaining party attach only after the retaining party has requested and the forensic practitioner has agreed to render professional services and an agreement regarding compensation has been reached. Forensic practitioners are aware that there are some responsibilities, such as privacy, confidentiality, and privilege that may attach when the forensic practitioner agrees to consider whether a forensic practitioner-retaining party relationship shall be established. Forensic practitioners, prior to entering into a contract, may direct the potential retaining party not to reveal any confidential or privileged information as a way of protecting the retaining party’s interest in case a conflict exists as a result of pre-existing relationships.

At the initiation of any request for service, forensic practitioners seek to clarify the nature of the relationship and the services to be provided including the role of the forensic practitioner (e.g., trial consultant, forensic examiner, treatment provider, expert witness, research consultant); which person or entity is the client; the probable uses of the services provided or information obtained; and any limitations to privacy, confidentiality, or privilege.
4.02 Multiple Relationships

A multiple relationship occurs when a forensic practitioner is in a professional role with a person and, at the same time or at a subsequent time, is in a different role with the same person; is involved in a personal, fiscal, or other relationship with an adverse party; at the same time is in a relationship with a person closely associated with or related to the person with whom the forensic practitioner has the professional relationship; or offers or agrees to enter into another relationship in the future with the person or a person closely associated with or related to the person (EPPCC Standard 3.05).

Forensic practitioners strive to recognize the potential conflicts of interest and threats to objectivity inherent in multiple relationships. Forensic practitioners are encouraged to recognize that some personal and professional relationships may interfere with their ability to practice in a competent and impartial manner and they seek to minimize any detrimental effects by avoiding involvement in such matters whenever feasible or limiting their assistance in a manner that is consistent with professional obligations.

4.02.01 Therapeutic-Forensic Role Conflicts

Providing forensic and therapeutic psychological services to the same individual or closely related individuals involves multiple relationships that may impair objectivity and/or cause exploitation or other harm. Therefore, when requested or ordered to provide either concurrent or sequential forensic and therapeutic services, forensic practitioners are encouraged to disclose the potential risk and make reasonable efforts to refer the request to another qualified provider. If referral is not possible, the forensic practitioner is encouraged to consider the risks and benefits to all parties and to the legal system or entity likely to be impacted, the possibility of separating each service widely in time, seeking judicial review and direction, and consulting with knowledgeable colleagues. When providing both forensic and therapeutic services, forensic practitioners seek to minimize the potential negative effects of this circumstance (EPPCC Standard 3.05).

4.02.02 Expert Testimony by Practitioners Providing Therapeutic Services

Providing expert testimony about a patient who is a participant in a legal matter does not necessarily involve the practice of forensic psychology even when that testimony is relevant to a psycholegal issue before the decision-maker. For example, providing testimony on matters such as a patient’s reported history or other statements, mental status, diagnosis, progress, prognosis, and treatment would not ordinarily be considered forensic practice even when the testimony is related to a psycholegal issue before the decision-maker. In contrast, rendering opinions and providing testimony about a person on psycholegal issues (e.g., criminal responsibility, legal causation, proximate cause, trial competence, testamentary capacity, the relative merits of parenting arrangements) would ordinarily be considered the practice of forensic psychology.

Consistent with their ethical obligations to base their opinions on information and techniques sufficient to substantiate their findings (EPPCC Standards 2.04, 9.01), forensic practitioners are encouraged to provide testimony only on those issues for which they have adequate foundation and only when a reasonable forensic practitioner engaged in similar circumstances would determine that the ability to make a proper decision is unlikely to be impaired. As with testimony regarding forensic examinees, the forensic practitioner strives to identify any substantive limitations that may affect the reliability and validity of the facts or opinions offered, and communicates these to the decision maker.

4.02.03 Provision of Forensic Therapeutic Services

Although some therapeutic services can be considered forensic in nature, the fact that therapeutic services are ordered by the court does not necessarily make them forensic.

In determining whether a therapeutic service should be considered the practice of forensic psychology, psychologists are encouraged to
consider the potential impact of the legal context on treatment, the potential for treatment to impact the psycholegal issues involved in the case, and whether another reasonable psychologist in a similar position would consider the service to be forensic and these Guidelines to be applicable.

Therapeutic services can have significant effects on current or future legal proceedings. Forensic practitioners are encouraged to consider these effects and minimize any unintended or negative effects on such proceedings or therapy when they provide therapeutic services in forensic contexts.

4.03 Provision of Emergency Mental Health Services to Forensic Examinees

When providing forensic examination services an emergency may arise that requires the practitioner to provide short term therapeutic services to the examinee in order to prevent imminent harm to the examinee or others. In such cases, the forensic practitioner is encouraged to limit disclosure of information and inform the retaining attorney, legal representative, or the court in an appropriate manner. Upon providing emergency treatment to examinees, forensic practitioners consider whether they can continue in a forensic role with that individual so that potential for harm to the recipient of services is avoided (EPPCC 3.04).

5. FEES

5.01 Determining Fees

When determining fees forensic practitioners may consider salient factors such as their experience providing the service, the time and labor required, the novelty and difficulty of the questions involved, the skill required to perform the service, the fee customarily charged for similar forensic services, the likelihood that the acceptance of the particular employment will preclude other employment, the time limitations imposed by the client or circumstances, the nature and length of the professional relationship with the client, the client’s ability to pay for the service, and any legal requirements.

5.02 Fee Arrangements

Forensic practitioners are encouraged to make clear to the client the likely cost of services whenever it is feasible, and make appropriate provisions in those cases in which the costs of services is greater than anticipated or the client’s ability to pay for services changes in some way.

Forensic practitioners seek to avoid undue influence that might result from financial compensation or other gains. Because of the threat to impartiality presented by the acceptance of contingent fees and associated legal prohibitions, forensic practitioners strive to avoid providing professional services on the basis of contingent fees. Letters of protection, financial guarantees, and other security for payment of fees in the future are not considered contingent fees unless payment is dependent on the outcome of the matter.

5.03 Pro Bono Services

Forensic psychologists recognize that some persons may have limited access to legal services as a function of financial disadvantage and strive to contribute a portion of their professional time for little or no compensation or personal advantage (EPPCC Principle E).

6. INFORMED CONSENT, NOTIFICATION AND ASSENT

Because substantial rights, liberties, and properties are often at risk in forensic matters, and because the methods and procedures of forensic practitioners are complex and may not be accurately anticipated by the recipients of forensic services, forensic practitioners strive to inform service recipients about the nature and parameters of the services to be provided (EPPCC Standards 3.04, 3.10).

6.01 Timing and Substance

Forensic practitioners strive to inform clients, examinees, and others who are the recipients of forensic services as soon as is feasible about the
nature and extent of reasonably anticipated forensic services.

In determining what information to impart, forensic practitioners are encouraged to consider a variety of factors including the person’s experience or training in psychological and legal matters of the type involved and whether the person is represented by counsel. When questions or uncertainties remain after they have made the effort to explain the necessary information, forensic practitioners may recommend that the person seek legal advice.

6.02 Communication with Those Seeking to Retain a Forensic Practitioner

As part of the initial process of being retained, or as soon thereafter as previously unknown information becomes available, forensic practitioners strive to disclose to the retaining party information that would reasonably be anticipated to affect a decision to retain or continue the services of the forensic practitioner. This disclosure may include, but is not limited to, the fee structure for anticipated services; prior and current personal or professional activities, obligations and relationships that would reasonably lead to the fact or the appearance of a conflict of interest; the forensic practitioner’s knowledge, skill, experience, and education relevant to the forensic services being considered, including any significant limitations; and the scientific bases and limitations of the methods and procedures which are expected to be employed.

6.03 Communication with Forensic Examinees

Forensic practitioners inform examinees about the nature and purpose of the examination (EPPCC Standard 9.03; American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 1999). Such information may include the purpose, nature, and anticipated use of the examination; who will have access to the information; associated limitations on privacy, confidentiality, and privilege including who is authorized to release or access the information contained in the forensic practitioner’s records; the voluntary or involuntary nature of participation, including potential consequences of participation or non-participation, if known; and, if the cost of the service is the responsibility of the examinee, the anticipated cost.

6.03.01 Persons Not Ordered or Mandated to Undergo Examination

If the examinee is not ordered by the court to participate in a forensic examination, the forensic practitioner seeks his or her informed consent (EPPCC Standards 3.10, 9.03). If the examinee declines to proceed after being notified of the nature and purpose of the forensic examination, the forensic practitioner may consider postponing the examination, advising the examinee to contact his or her attorney, and notifying the retaining party about the examinee’s unwillingness to proceed.

6.03.02 Persons Ordered or Mandated to Undergo Examination or Treatment

If the examinee is ordered by the court to participate, the forensic practitioner can conduct the examination over the objection, and without the consent, of the examinee (EPPCC Standards 3.10, 9.03). If the examinee declines to proceed after being notified of the nature and purpose of the forensic examination, the forensic practitioner may consider a variety of options including postponing the examination, advising the examinee to contact his or her attorney, and notifying the retaining party about the examinee’s unwillingness to proceed.

When an individual is ordered to undergo treatment but the goals of treatment are determined by a legal authority rather than the individual receiving services, the forensic practitioner informs the service recipient of the nature and purpose of treatment, and any limitations on confidentiality and privilege (EPPCC Standards 3.10, 10.01).
**6.03.03 Persons Lacking Capacity to Provide Informed Consent**

Forensic practitioners appreciate that the very conditions that precipitate psychological examination of individuals involved in legal proceedings can impair their functioning in a variety of important ways, including their ability to understand and consent to the evaluation process.

For examinees adjudicated or presumed by law to lack the capacity to provide informed consent for the anticipated forensic service, the forensic practitioner nevertheless provides an appropriate explanation, seeks the examinee's assent, and obtain appropriate permission from a legally authorized person, as permitted or required by law (EPPCC Standards 3.10, 9.03).

For examinees whom the forensic practitioner has concluded lack capacity to provide informed consent to a proposed, non-court-ordered service, but who have not been adjudicated as lacking such capacity, the forensic practitioner strives to take reasonable steps to protect their rights and welfare (EPPCC Standard 3.10). In such cases, the forensic practitioner may consider suspending the proposed service or notifying the examinee’s attorney or the retaining party.

**6.03.04 Evaluation of Persons Not Represented by Counsel**

Because of the significant rights that may be at issue in a legal proceeding, forensic practitioners carefully consider the appropriateness of conducting a forensic evaluation of an individual who is not represented by counsel. Forensic practitioners may consider conducting such evaluations or delaying the evaluation so as to provide the examinee with the opportunity to consult with counsel.

**6.04 Communication with Collateral Sources of Information**

Forensic practitioners disclose to potential collateral sources information that might reasonably be expected to inform their decisions about participating that may include, but may not be limited to, who has retained the forensic practitioner; the nature, purpose, and intended use of the examination or other procedure; the nature of and any limits on privacy, confidentiality, and privilege; and whether their participation is voluntary (EPPCC Standard 3.10).

**6.05 Communication in Research Contexts**

When engaging in research or scholarly activities conducted as a service to a client in a legal proceeding, forensic practitioners attempt to clarify any anticipated use of the research or scholarly product, disclose their role in the resulting research or scholarly products, and obtain whatever consent or agreement is required. In advance of any scientific study, forensic practitioners seek to negotiate with the client the circumstances under and manner in which the results may be made known to others. Forensic practitioners strive to balance the potentially competing rights and interests of the retaining party with the inappropriateness of suppressing data, for example, by agreeing to report the data without identifying the jurisdiction in which the study took place. Forensic practitioners represent the results of research in an accurate manner (EPPCC Standard 5.01).

**7. CONFLICTS IN PRACTICE**

In forensic psychology practice conflicting responsibilities and demands may be encountered. When conflicts occur, forensic practitioners seek to make the conflict known to the relevant parties or agencies, and consider the rights and interests of the retaining party or agencies in their attempts to resolve the conflict.

**7.01 Conflicts with Legal Authority**

When their responsibilities conflict with law, regulations, or other governing legal authority, forensic practitioners make known their commitment to the EPPCC, and take steps to resolve the conflict. In situations in which the EPPCC or Guidelines are in conflict with the law,
attempts to resolve the conflict are made in accordance with the EPPCC (EPPCC Standard 1.02).

When the conflict cannot be resolved by such means, forensic practitioners may adhere to the requirements of the law, regulations, or other governing legal authority, but only to the extent required and not in any way that violates a person’s human rights (EPPCC Standard 1.03).

Forensic practitioners are encouraged to consider the appropriateness of complying with court orders when such compliance creates potential conflicts with professional standards of practice.

7.02 Conflicts with Organizational Demands

When the demands of an organization with which they are affiliated or for whom they are working conflict with their professional responsibilities and obligations, forensic practitioners strive to clarify the nature of the conflict and, to the extent feasible, resolve the conflict in a way consistent with professional obligations and responsibilities (EPPCC Standard 1.03).

7.03 Resolving Ethical Issues with Fellow Professionals

When an apparent or potential ethical violation has caused, or is likely to cause, substantial harm, forensic practitioners are encouraged to take action appropriate to the situation and consider a number of factors including the nature and the immediacy of the potential harm; applicable privacy, confidentiality, and privilege; how the rights of the relevant parties may be affected by a particular course of action; and any other legal or ethical obligations (EPPCC Standard 1.04). Steps to resolve perceived ethical conflicts may include, but are not be limited to, obtaining the consultation of knowledgeable colleagues, obtaining the advice of independent counsel, and conferring directly with the client.

When forensic practitioners believe there may have been an ethical violation by another professional, an attempt is made to resolve the issue by bringing it to the attention of that individual, if that attempt does not violate any rights or privileges that may be involved, and if an informal resolution appears appropriate (EPPCC Standard 1.04). If this does not result in a satisfactory resolution, the forensic practitioner may have to take further action appropriate to the situation, including making a report to third parties of the perceived ethical violation (EPPCC Standard 1.05). In most instances, in order to minimize unforeseen risks to the party’s rights in the legal matter, forensic practitioners consider consulting with the client before attempting to resolve a perceived ethical violation with another professional.

8. PRIVACY, CONFIDENTIALITY, AND PRIVILEGE

Forensic practitioners recognize their ethical obligations to maintain the confidentiality of information relating to a client or retaining party, except insofar as disclosure is consented to by the client or retaining party, or required or permitted by law (EPPCC Standard 4.01).

8.01 Release of Information

Forensic practitioners are encouraged to recognize the importance of complying with properly noticed and served subpoenas or court orders directing release of information, or other legally proper consent from duly authorized persons, unless there is a legally valid reason to offer an objection. When in doubt about an appropriate response or course of action, forensic practitioners may seek assistance from the retaining client, retain and seek legal advice from their own attorney, or formally notify the drafter of the subpoena or order of their uncertainty.

8.02 Access to Information

If requested, forensic practitioners seek to provide the retaining party access to, and a meaningful explanation of, all information that is in their records for the matter at hand, consistent with the relevant law, applicable codes of ethics and professional standards, and institutional rules and
regulations. Forensic examinees typically are not provided access to the forensic practitioner’s records without the consent of the retaining party. Access to records by anyone other than the retaining party is governed by legal process, usually subpoena or court order, or by explicit consent of the retaining party. Forensic practitioners may charge a reasonable fee for the costs associated with the storage, reproduction, review, and provision of records.

8.03 Acquiring Collateral and Third Party Information

Forensic practitioners strive to access information or records from collateral sources with the consent of the relevant attorney or the relevant party, or when otherwise authorized by law or court order.

8.04 Use of Case Materials in Teaching, Continuing Education, and Other Scholarly Activities

Forensic practitioners using case materials for purposes of teaching, training, or research strive to present such information in a fair, balanced, and respectful manner. They attempt to protect the privacy of persons by disguising the confidential, personally identifiable information of all persons and entities who would reasonably claim a privacy interest; using only those aspects of the case available in the public domain; or obtaining consent from the relevant clients, parties, participants, and organizations to use the materials for such purposes (EPPCC Standard 4.07; also see Sections 11.06 and 11.07 of these guidelines).

9. METHODS AND PROCEDURES

9.01 Use of Appropriate Methods

Forensic practitioners strive to utilize appropriate methods and procedures in their work. When performing examinations, treatment, consultation, educational activities or scholarly investigations, forensic practitioners seek to maintain integrity by examining the issue or problem at hand from all reasonable perspectives and seek information that will differentially test plausible rival hypotheses.

9.02 Use of Multiple Sources of Information

Forensic practitioners ordinarily avoid relying solely on one source of data, and corroborate important data whenever feasible (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, in press). When relying upon data that have not been corroborated, forensic practitioners seek to make known the uncorroborated status of the data, any associated strengths and limitations, and the reasons for relying upon the data.

9.03 Opinions Regarding Persons Not Examined

Forensic practitioners recognize their obligations to only provide written or oral evidence about the psychological characteristics of particular individuals when they have sufficient information or data to form an adequate foundation for those opinions or to substantiate their findings (EPPCC Standard 9.01). Forensic practitioners seek to make reasonable efforts to obtain such information or data, and they document their efforts to obtain it. When it is not possible or feasible to examine individuals about whom they are offering an opinion, forensic practitioners strive to make clear the impact of such limitations on the reliability and validity of their professional products, opinions, or testimony.

When conducting a record review or providing consultation or supervision that does not warrant an individual examination, forensic practitioners seek to identify the sources of information on which they are basing their opinions and recommendations, including any substantial limitations to their opinions and recommendations.

10. ASSESSMENT

10.01 Focus on Legally Relevant Factors

Forensic examiners seek to assist the trier of fact to understand evidence or determine a fact in issue, and they provide information that is most relevant to the psycholegal issue. In reports and
testimony forensic practitioners typically provide information about examinees’ functional abilities, capacities, knowledge, and beliefs, and address their opinions and recommendations to the identified psycholegal issues (American Bar Association and American Psychological Association, 2008; Grisso, 1986, 2003; Heilbrun, Marczyk, DeMatteo, & Mack-Allen, 2007).

Forensic practitioners are encouraged to consider the problems that may arise by using a clinical diagnosis in some forensic contexts, and consider and qualify their opinions and testimony appropriately.

10.02 Selection and Use of Assessment Procedures

Forensic practitioners use assessment procedures in the manner and for the purposes that are appropriate in light of the research on or evidence of their usefulness and proper application (EPPCC Standard 9.02, American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, in press). This includes assessment techniques, interviews, tests, instruments, and other procedures and their administration, adaptation, scoring, and interpretation, including computerized scoring and interpretation systems.

Forensic practitioners use assessment instruments whose validity and reliability have been established for use with members of the population assessed. When such validity and reliability have not been established, forensic practitioners consider and describe the strengths and limitations of their findings. Forensic practitioners use assessment methods that are appropriate to an examinee's language preference and competence, unless the use of an alternative language is relevant to the assessment issues (EPPCC Standard 9.02).


When the validity of an assessment technique has not been established in the forensic context or setting in which it is being used, the forensic practitioner seeks to describe the strengths and limitations of any test results and explain the extrapolation of these data to the forensic context. Because of the many differences between forensic and therapeutic contexts, forensic practitioners consider and seek to make known that some examination results may warrant substantially different interpretation when administered in forensic contexts (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, in press).

Forensic practitioners consider and seek to make known that forensic examination results can be affected by factors unique to, or differentially present in, forensic contexts including response style, voluntariness of participation, and situational stress associated with involvement in forensic or legal matters (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, in press).

10.03 Appreciation of Individual Differences

When interpreting assessment results forensic practitioners consider the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational,
personal, linguistic, and cultural differences that might affect their judgments or reduce the accuracy of their interpretations (EPPCC Standard 9.06). Forensic practitioners strive to identify any significant strengths and limitations of their procedures and interpretations.

Forensic practitioners are encouraged to consider how the assessment process may be impacted by any disability an examinee is experiencing, make accommodations as possible, and consider such when interpreting and communicating the results of the assessment (American Psychological Association Task Force on Guidelines for Assessment and treatment of Persons with Disabilities, 2011).

10.04 Consideration of Assessment Settings

In order to maximize the validity of assessment results, forensic practitioners strive to conduct evaluations in settings that provide adequate comfort, safety and privacy.

10.05 Provision of Assessment Feedback

Forensic practitioners take reasonable steps to explain assessment results to the examinee or a designated representative in language they can understand (EPPCC Standard 9.10). In those circumstances in which communication about assessment results is precluded, the forensic practitioner explains this to the examinee in advance (EPPCC Standard 9.10).

Forensic practitioners seek to provide information about professional work in a manner consistent with professional and legal standards for the disclosure of test data or results, interpretation of data, and the factual bases for conclusions.

10.06 Documentation and Compilation of Data Considered

Forensic practitioners are encouraged to recognize the importance of documenting all data they consider with enough detail and quality to allow for reasonable judicial scrutiny and adequate discovery by all parties. This documentation includes, but is not limited to, letters and consultations; notes, recordings, and transcriptions; assessment and test data, scoring reports and interpretations; and all other records in any form or medium that were created or exchanged in connection with a matter.

When contemplating third party observation or audio/video-recording of examinations forensic practitioners strive to consider any law that may control such matters, the need for transparency and documentation, and the potential impact of observation or recording on the validity of the examination and test security (American Psychological Association Committee on Psychological Tests and Assessment, 2007).

10.07 Provision of Documentation

Pursuant to proper subpoenas or court orders, or other legally proper consent from authorized persons, forensic practitioners seek to make available all documentation described in 10.05, all financial records related to the matter, and any other records including reports (and draft reports if they have been provided to a party, attorney, or other entity for review), that might reasonably be related to the opinions to be expressed.

10.08 Recordkeeping

Forensic practitioners establish and maintain a system of recordkeeping and professional communication (EPPCC Standard 6.01; American Psychological Association, 2007), and attend to relevant laws and rules. When indicated by the extent of the rights, liberties, and properties that may be at risk, the complexity of the case, the amount and legal significance of unique evidence in the care and control of the forensic practitioner, and the likelihood of future appeal, forensic practitioners strive to inform the retaining party of the limits of recordkeeping times. If requested to do so, forensic practitioners consider maintaining such records until notified that all appeals in the matter have been exhausted, or sending a copy of any unique components/aspects of the record in their care and control to the retaining party before destruction of the record.
11. PROFESSIONAL AND OTHER PUBLIC COMMUNICATIONS

11.01 Accuracy, Fairness, and Avoidance of Deception

Forensic practitioners make reasonable efforts to ensure that the products of their services, as well as their own public statements and professional reports and testimony, are communicated in ways that promote understanding and avoid deception (EPPCC Standard 5.01).

When in their role as expert to the court or other tribunals, the role of forensic practitioners is to facilitate understanding of the evidence or dispute. Consistent with legal and ethical requirements, forensic practitioners do not distort or withhold relevant evidence or opinion in reports or testimony. When responding to discovery requests and providing sworn testimony, forensic practitioners strive to have readily available for inspection all data which they considered, regardless of whether the data supports their opinion, subject to and consistent with court order, relevant rules of evidence, test security issues, and professional standards (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, in press; American Psychological Association Committee on Legal Issues, 2006; Bank & Packer, 2007; Golding, 1990).

When providing reports and other sworn statements or testimony in any form, forensic practitioners strive to present their conclusions, evidence, opinions, or other professional products in a fair manner. Forensic practitioners do not, by either commission or omission, participate in misrepresentation of their evidence, nor do they participate in partisan attempts to avoid, deny or subvert the presentation of evidence contrary to their own position or opinion (EPPCC Standard 5.01). This does not preclude forensic practitioners from forcefully presenting the data and reasoning upon which a conclusion or professional product is based.

11.02 Differentiating Observations, Inferences, and Conclusions

In their communications, forensic practitioners strive to distinguish observations, inferences, and conclusions. Forensic practitioners are encouraged to explain the relationship between their expert opinions and the legal issues and facts of the case at hand.

11.03 Disclosing Sources of Information and Bases of Opinions

Forensic practitioners are encouraged to disclose all sources of information obtained in the course of their professional services, and to identify the source of each piece of information that was considered and relied upon in formulating a particular conclusion, opinion or other professional product.

11.04 Comprehensive and Accurate Presentation of Opinions in Reports and Testimony

Consistent with relevant law and rules of evidence, when providing professional reports and other sworn statements or testimony, forensic practitioners strive to offer a complete statement of all relevant opinions that they formed within the scope of their work on the case, the basis and reasoning underlying the opinions, the salient data or other information that was considered in forming the opinions, and an indication of any additional evidence that may be used in support of the opinions to be offered. The specific substance of forensic reports is determined by the type of psycholegal issue at hand as well as relevant laws or rules in the jurisdiction in which the work is completed.

Forensic practitioners are encouraged to limit discussion of background information that does not bear directly upon the legal purpose of the examination or consultation. Forensic practitioners avoid offering information that is irrelevant and that does not provide a substantial basis of support for their opinions, except when required by law (EPPCC Standard 4.04).
11.05 Commenting Upon Other Professionals and Participants in Legal Proceedings

When evaluating or commenting upon the work or qualifications of other professionals involved in legal proceedings, forensic practitioners seek to represent their disagreements in a professional and respectful tone, and base them on a fair examination of the data, theories, standards and opinions of the other expert or party. When describing or commenting upon clients, examinees, or other participants in legal proceedings, forensic practitioners strive to do so in a fair and impartial manner. Forensic practitioners strive to report the representations, opinions, and statements of clients, examinees, or other participants in a fair and impartial manner.

11.06 Out of Court Statements

Ordinarily, forensic practitioners seek to avoid making detailed public (out-of-court) statements about legal proceedings in which they have been involved. However, sometimes public statements may serve important goals such as educating the public about the role of forensic practitioners in the legal system, the appropriate practice of forensic psychology, and psychological and legal issues that are relevant to the matter at hand. When making public statements, forensic practitioners refrain from releasing private, confidential, or privileged information, and attempt to protect persons from harm, misuse, or misrepresentation as a result of their statements (EPPCC Standard 4.05).

11.07 Commenting Upon Legal Proceedings

Forensic practitioners strive to address particular legal proceedings in publications or communications only to the extent that the information relied upon is part of a public record, or when consent for that use has been properly obtained from any party holding any relevant privilege (also see Section 8.04).

When offering public statements about specific cases in which they have not been involved, forensic practitioners offer opinions for which there is sufficient information or data and make clear the limitations of their statements and opinions resulting from having had no direct knowledge of or involvement with the case (EPPCC Standard 9.01).
References


APPENDIX I: BACKGROUND OF THE GUIDELINES AND THE REVISION PROCESS

A. History of the Guidelines

The previous version of the *Specialty Guidelines for Forensic Psychologists* (Committee on Ethical Guidelines for Forensic Psychologists, 1991) was approved by the American Psychology-Law Society, Division 41 of the American Psychological Association, and the American Academy of Forensic Psychology in 1991. The current revision, now called the *Specialty Guidelines for Forensic Psychology* (referred to as *Guidelines* throughout this document), replace the 1991 *Specialty Guidelines for Forensic Psychologists*.

B. Revision Process

This revision of the *Guidelines* was coordinated by the Committee for the Revision of the Specialty Guidelines for Forensic Psychology, which was established by the American Academy of Forensic Psychology and the American Psychology-Law Society (Division 41 of the American Psychological Association) in 2002 and operated through 2011. This Committee consisted of two representatives from each organization (Solomon Fulero, PhD, JD, Stephen Golding, PhD, ABPP, Lisa Piechowski, PhD, ABPP, Christina Studebaker, PhD) a Chairperson (Randy Otto, PhD, ABPP), and a liaison from APA Division 42 (Jeffrey Younggren, PhD, ABPP).

This document was revised in accordance with American Psychological Association Rule 30.08 and the APA policy document *Criteria for the development and evaluation of practice guidelines* (APA, 2001). The Committee posted announcements regarding the revision process to relevant electronic discussion lists and professional publications (i.e., Psylaw-L email listserve, American Academy of Forensic Psychology listserve, American Psychology-Law Society Newsletter). In addition, an electronic discussion list devoted solely to issues concerning revision of the *Guidelines* was operated between December 2002 and July 2007, followed by establishment of an e-mail address in February 2008 (sgfp@yahoo.com). Individuals were invited to provide input and commentary on the existing *Guidelines* and proposed revisions via these means. In addition, two public meetings were held throughout the revision process at biennial meetings of the American Psychology-Law Society.

Upon development of a draft that the Revisions Committee deemed suitable, the revised *Guidelines* were submitted for review to the Executive Committee of the American Psychology-Law Society and Division 41 of the American Psychological Association, and to the American Board of Forensic Psychology. Once the revised *Guidelines* were approved by these two organizations, they were submitted to the American Psychological Association for review, commentary, and acceptance, consistent with the American Psychological Association’s Criteria for Practice Guideline Development and Evaluation (Committee on Professional Practice and Standards, 2001) and Rule 30-8. They were subsequently revised by the Revisions Committee and were adopted by the American Psychological Association Council of Representatives on August 3, 2011.

C. Developers and Support

The *Specialty Guidelines for Forensic Psychology* were developed by the American Psychology-Law Society (Division 41 of the American Psychological Association) and the American Academy of Forensic Psychology.

D. Current Status

These *Guidelines* are scheduled to expire August 3, 2021. After this date, users are encouraged to contact the American Psychological Association Practice Directorate to confirm that this document remains in effect.
APPENDIX II: DEFINITIONS AND TERMINOLOGY

For the purposes of these Guidelines:

**Appropriate**, when used in relation to conduct by a forensic practitioner means that, according to the prevailing professional judgment of competent forensic practitioners, the conduct is apt and pertinent and is considered befitting, suitable and proper for a particular person, place, condition, or function. “Inappropriate” means that, according to the prevailing professional judgment of competent forensic practitioners, the conduct is not suitable, desirable, or properly timed for a particular person, occasion, or purpose; and may also denote improper conduct, improprieties, or conduct that is discrepant for the circumstances.

**Agreement** refers to the objective and mutual understanding between the forensic practitioner and the person or persons seeking the professional service and/or agreeing to participate in the service. See also Assent, Consent, and Informed Consent.

**Assent** refers to the agreement, approval, or permission, especially regarding verbal or nonverbal conduct, that is reasonably intended and interpreted as expressing willingness, even in the absence of unmistakable consent. Forensic practitioners attempt to secure assent when consent and informed consent can not be obtained or when, because of mental state, the examinee may not be able to consent.

**Consent** refers to agreement, approval, or permission as to some act or purpose.

**Client** refers to the attorney, law firm, court, agency, entity, party, or other person who has retained, and who has a contractual relationship with, the forensic practitioner to provide services.

**Conflict of Interest** refers to a situation or circumstance in which the forensic practitioner’s objectivity, impartiality, or judgment may be jeopardized due to a relationship, financial, or any other interest that would reasonably be expected to substantially affect a forensic practitioner’s professional judgment, impartiality, or decision-making.

**Decisionmaker** refers to the person or entity with the authority to make a judicial decision, agency determination, arbitration award, or other contractual determination after consideration of the facts and the law.

**Examinee** refers to a person who is the subject of a forensic examination for the purpose of informing a decision maker or attorney about the psychological functioning of that examinee.

**Forensic Examiner** refers to a psychologist who examines the psychological condition of a person whose psychological condition is in controversy or at issue.

**Forensic Practice** refers to the application of the scientific, technical, or specialized knowledge of psychology to the law and the use of that knowledge to assist in resolving legal, contractual, and administrative disputes.

**Forensic Practitioner** refers to a psychologist when engaged in forensic practice.

**Forensic Psychology** refers to all forensic practice by any psychologist working within any sub-discipline of psychology (e.g., clinical, developmental, social, cognitive).

**Informed Consent** denotes the knowledgeable, voluntary, and competent agreement by a person to a proposed course of conduct after the forensic practitioner has communicated adequate information and explanation about the material risks and benefits of, and reasonably available alternatives to, the proposed course of conduct.

**Legal Representative** refers to a person who has the legal authority to act on behalf of another.

**Party** refers to a person or entity named in litigation, or who is involved in, or is witness to, an activity or relationship that may be reasonably anticipated to result in litigation.
Reasonable or Reasonably, when used in relation to conduct by a forensic practitioner, denotes the conduct of a prudent and competent forensic practitioner who is engaged in similar activities in similar circumstances.

Record or Written Record refers to all notes, records, documents, memorializations, and recordings of considerations and communications, be they in any form or on any media, tangible, electronic, hand-written, or mechanical, that are contained in, or are specifically related to, the forensic matter in question or the forensic service provided.

Retaining Party refers to the attorney, law firm, court, agency, entity, party, or other person who has retained, and who has a contractual relationship with, the forensic practitioner to provide services.

Tribunal denotes a court or an arbitrator in an arbitration proceeding, or a legislative body, administrative agency, or other body acting in an adjudicative capacity. A legislative body, administrative agency or other body acts in an adjudicative capacity when a neutral official, after the presentation of legal argument or evidence by a party or parties, renders a judgment directly affecting a party’s interests in a particular matter.

Trier of Fact refers to a court or an arbitrator in an arbitration proceeding, or a legislative body, administrative agency, or other body acting in an adjudicative capacity. A legislative body, administrative agency or other body acts in an adjudicative capacity when a neutral official, after the presentation of legal argument or evidence by a party or parties, renders a judgment directly affecting a party’s interests in a particular matter.
ETHICS GUIDELINES

THE UNITED STATES ASSOCIATION FOR
BODY PSYCHOTHERAPY

Approved October 2001
Revised September 2007
INTRODUCTION

The United States Association for Body Psychotherapy (USABP) is an association of body-oriented psychotherapists, allied somatic practitioners, and interns trained in related modalities. The purpose of the USABP is to support the practice and further evolution of the field of body psychotherapy.

Body psychotherapists recognize the intrinsic unity of the human being in our somatic nature. Body psychotherapists, therefore, work in ways that foster the integration of bodily sensation, thought, affect, and movement to promote more integral human functioning and the resolution of psychotherapeutic concerns. Body psychotherapeutic methods, including language, gesture and touch, when used in responsible, ethical and competent ways, make an essential contribution to the psychotherapeutic process by including the missing and often alienated aspects of our being which are rooted in our bodily nature and experience.

These ethical guidelines set forth the principles and standards which guide the practice of this profession. These principles and standards represent a cumulative lived wisdom in the field of body psychotherapy. They are not meant to be all-inclusive. The principles in this code are intended to be aspirational, while the standards are directive. Members of the USABP seek consultation with health care and other professionals, and consider cultural and contextual factors, other certification and licensure regulations for their professions, state and federal laws, and the dictates of their own consciences when determining ethical conduct.

Body psychotherapists recognize their ethical responsibility to maintain the standards of conduct and care, and of personal and professional development. Thus, body psychotherapists commit themselves to the continual examination of their actions, motives and attitudes in their professional relationships to support the safety and welfare of their clients and to nurture the effective practice of their profession. Body psychotherapists likewise expect, encourage and support ethical behavior and self-examination from their students, supervisees, employees, and colleagues.

GENERAL PRINCIPLES OF BODY PSYCHOTHERAPISTS

Principle A: Competence

Body psychotherapists strive to maintain high standards of competence in their work and to recognize the boundaries of their competence and the limitations of their expertise. Body psychotherapists recognize the need for ongoing education and keep abreast of and utilize scientific, professional, technical and administrative resources to inform their work with clients.

Principle B: Integrity

Body psychotherapists seek to promote integrity in the science, art, teaching, and practice of body psychotherapy. In these activities, body psychotherapists strive to be honest, fair and respectful of others and to be aware of their own belief systems, values, needs, and limitations and the effect of these on their work.

Principle C: Professional and Scientific Responsibility

Body psychotherapists are committed to upholding professional standards of conduct; clarifying their professional roles and obligations; accepting appropriate responsibility for their behavior; and adapting their methods to the needs of different clients. When undertaking research, Body psychotherapists strive to advance human welfare and the science and art of Body psychotherapy. They try to avoid misuse of their work. They recognize the need to consult with, refer to, and cooperate with other professionals and institutions to the extent necessary to serve the best interests of their patients, clients or other recipients of their services.

Principle D: Respect For People's Rights And Dignity

Body psychotherapists strive to be respectful of the fundamental rights, dignity and worth of people. Body psychotherapists are aware of cultural, individual, and role differences and strive to be non-discriminatory regarding age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, and socio-economic factors. They respect the rights of individuals to privacy, confidentiality, self-determination, and autonomy.
Principle E: Concern for Others’ Welfare

Body psychotherapists seek to contribute to the welfare of those with whom they interact professionally. In their professional actions, they weigh the welfare and rights of their patients or clients, students, supervisees, human research participants, and other affected persons and the welfare of animal subjects of research. Body psychotherapists are sensitive to real and ascribed differences in power between others and themselves and they strive not to exploit or mislead people before, during or after professional relationships.

Principle F: Social Responsibility

Body psychotherapists are aware of their professional and scientific responsibilities to the community and the society in which they work and live. They apply and make public their professional knowledge in order to contribute to human welfare. They are concerned about and work to mitigate the causes and effects of human suffering. They encourage the development of law and social policy that serves the interests of their patients, clients and the public. They consider the realities of social injustice, and strive to have a positive impact on these concerns, as professionals and as individuals.

Principle G: Adherence to Professional Codes, and to Local, State, Federal Law

Members of USABP follow the principles and guidelines outlined in this code. They also comply with local, state and federal law and regulations regarding professional practice, as well as codes of ethics of their professional associations, organizations, and accrediting boards. Where there are variations in codes or guidelines, * licensed practitioners, who are bound by other ethical codes, strive to balance the requirements of the various codes in a way that best embodies ethical behavior and resolves the conflict in a responsible manner. If the conflict is unresolvable, the body psychotherapist adheres to the requirements of the law, regulations, or other governing legal authority.

ETHICAL STANDARDS

I. COMPETENCE

Practitioners seek to perform their responsibilities at the highest level of competence. In areas of practice where professional standards are in evolution, they obtain adequate training and utilize appropriate consultation in order to protect the welfare of those with whom they work. They refer clients to appropriate professionals in their own as well as other fields of expertise as needed.

1. Body psychotherapists do not diagnose, treat or advise on concerns outside the recognized boundaries of their competence. Recognizing the limitations of their expertise, they only provide those services and use those techniques for which they are qualified by education, training and experience.

2. Body psychotherapists provide services, teach or conduct research in new areas or involving new techniques only after first undertaking appropriate study, training, supervision, and/or consultation from persons who are competent in those areas or techniques. If they are forging new paradigms, they proceed with caution and seek appropriate advice and support as needed and obtain appropriate informed consent.

3. Body psychotherapists strive to remain reasonably current regarding new developments in body psychotherapeutic knowledge and practice through educational activities, supervision and/or consultation. They obtain professional or peer supervision/consultation as a standard part of professional practice.

4. Body psychotherapists seek appropriate professional assistance for personal problems or conflicts that may impair work performance or clinical judgment.

5. As teachers/supervisors/researchers dedicated to high standards of scholarship and the presentation of accurate information, body psychotherapists make every effort to present accurate and cogent information to students, supervisees, colleagues, and the public and to prevent the distortion or misuse of their clinical and
research findings. They rely on scientifically and professionally derived knowledge in their teaching practice. They present themselves and the field accurately and professionally to the public.

6. When presenting information that lies outside the boundaries of the generally recognized professional and/or scientific knowledge base, body psychotherapists so identify it, specify the database on which the information rests, and provide access to that database should it not be generally available.

II. INTEGRITY

Body psychotherapists seek to promote integrity in the science, art, teaching, and practice of body psychotherapy. In these activities, body psychotherapists strive to be honest, fair and respectful of others and to be aware of their own belief systems, values, needs, and limitations and the effect of these on their work.

1. Body psychotherapists seek to communicate honestly and truthfully in all their public statements regarding their work and work-related activities. This includes their research, practice, or other work related activities or those of persons or organizations with which they are affiliated. Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant and credentialing applications, personal resumes or curriculum vitae, or comments for use in the media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations and published materials. Body psychotherapists do not knowingly make public statements that are false, deceptive, or fraudulent.

2. Body psychotherapists communicate honestly and truthfully concerning their training, experience, and competence. Likewise they make truthful and accurate statements regarding their credentials, their academic degrees, their institutional or association affiliations, their services, the scientific or clinical basis for, or results or degrees of success of, their services, their fees, or their publications or research findings.

3. Body psychotherapists, in their reports to payors, accurately state the nature of the service provided or research conducted, the fees, charges, or payments, their academic degrees, and when applicable, the identity of the provider, the findings, and the diagnosis.

III. INFORMED CONSENT

Body psychotherapists provide services to clients only in the context of a professional relationship based on valid, on-going informed consent. Initial informed consent to use body psychotherapy is expected and should be updated and documented as appropriate during the relationship. Informed consent requires that the person has the capacity to consent, has been informed of and understands necessary information concerning the course of their treatment, and that this consent has been given without undue influence.

1. Body psychotherapists use clear, understandable language to inform clients of the purpose of treatment, the risks related to treatment, reasonable alternatives to the proposed treatment, limits to the provision of treatment, and the right to seek a second opinion. Recommended additional topics for consent and/or discussion include but are not limited to: confidentiality and its limits, client's right to refuse or withdraw consent, nature of the business contract, health care benefits, fees, record keeping, termination, supervision, use of touch, complaint or disagreement process and contact information. Ample opportunity for the client to ask questions is provided.

2. In the event that a client is legally incapable of giving informed consent, body psychotherapists obtain informed permission from a legally authorized person, if applicable laws permit such substitute consent. When proceeding with substitute consent, they inform those legally unable to give informed consent about the proposed interventions in a manner commensurate with the person's mental and cognitive capacities, seek their agreement to those interventions, and take into account their preferences and best interests.

IV. AVOIDING HARM

Body psychotherapists avoid engaging in any activities which are harmful or exploitative or which could reasonably be expected to be harmful or exploitative. Body psychotherapists are sensitive to issues of possible
harm, solicit discussion of such situations, as appropriate, even when they are not directly raised by the client, and take appropriate action to prevent and minimize harm that might occur.

1. Body psychotherapists are professional in attitude and conduct, reliable about agreements and appointments. They are clear about their policies regarding cancellations and work within the frame of that agreement in good faith with their clients.

2. Sexual relationships between body psychotherapists and their clients are prohibited during the therapeutic relationship and for a minimum of 2 years following the termination of that professional relationship. A body psychotherapist who considers engaging in sexual intimacy with a former client after the 2 years following cessation or termination of treatment bears the burden of demonstrating that there has been no exploitation, in light of all relevant factors that would influence the client's ability to freely enter such a relationship.

3. Body psychotherapists do not engage in sexual intimacies with individuals they know to be the parents, guardians, spouses, partners, offspring, or siblings of current clients. Body psychotherapists do not terminate therapy to circumvent this rule.

4. Body psychotherapists do not accept as therapy clients persons with whom they have engaged in sexual intimacies.

5. Body psychotherapists refrain from engaging in any behavior which could reasonably be interpreted as harassment, sexual or non-sexual. They monitor their therapeutic relationships to ascertain if clients perceive any harassment and address that concern promptly.

6. Body psychotherapists make reasonable efforts to ensure continuity of treatment. When services must be terminated for a legitimate reason, the therapist makes every reasonable effort to insure that appropriate referrals are made for the ongoing needs of the client prior to termination and makes reasonable efforts to terminate the relationship satisfactorily.

7. Should a client desire to terminate the therapeutic relationship, body psychotherapists provide professional insights into the benefits and consequences of this course of action without explicit or implicit coercion to maintain the relationship against the client's wishes. At all times they make clear the client's right to terminate when he/she chooses.

8. Body psychotherapists seek appropriate consultation and/or supervision for any circumstance in which the ethics of their behavior comes into question.

V. MULTIPLE RELATIONSHIPS

Body Psychotherapists avoid exploitive multiple relationships. A multiple relationship occurs when a Body Psychotherapist is in a psychotherapeutic relationship with a person and is at the same time, or sequentially, in another relationship with the same person. Body Psychotherapists make a distinction between normally occurring community interactions and multiple relationships. Body Psychotherapists do not accept as a client anyone with whom they have had a sexual, close personal, or financial relationship or family or relatives of such persons. The boundaries of the therapeutic relationship should be clearly defined otherwise they have the potential to impair judgment, cause damage and undermine the purpose of the therapy.

1. Considerations about potential exploitation include the: nature and intensity of the professional relationship and of the secondary relationship, stage of therapy, amount of transference, degree of the role conflict, level of communication skills, and existence of an evaluative role.

2. Body Psychotherapists are aware of the differences in power that may exist in their relationships with clients, students and supervisees. Body Psychotherapists will be sensitive to the real and ascribed differences in power, be responsible for bringing potential issues into the awareness of those involved, and be available for reasonable processing with those involved.

3. In some situations, for example in small geographical or modality communities, a multiple relationship that is non-exploitive may be undertaken. In these cases, the Body Psychotherapist takes precautions to protect the client from exploitation and damage. Such precautions may include, but are not limited to, acknowledgment of the multiple relationship...
and its inherent risk to the client, ongoing dialogue, informed consent, documentation, and case consultation and/or supervision.

4. In the event that a Body Psychotherapist is providing services to several persons who have a relationship (partners, parents and children, siblings, families) the therapist attempts to clarify at the onset of the therapy, the relationship they will have with each individual. At any time, if it becomes apparent that the Body Psychotherapist is in multiple relationships which compromise the treatment situation or threaten to impair the objectivity or judgment of the therapist in any way, they clarify, adjust or withdraw from conflicting roles.

5. Barter is the acceptance of goods or services from clients in return for psychological services. Body Psychotherapists do not barter (including work exchange) unless the bartering arrangements are appropriate in the context of the therapeutic relationship, indicated by the needs of the client, and for the welfare of the client. Where bartering is used, the therapist and client make agreements in writing related to the exchange of goods or services to ensure that both understand the scope and limitations of the agreement. Body Psychotherapists consult or obtain supervision to ensure that the bartering arrangement is not harmful to the client, that the client is being given fair value in the exchange, and that no exploitation of and/or damage to the client is involved.

6. As teachers, Body Psychotherapists acknowledge that their relationships with students and/or supervisees include factors which often make avoiding multiple relationships difficult. They monitor their teaching and supervision relationships to ensure that they do not become exploitive and/or damaging. Body Psychotherapists do not have sexual relations with students or supervisees and do not subject them to sexual harassment.

VI. COLLEGIAL RELATIONSHIPS

Body psychotherapists maintain respect for colleagues. They refrain from the exploitation of professional relationships for personal gain, whether financial, personal, professional or for research purposes.

1. Body psychotherapists try to avoid entering into a therapeutic relationship with someone who is currently seeing another therapist without the knowledge of that therapist. However, they acknowledge that it is the clients’ right to seek out treatment which they feel best meets their needs. Body psychotherapists inform the client of the potential problems in precipitous terminations and urge them to complete the termination process with their former therapist if it will not be detrimental to the client to do so.

2. If it appears that a client has been abused in a former or concurrent professional relationship, body psychotherapists inform the client how to seek appropriate recourse.

3. The Ethical Guidelines of the USABP makes no attempt to limit the free speech of its members. In exercising their right to free speech, body psychotherapists ensure that their statements are professional and non-combative in tone, balanced and factually accurate.

4. If a body psychotherapist believes that there has been an ethical violation by a colleague, he/she may bring it to the attention of the individual and seek resolution provided such action does not violate any confidentiality rights. Colleagues should seek counsel, guidance, supervision, and consultations as needed in relation to the process and/or issues.

5. If disputes of a serious nature arise between body psychotherapists regarding professional matters, they utilize outside consultation if unable to settle the matter between themselves.

6. When involved in professional writing for publicity, for inclusion in training programs, or for publication in journals and books, body psychotherapists do not take credit for the intellectual work of others but accurately credit their sources and influences.

VII. PRIVACY AND CONFIDENTIALITY

Body psychotherapists have a primary obligation and responsibility to take precautions to respect the confidentiality of those with whom they work or consult.

1. Confidential information includes all information obtained in the context of the professional relationship. They
maintain the confidentiality of clients and former clients. Body psychotherapists take appropriate steps to protect their confidential information and to limit access by others to confidential information.

2. Body psychotherapists disclose confidential information without the consent of the client only as mandated by law, or where permitted by law. Such situations include, but may not be limited to: providing essential professional services to the client, obtaining appropriate professional consultation, or protecting the client or others from harm.

3. Unless unfeasible or contraindicated, the discussion of confidentiality and its limits occurs at the beginning of the professional relationship and thereafter as circumstances may warrant. When appropriate, body psychotherapists clarify at the beginning of treatment issues related to the involvement of third parties.

4. Body psychotherapists may disclose confidential information with the appropriate consent of the patient or the individual or organizational client (or of another legally authorized person on behalf of the patient or client), unless prohibited by law.

5. When agreeing to provide services to several persons who have a relationship (such as partners or parents and children), body psychotherapists attempt to clarify at the outset 1) which of the individuals are clients and 2) the relationship body psychotherapy will have with each person. This clarification includes the role of the body psychotherapist and the probable uses of the services provided or the information obtained.

6. If and when it becomes apparent that the body psychotherapist may be called on to perform potentially conflicting roles (such as marital counselor to husband and wife, and then witness for one party in a divorce proceeding), body psychotherapists attempt to clarify and adjust, or withdraw from, roles appropriately.

7. In cases where there is more than one person involved in treatment by the same therapist (such as with groups, families and couples), the therapist obtains an initial agreement with those involved concerning how confidential information will be handled both within treatment and with regard to third parties.

8. Body psychotherapists maintain and retain appropriate records as necessary to render competent care and as required by law or regulation.

9. Body psychotherapists are aware of the possible adverse effects of technological changes with respect to the confidential dissemination of patient information and take reasonable care to ensure secure and confidential transmission of such information.

10. Body psychotherapists take steps to protect the confidentiality of client records in their storage, transfer, and disposal. They conform to applicable state laws governing the length of storage and procedures for disposal.

11. Body psychotherapists take appropriate steps to ensure, as far as possible, that employees, supervisees, assistants, and volunteers maintain the confidentiality of clients. They take appropriate steps to protect the client's identity or to obtain prior, written authorization for the use of any identifying clinical materials in teaching, writing and public presentations.

12. When working with groups, body psychotherapists explain to participants the importance of maintaining confidentiality and obtain agreement from group participants to respect the confidentiality and privacy of other group members but they also inform group members that privacy and confidentiality cannot be guaranteed.

13. Body psychotherapists obtain written consent from clients/students before taping or filming any session, such consent to include the intended use of the material and the limits of confidentiality.

VIII. ETHICS OF TOUCH

The use of touch has a legitimate and valuable role as a body-oriented mode of intervention when used skillfully and with clear boundaries, sensitive application and good clinical judgment. Because use of touch may make clients especially vulnerable, body-oriented therapists pay particular attention to the potential for dependent, infantile or erotic transference and seek healthy containment rather than therapeutically inappropriate
accentuation of these states. Genital or other sexual touching by a therapist or client is always inappropriate, never appropriate.

1. Body psychotherapists evaluate the appropriateness of the use of touch for each client. They consider a number of factors such as the capacity of the client for genuine informed consent; the client's developmental capacity and diagnosis; the transferential potential of the client's personal history in relation to touch; the client's ability to usefully integrate touch experiences; and the interaction of the practitioner's particular style of touch work with the client's. They record their evaluations and consultation in the client's record.

2. Body psychotherapists obtain informed consent prior to using touch-related techniques in the therapeutic relationship. They make every attempt to ensure that consent for the use of touch is genuine and that the client adequately understands the nature and purposes of its use. As in all informed consent, written documentation of the consent is strongly recommended.

3. Body psychotherapists recognize that the client's conscious verbal and even written consent for touch, while apparently genuine, may not accurately reflect objections or problems with touch of which the client is currently unaware. Knowing this, body psychotherapists strive to be sensitive to the client's spoken and unspoken cues regarding touch, taking into account the particular client's capacity for authentic and full consent.

4. Body psychotherapists continue to monitor for ongoing informed consent to ensure the continued appropriateness of touch-based interventions. They maintain periodic written records of ongoing consent and consultation regarding any questions they or a client may have.

5. Body psychotherapists recognize and respect the right of the client to refuse or terminate any touch on the part of the therapist at any point, and they inform the client of this right.

6. Body psychotherapists recognize that, as with all aspects of the therapy, touch is only used when it can reasonably be predicted and/or determined to benefit the client. Touch may never be utilized to gratify the personal needs of the therapist, nor because it is seen as required by the therapist's theoretical viewpoint in disregard of the client's needs or wishes.

7. The application of touch techniques requires a high degree of internal clarity and integration on the part of the therapist. Body psychotherapists prepare themselves for the use of therapeutic touch through thorough training and supervision in the use of touch, receiving therapy that includes touch, and appropriate supervision or consultation should any issues arise in the course of treatment.

8. Body psychotherapists do not engage in genital or other sexual touching nor do they knowingly use touch to sexually stimulate a client. Therapists are responsible to maintain clear sexual boundaries in terms of their own behavior and to set limits on the client's behavior towards them which prohibits any sexual touching. Information about the therapeutic value of clear sexual boundaries in the use of touch is conveyed to the client prior to and during the use of touch in a manner that is not shaming or derogatory.

IX. EDUCATION AND TRAINING

Body psychotherapists who are responsible for education and training programs seek to ensure that the programs are competently designed and provide appropriate experiences and training to fulfill the stated objectives. They recognize the power they hold over students and supervisees and therefore make reasonable efforts to engage in conduct that is personally affirming and respectful toward students and supervisees.

1. Body psychotherapists attempt to ensure that any education and training programs for which they are responsible have accurate descriptions of the program content, training goals, objectives, and requirements that must be met for satisfactory admission to and completion of the program. This information is made readily available to all interested parties.

2. When engaged in teaching or training, educators present pertinent information accurately and objectively with
respectful critiques when appropriate. The educational content in their programs is based on information that has some form of valid, publicly available evidence and/or investigation behind it. Educational programs provide exposure to varied theoretical positions as well as scientifically and professionally derived knowledge.

3. Body psychotherapists establish appropriate processes for providing feedback to students and supervisees. They evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements. Additionally, they seek, encourage and utilize feedback from students and supervisees. This feedback may be written, verbal, formal, or informal.

4. When performing the role of teacher or trainer, body psychotherapists maintain a level of confidentiality appropriate for the teaching environment. Teachers and trainers discuss trainees and supervisees only in accord with publicly stated policy or mutual agreement and for the purpose of enriching the educational opportunities of the individual.

5. Body psychotherapists inform trainees and supervisees of the legal/ethical prohibition against representing themselves as competent to perform professional services beyond their level of training, experience or competence.

6. Educators must be able to present adequate credentials that demonstrate that their teaching is within their scope of learning and expertise.

X. RESEARCH

Body psychotherapists design, conduct and report research in accordance with recognized standards of scientific competence and ethics, minimizing the possibility that the results might be misleading. If an ethical issue is unclear, body psychotherapists resolve the issue through consultation with institutional review boards, peer consultations, or other proper mechanisms. They take reasonable steps to implement appropriate protections for the rights and welfare of human participants, other persons affected by the research, and animal subjects.

1. Body psychotherapists conduct research competently and with due concern for the dignity and welfare of the participants.

2. Body psychotherapists are responsible for the ethical conduct of research implemented by them or by others under their supervision.

3. Researchers and assistants are permitted to perform only those tasks for which they are appropriately trained and prepared.

4. As part of the process of development and implementation of research projects, body psychotherapists consult those with expertise concerning any special population under investigation or likely to be affected.

5. Body psychotherapists plan and conduct research in a manner consistent with federal and state law and regulations.

6. Prior to conducting any research (excluding anonymous surveys, naturalistic observations, or similar research) body psychotherapists enter into an agreement with participants that clarifies the nature of the research and the responsibilities of each party. They take special care to protect the prospective participants from adverse consequences of declining or withdrawing from participation. Whether research participation is an academic course requirement or a voluntary activity, the prospective participant is given the choice of equitable alternative activities.

7. Body psychotherapists use language that is understandable to research participants in obtaining their appropriate informed consent. Such informed consent is appropriately documented.

8. For persons who are certified legally incapable of giving informed consent, body psychotherapists provide an appropriate explanation, obtain the participant's assent, and obtain appropriate permission from a legally
authorized person, if such substitute consent is permitted by law.

9. When offering professional services as an inducement to research participants, body psychotherapists make clear the nature of the services, as well as the risks, obligations and limitations. They do not offer excessive or inappropriate financial or other inducements to obtain research participants, particularly when it might tend to coerce participation or distort the results.

10. Body psychotherapists never deceive research participants about aspects that would affect their willingness to participate, such as physical risks, discomfort or unpleasant emotional experiences. Any other deception that is an integral and necessary feature of the design and conduct of an experiment must be explained to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the research.

11. Body psychotherapists inform research participants of the anticipated sharing or further use of personally identifiable research data and of the possibility of unanticipated future uses.

12. Body psychotherapists provide a prompt, clear opportunity for participants to obtain appropriate information about the nature, results and conclusions of the research and make a good faith attempt to correct any misconceptions that participants may have. If scientific or humane values justify delaying or withholding this information, they take reasonable measures to reduce the risk of harm.

13. When conducting research involving animals, body psychotherapists treat them humanely. They ensure that all individuals using animals under their supervision have received instruction in research methods and in the care, maintenance and handling of the species being used, to the extent appropriate to their role.

14. Body psychotherapists do not fabricate data or falsify results in publications. If they discover significant errors in their published data, they take reasonable steps to correct such errors in every situation where the errors have material effect.

15. Body psychotherapists do not present substantial portions or elements of another's work or data as their own. When they do present aspects of another's work, they provide clear and obvious attribution.

16. Body psychotherapists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have contributed. (A student is usually listed as principal author on any multiple-authored article that is substantially based on the student's dissertation or thesis.)

17. When reviewing material that has been submitted for publication, grant or research proposal review, body psychotherapists respect the confidentiality and proprietary rights of the authors.

ADDENDUM
* When codes have differed in content the ethics committee has chosen to follow the code of the American Psychological Association. Portions of this code have been adapted from existing professional codes including: American Psychological Association, Ethical Principles of Psychologists and Code of Conduct; American Association for Marriage and Family Therapy Code of Ethics; The National Association of Social Workers Code of Ethics; The International Institute for Bioenergetic Analysis Code of Ethics; The Hakomi Institute Code of Ethics.
The 2008 NASW Delegate Assembly approved the following revisions to the NASW Code of Ethics:

1.05 Cultural Competence and Social Diversity

(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.

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.

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.

6.04 Social and Political Action

(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.

Preamble

The primary mission of the social work profession is to enhance human wellbeing 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 wellbeing in a social context and the wellbeing 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.*

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 wellbeing 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 wellbeing 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 wellbeing 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 wellbeing 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 wellbeing.

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 LaborManagement 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’ wellbeing, 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.
**Additional Sources**


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2. **DO NOT** bend or fold your Scan Evaluation Form.
3. Please make solid marks that fill the response completely without any stray marks.
4. Complete your first and last name in ALL CAPS (if you do not have enough space for your full name, simply use all boxes that are available.)
5. Write in your registration number in the appropriate box.
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8. Clearly mark all boxes appropriately.
9. Complete the back page of the evaluation; your Seminar Evaluation Objectives are on the following page for you.
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Seminar Evaluation Objectives

Avoiding Ethical & Legal Pitfalls in Mental Health Practice

Speaker: Bob Stinson, Psy.D., J.D., ABPP

The purpose/goal of this activity is to not put your clients or career at risk! This interactive workshop addresses crucial topics in mental health law and ethics, covering up-to-date regulations, state-specific standards, and an integrative, decision-making model for your practice.

Objectives:

1. Implement a decision-making model relevant to your practice and clients?

2. Discuss differences between ethics codes, regulatory rules, and laws; and how to access each?

3. Stay up-to-date on regulatory changes affecting your practice?

4. Determine when you can release confidential information and know how to respond in difficult situations (i.e. receive a subpoena)?

5. Outline mandatory reporting requirements?

6. Explain how to handle various medical record requests including those related to divorce, child custody, couples therapy, and/or requests which may not be in your client’s best interest?
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Avoiding Ethical and Legal Pitfalls in Mental Health Practice
Bob Stinson, Psy.D., J.D., ABPP

1. According to the APAIT, a professional liability insurance company, which of the following is the number one reason mental health professional might have a complaint or lawsuit filed against them
   a. Clinical Management
   b. Breach of Confidentiality
   c. Disgruntled Parents in Custody Disputes
   d. Mandatory Reporting Obligations

2. Which of the following is NOT a part of Koocher & Keith-Spiegel’s Ethics Decision Making Model?
   a. Decide whether the matter truly involves ethics
   b. Consult with a trusted colleague
   c. Generate alternative decisions
   d. Defer making a decision until you can assure no one will be harmed

3. Which of the following is in Pope & Vasquez’s ethics decision making model, but is not in Koocher & Keith-Spiegel’s?
   a. Consultation
   b. Generate alternative course of action
   c. Identify who, if anyone, is the client
   d. Make a decision

4. Which of the following statements is true?
   a. A deontological approach to problem solving is better than a consequentialism approach
   b. A consequentialism approach to problem solving is better than a deontological approach
   c. Both a deontological approach and a consequentialism approach to problem solving should be avoided
   d. Neither a deontological approach nor a consequentialism approach to problem solving is inherently better than the other
5. Which of the following ethical principles is known, generally, as “Do no harm”?  
   a. Nonmaleficence  
   b. Beneficence  
   c. Fidelity  
   d. Justice

6. True or False: If we study the ethics code governing our profession carefully enough, we will eventually find the single best solution to any ethics dilemma that can arise in our practice.  
   a. True  
   b. False

7. True or False: Ethical awareness is a passive process that just happens to us over time.  
   a. True  
   b. False

8. The following are created by administrative agencies, such as state licensing boards:  
   a. Laws  
   b. Regulations and Rules  
   c. Ethics Codes promulgated by national associations  
   d. None of the above

9. Elected legislators create:  
   a. Laws  
   b. Regulations and Rules  
   c. Ethics Codes promulgated by national associations  
   d. None of the above

10. Which of the following might be a good way to stay up to date on changes in the law in your jurisdiction?  
    a. Referring to your state board’s website  
    b. A lawyer  
    c. Both A & B  
    d. None of the above
11. Which of the following might be a good way to stay up to date on changes in your ethics code?
   a. Professional organizations
   b. Colleagues
   c. Both A & B
   d. None of the above

12. In making a clinical record, your record should be all of the following, EXCEPT:
   a. Legible
   b. Accurate
   c. Timely
   d. Void of separate sections

13. True or False: The clinical record is an appropriate place for you to make it known that you are providing good care.
   a. True
   b. False

14. True or False: Because the clinical record only exposes you to risk—and cannot help to manage your risk—you should always include as little information as possible.
   a. True
   b. False

15. True or False: If you do testing, you should not include raw test data as part of the clinical record.
   a. True
   b. False

16. Records should be maintained:
   a. At least as long as required by law
   b. No longer than required by law
   c. Longer than required by law unless your client requests early destruction
   d. As long as your client requests

17. Which of the following statements is true?
   a. Use of email in clinical practices is illegal
   b. Use of email in clinical practices is a per se violation of HIPAA
   c. Use of email in clinical practices is not currently regulated
   d. Use of email in clinical practice creates some risks
18. As it relates to billing for services:
   a. Clients should be notified no later than the first time you send an invoice
   b. Clients should be notified as part of the informed consent process
   c. Clients need not be notified because of the sensitivity of the information
   d. Clients have a responsibility to inquire in writing if they want to be informed

19. If you are moving from a paper file to an electronic medical file in your office:
   a. It is an easy process that can be accomplished in a couple hours
   b. You will need to close your office for at least 6 months first
   c. You should obtain technical consultation if you are not an expert in the area
   d. You will only need a laptop computer

20. Privilege is:
   a. The promise to your patients not to disclose their information to anyone
   b. Only pertains to legal proceedings
   c. Can only be waived by your client
   d. All of the above

21. Confidentiality is:
   a. The same as privilege
   b. Different from privilege
   c. Not relevant if the communication is privileged
   d. Only relevant if the communication is privileged

22. The following may result in the waiver of privilege:
   a. A third party non-agent being present
   b. Your client telling you something when your supervisee is present
   c. Your client telling you something when his or her attorney is present
   d. Your client refusing to talk about his or her mental state

23. Which of the following need not be included in a release of information form:
   a. An expiration date
   b. A witness signature
   c. The purpose of the requested disclosure
   d. A statement about re-disclosure
24. The Code of Federal Regulations suggests the following as it relates to release of information forms:
   a. Use technical jargon to confuse your patients
   b. Use legal jargon so you can assure your forms comport with the law
   c. Use plain language
   d. Use the language of your client’s native tongue otherwise you are violation a federal law

25. True or False: You are required to keep a log of all disclosures of client records:
   a. True
   b. False

26. The general rule about deferring to children when they want their records released is:
   a. Follow the children’s instructions if they are teenagers
   b. Always follow the children’s instructions if they are your client
   c. Defer to the parent or guardian
   d. Don’t do anything unless the parent and child can agree

27. The most important document for clarifying who is the client in therapeutic situations that involve more than one person in the therapy room is:
   a. The financial agreement (who is paying)
   b. The informed consent document
   c. The therapist’s notes
   d. A subpoena

28. If a therapist does not want to release records to a patient because the therapist is concerned it will harm the patient, the therapist should refer to:
   a. The law
   b. His or her ethics code
   c. Common sense
   d. All of the above

29. A subpoena requires:
   a. Absolute compliance
   b. Disclosure of requested information
   c. A response
   d. All of the above
30. A subpoena duces tecum is a request for:
   a. You
   b. Your records
   c. Both you and your records
   d. Neither you nor your records

31. You might object to a subpoena because:
   a. The request is for copyrighted information
   b. The request is for privileged information
   c. The request unreasonably burdens you
   d. All of the above

32. If your client does not want you to turn over records and you have received a subpoena to turn over those records, you should:
   a. Turn over the records right away
   b. Tell your client to get his or her attorney involved
   c. Refuse to turn over the records under any circumstances
   d. Deny having the records

33. Research has demonstrated that, as it relates to one’s duties with dangerous patients:
   a. Most mental health professionals are well informed about their duties
   b. Most mental health professionals lack confidence in their abilities
   c. Most mental health professionals are not well informed about their duties
   d. Most mental health professionals do not care about their duties

34. True or False: Mental health professional have complaints and lawsuits filed more because of custody case disputes than any other reason:
   a. True
   b. False

35. True or False: If mental health professionals keep the best interest of their clients in mind, ethical dilemmas are generally conflict-free and easy to resolve:
   a. True
   b. False

36. True or False: Mental health professionals always have personal biases, feelings, and self-interests that can affect their decision making:
   a. True
   b. False
37. Fidelity refers to:
   a. Doing no harm
   b. Being helpful
   c. Being truthful
   d. Allowing for self-direction

38. True or False: If you need consultation, it is likely because you are practicing outside your area of competence:
   a. True
   b. False

39. True or False: A basic assumption about ethics is that many of us find it easier to question the ethics of others than ourselves
   a. True
   b. False

40. True or False: Because administrative rules and regulations are technically laws, the consequences of violating them cannot be severe
   a. True
   b. False

41. True or False: Laws, rules, regulations, and ethics codes often overlap one another
   a. True
   b. False

42. True or False: Because listservs and blogs are not peer reviewed, they should not be used as a source of information for updates in law, rules, and ethics codes
   a. True
   b. False

43. True or False: Psychotherapy notes must always be kept separate from the rest of the file
   a. True
   b. False

44. True or False: Mental health professionals may be held responsible for breaches in confidentiality committed by others in their practices
   a. True
   b. False
45. True or False: Records you receive from a third party are no longer protected since they have been released once
   a. True
   b. False

46. Mental health professional owe what duty to their clients:
   a. Confidentiality
   b. Privilege
   c. Both confidentiality and privilege
   d. Neither confidentiality nor privilege

47. Which of the following does NOT distinguish confidentiality from privilege:
   a. Once waived, the waiver for confidentiality can be revoked but the waiver for privilege cannot
   b. Confidentiality is a standard of professional conduct while privilege is a legal concept
   c. Confidentiality continues even if a third party is informed of the information, but the same is not true for privilege
   d. Confidentiality prevents the disclosure of information, but privilege does not

48. True or False: The United State Supreme Court recognizes a federal psychotherapist-patient privilege
   a. True
   b. False

49. It would be improper for a mental health professional to do the following if a judge orders you to turn over a patient’s records
   a. Request an in-camera review first
   b. Request a limiting order
   c. Request a protection order
   d. Request the judge recuse himself or herself from the case

50. Because confidentiality is such an important component of psychotherapy, the law protects disclosure of information unless:
   a. The client authorizes the disclosure
   b. There is an exception created in the law for public policy purposes
   c. Both A & B
   d. None of the above