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A handbook for mental health counselors in Arizona on ethics and law

Christensen, Elizabeth Helene, M.A.

The University of Arizona, 1991

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A HANDBOOK FOR MENTAL HEALTH COUNSELORS
IN ARIZONA ON ETHICS AND LAW

by

Elizabeth Helene Christensen

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A Thesis Submitted to the Faculty of the
SCHOOL OF FAMILY AND CONSUMER RESOURCES
In Partial Fulfillment of the Requirements
For the Degree of
MASTER OF ARTS
WITH A MAJOR IN COUNSELING AND GUIDANCE

In the Graduate College
THE UNIVERSITY OF ARIZONA

1991
STATEMENT BY AUTHOR

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This thesis has been approved on the date shown below:

Philip J. Lauber
Associate Professor of Family
and Consumer Resources

Date
This work is dedicated to
my late brother,
Hubert Harder,
whose courage and persistence
in the face of adversity
inspires me in difficult times.
ACKNOWLEDGMENTS

I want to give special thanks to Dr. Philip Lauver, my thesis advisor, for his encouragement, knowledge, and enthusiasm. He provided answers to my many questions and helped create order when I could only see chaos. Thank you also to my other committee members, Drs. Oscar Christensen and Mary Hotvedt. Their support and humor at my defense were two components that greatly relieved my tension and anxiety.

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ABSTRACT

The purpose of this study was the production of a handbook on ethics and law for mental health counselors in Arizona. The handbook is the summation of information from: professional literature, state statutes, professional codes of ethics, state agencies, a survey of Arizona counselors, evaluations by practicing counselors and graduate students in counseling, and personal interviews.

A survey of Arizona Counselors Association members was conducted by a mailed questionnaire. The purpose of the questionnaire was to identify and assess typical counseling practices and to determine the perceived usefulness of the proposed handbook. Results of the survey indicate that respondent counselors' typical practices do not vary substantially from one Arizona metropolitan area to the next and that almost all of them would find the handbook useful.

Some of the evaluators' suggestions for modifications of the proposed handbook have been incorporated in the version which is Appendix A to this thesis.
CHAPTER 1

INTRODUCTION

Mental health counseling, as a distinct discipline, is still in its adolescence. Indeed, mental health counselors (MHCs) have gained professional status only in the last decade (VanZandt, 1990; Weikel & Palmo, 1989). A growing recognition that MHCs are separate and distinct from such other mental health professionals as psychologists, psychiatrists, social workers, and psychiatric nurses is an indication of the growth of this discipline.

Common to all MHCs is a sense of professionalism characterized in part by adherence to high personal standards of competence, improvement of skills through professional development, and pursuit of quality and ideals within the profession (VanZandt, 1990).

As the discipline of mental health counseling continues to mature and as its practitioners strive for competence, knowledge of the boundaries of proper practice becomes increasingly important. These boundaries are defined by ethical codes, state laws, and licensing and credentialling boards. MHCs must maintain a current awareness of all three areas of definition because boundaries can frequently change as the discipline adjusts to societal norms, expectations, and practices (Schwartz, 1989; Remley, 1988; Mabe & Rollin, 1986).

Studies have shown that counselors are sometimes confused about ethical and legal aspects of their practices (Conte, Plutchik, Picard, & Karasu, 1989; Smith, 1986). Part of this confusion arises because guidelines and laws do not always clearly define professional obligations. Answers to questions of law and ethics often require the mental health practitioner to rely heavily upon conscience and professional judgement (Turkington, 1987).

The need for knowledge in legal and ethical areas is heightened by the increase in lawsuits against mental health practitioners (Snider, 1987). Our society is one of the most litigious in the history of civilization. One of the important adjuncts to our freedom is the
right to sue and the commensurate burden to be sued; we usually employ litigation rather than physical violence to resolve important differences (Wills, 1987).

While ethical codes apply substantially uniformly across the country, laws vary significantly from state to state (Hopkins & Anderson, 1990). MHCs, like other mental health professionals, can learn about their state laws through professional mailings from their state associations, seminars, attorneys, other counseling professionals, state statutes, and other sources. How often, and how many, MHCs utilize these different sources is unknown.

Contact with other professionals is considered to be one of the best ways to maintain and increase professional competence (Palmo & Weikel, 1986; Tennyson & Strom, 1986). Such contact is more readily available to MHCs who work in agencies; MHCs in private practice are more isolated (Richards, 1990; Jones, 1986) and often must take more initiative to become knowledgeable about legal and ethical issues.

Mental health agencies generally require all counselors on their staff to be licensed or certified. Through licensure and certification, such counselors become part of a state and national network of mental health practitioners who receive current information through mailings and professional journals. But no such requirement exists for counselors in private practice in Arizona. How do these counselors become knowledgeable about information that is a central part of a competent practice?

**Purpose of the Thesis**

The purpose of this thesis is to develop a practical handbook concerning legal and ethical issues for mental health counselors in Arizona. The handbook is written to inform counselors about specific state laws that directly apply to their practices, areas of law that may apply in less direct ways, and practical ethical considerations. The primary goals of this handbook are to help counselors untangle the sometimes confusing array of rules and regulations governing their discipline, to help them increase professionalism both in their
individual practices and in counseling generally, and to acquaint them with some of the resources available when specific ethical and legal problems arise.

The handbook is intended as a useful guide and not as a definitive work on ethics or law. While its primary function is to educate, it is also intended to help solve ethical and legal problems more efficiently. It is written primarily for mental health counselors, but it may also be of interest to clients and other counselors because many legal and ethical issues overlap various mental health professions.

**Background**

The mental health professions in this country trace their beginnings back to the 1870s. The post-World War II period witnessed a dramatic increase in the perceived need for psychological treatment and to the passage of the National Mental Health Act. Until the mid-1960s, the post-war period was characterized by increased mental health spending, a burgeoning network of national mental health centers and a growing body of mental health professionals (Hershenson & Power, 1987). An important change in mental health care came when the "mechanistic-deterministic" philosophy of behaviorism gave way to the "self-determinism" of the humanistic philosophy of Carl Rogers (Palmo, 1986).

The period of the late 1960s and 1970s was a time of consolidation and reassessment during which mental health care consumers began to participate in the process of treatment, patients were more readily released from mental hospitals, "boom areas" arose, and federal funding for mental health care decreased. "Boom areas" were metropolitan centers characterized by rapid, substantial growth, primarily in minority populations. Such areas developed high needs for mental health services (Hershenson & Power, 1987).

During the late 1960s and 1970s, counselors gradually began leaving schools where they had been predominantly found, joining the ranks of other mental health professionals in agencies around the country. They were generally considered paraprofessionals and they worked
under a variety of job titles: psyche tech, mental health specialist II, and psychiatric aide, to name a few. Describing the somewhat ambiguous nature of their position, Weikel and Palms (1989, p. 7) wrote that "[the] mental health counselor (MHC) is a hybrid, born from an uneasy relationship between psychology and educational counseling, but with family ties to all of the core mental health care disciplines."

Mental health counselors finally received a kind of formal recognition in 1976 when the American Mental Health Counselor's Association (AMHCA) was founded. The AMHCA provided a home for "community" and "agency" counselors who previously had no established organization (Weikel & Palmo, 1989; Palmo, 1986). In 1977 the AMHCA joined the American Personnel and Guidance Association (APGA), which later became the American Association for Counseling and Development (AACD) (Hershenson & Power, 1987). Today AMHCA is the second largest division of AACD (Robert Rencken, head of the Arizona Counselors Association, 1991).

During the 1980s, an increasing number of mental health counselors entered private practice. By 1985 22% of AMHCA members worked in private practice, more than in any other work setting (Hershenson & Power, 1987) (Table 1). This migration into private practice may have been due in part to the licensure and credentialing of counselors (Weikel, 1985).

The profession of mental health counseling is "in a continuous state of evolution" (Seiler, Brooks, & Beck, 1987, p. 204) MHCs are still trying to define their relationship to other mental health practitioners and to the consuming public. Some MHCs believe that professional identity may be the single most significant issue facing them today. The public often seems to assume that "counselors" are all the same, and may see little difference between psychologists, social workers, psychiatric nurses and MHCs (Weikel & Palmo, 1989; Seay, 1986).

Even professionals sometimes blur the distinction among the different mental health practitioners. Remley (1988, p. 170), in an article for the Journal of Mental Health Counseling, wrote: "All professional counselors are mental health counselors."
Table 1. Work settings of mental health counselors—From Hershenson & Power, 1987, p. 20.

<table>
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<th>Settings</th>
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<td>Colleges and Universities</td>
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<td>Community Mental Health Centers</td>
<td>11</td>
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<tr>
<td>Rehabilitation Centers</td>
<td>5</td>
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<tr>
<td>Community Agencies</td>
<td>4</td>
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<tr>
<td>State or Local Government</td>
<td>4</td>
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<tr>
<td>Elementary Schools</td>
<td>3</td>
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<tr>
<td>Junior Colleges</td>
<td>2</td>
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<td>Business and Industry</td>
<td>2</td>
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<tr>
<td>Federal Government</td>
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If MHCs are to establish a true identity they must explore similarities and differences between themselves and the other core mental health professionals: psychiatrists, psychologists, social workers and psychiatric nurses (Remley, 1988). An integral part of establishing that identity is the implementation of a concept of professionalism that embraces a personal commitment to the profession (VanZandt, 1990).

The Random House Dictionary (1966) defines "professionalism" as:  "1. professional character, spirit, or methods. 2. the standing practice, or methods of a profession" (p. 1148). "Professionalism" derives from "profess," which means ". . . to declare oneself skilled or expert in; claim to have knowledge of; make a thing of one's profession or business" (p. 1148). Professionalism is the result of an individual's adherence to high standards of competence (VanZandt, 1990).
There is general agreement among mental health professionals that a working knowledge of ethical guidelines and applicable law is paramount to any competently run practice of counseling. A professional code of ethics primarily establishes a framework for professional behavior and responsibility (Mabe & Rollin, 1986). "Law governs relationships of private individuals and organizations both to other private individuals and to the government, the paramount authority of the society" (Beis, 1984, p. 9). While a violation of the law may not be an ethical violation, and vice versa, ethical codes and the law overlap in some areas (Beis, 1984).

It is not uncommon for legislatures or judges to set legal standards for professional conduct "when ethical guidelines are not enforced or are insufficient to protect clients" (Sheldon-Wildgen, 1982, p. 165). Ethical codes are generally not at the "cutting edge" of social thought; rather, they are more reactive to issues developed elsewhere. In some cases, the law and ethical codes are in conflict (Mappes, Robb, & Engels, 1985).

Summary

Mental health counseling, as a profession, had its beginnings over one hundred years ago. The professional mental health counselor, however, has been officially recognized for only a little more than a decade. As the profession has grown and matured, its members have become increasingly cognizant of the special duties that are an integral part of maintaining professionalism. A part of those duties is adherence to the ethical guidelines of the profession and knowledge of applicable state law.

Scope and Limitations

The scope of the handbook is to provide: some clarity about the profession of mental health counseling, general information on law as it applies to counselors; specific information on select Arizona statutes; guidelines for ethical behavior, and sources of further information.
The handbook is written for mental health counselors who are new to the profession and for those who have been in practice for years. It is primarily intended for mental health counselors in private practice, although some of the information may be useful to mental health professionals in other settings.

The handbook is limited in several ways. The specific state laws and ethical guidelines cited have limited educational value because they are regularly revised. Questionnaires were sent only to Arizona Counselors Association members and may be limited to those members. Further, the profile of members who chose not to answer the questionnaire is unknown; the practices of questionnaire respondents may, therefore, vary substantially from those who did not respond.

**Delimitations**

1. The handbook does not include every aspect of law and ethics that applies to the mental health professions. Rather, it includes an overview of legal and ethical issues.
2. The questionnaire population, the Arizona Counselors Association mailing list, was chosen for its convenient availability.

**Assumptions**

1. Information about ethics and law available to counselors has not been adequate to meet the needs of the profession.
2. The material presented by the handbook will be useful to counselors.
3. Counseling practices in the various mental health professions are sufficiently similar that information from one discipline will also apply to another.
Definitions

**Mental health counselor:** This title refers to those counseling professionals "whose primary affiliation and theoretical basis is counseling and not psychotherapy, psychology, or social work" (Messina, 1985, p. 41).

**Counseling:** The terms therapy and counseling seem to be used interchangeably in the professional literature. For the purposes of this study, counseling is defined according to the Arizona Revised Statutes definition: "... the professional application of counseling principles, methods, procedures, or services to assist individuals, couples, families and groups to achieve interpersonal, intrapersonal and to promote optimal mental health" (Amended §32-3251). "Counseling" will be used throughout this study when referring to the practice of counselors, except when the literature specifically uses the term "therapy."

**Client:** A client is an individual who seeks counseling; a patient is an individual who seeks therapy (Vriend, 1985).
CHAPTER 2

REVIEW OF SUPPORTIVE LITERATURE

Introduction to Chapter 2

The Code of Ethics for Mental Health Counselors, 1987, under Principle 2. Competence, states: "The maintenance of high standards of professional competence is a responsibility shared by all mental health counselors in the interest of the public and the profession as a whole. . . . Throughout their careers, mental health counselors maintain knowledge of professional information related to the services they render."

In the last few years, mental health professionals have become increasingly concerned with legal and ethical issues in their practice. Practitioners are expected to be aware of and knowledgeable about "the latest ethical and legal developments" of their profession. This responsibility may seem overwhelming given the vast amount of professional information published each year from numerous sources (Rinas & Clyne-Jackson, 1988, p. ix).

This chapter is a review of some of that information as it relates in general to mental health counselors, and specifically as it relates to counselors in Arizona.

RELATED LITERATURE TO SECTION I:
THE PROFESSION OF MENTAL HEALTH COUNSELING

Mental Health Counselors

Core Providers

The professional counseling literature distinguishes counselors from four other core mental health providers: psychiatrists, psychologists, social workers, and psychiatric nurses. Counselors cannot always be easily distinguished from psychologists and social workers (West, Hosie, & Mackey, 1987; Ivey & Rigazio-DiGilio, 1991) because each profession is involved in
some kind of counseling or therapy (Palmo, 1986). Colorado recognizes the professions' overlapping functions when it calls psychotherapy an "amorphous field" (Yu, 1990, p. 71).

Arizona law regulates psychiatrists, psychologists, counselors, social workers, marital and family therapists, and substance abuse counselors. Psychiatric nurses are not regulated as a separate specialty from the general practice of nursing (Miller & Sales, 1986). The following definitions appear in the Arizona Revised Statutes (ARS):

**Psychiatrist:** Psychiatrist means a licensed physician who has completed three years of graduate training in psychiatry in a program approved by the American medical association or the American osteopathic association (Mental Health Services, ARS §36-501, 1985).

**Psychologist:** Psychologist means a person who is certified as a psychologist by the board. [The board is the Board of Psychologist Examiners.] (Psychologists, ARS §32-2061, 1980).

[No further definition of psychologist is provided; the practice of psychology is primarily defined by the requirements for certification and by a description of unprofessional conduct (Board of Psychologist Examiners, R4-26-150, Article 3. Regulation, 1984).]

**Practice of social work:** Practice of social work means professional services that are developed to effect change in human behavior, emotional responses and social conditions of individuals, couples, families, groups, and communities and that involve specialized knowledge and skill related to human development, including an understanding of unconscious motivation, the potential of human growth, the availability of social resources and knowledge of social systems. Practice of social work includes:

1. The use of psychotherapy for the purpose of diagnosis, evaluation and treatment of individuals, couples, families and groups.
2. Social planning, administration and research for community social services delivery systems.

Social work practice means both private, self-employed practice on a fee for service basis by an individual social worker or as part of a group practice and autonomous self-regulated practice by a social worker under the auspices of a public or private agency or facility (Behavioral Health Professionals, ARS §32-3251, 1989).

**Practice of professional counseling:** Practice of professional counseling means the professional application of counseling principles, methods, procedures or services to assist individuals, couples, families and groups, to achieve interpersonal, intrapersonal, social, educational or vocational development and adjustment and to promote optimal mental health (ARS §32-3251, as amended under Senate Bill 1138; awaiting passage in the House of Representatives, 1991).

**Practice of marital and family therapy:** Practice of marital and family therapy means the professional application of marital and family theories and techniques in the diagnosis and treatment of mental emotional conditions in individuals, couples and families and involves the presence of a diagnosed mental or physical disorder in at least one member of the couple or family being treated (Behavioral Health Professionals, ARS §32-3251, 1989).

Substance abuse counselors are not defined separately.

**Specialty of Mental Health Counseling**

Mental health counselors work primarily with "normal populations" and stress prevention and mental health versus remediation and mental illness (Weikel & Palmo, 1989) (Figure 1). They look at the global view of client concerns and work in cooperation with other mental health professionals (Palmo, 1986; Ivey & Rigazio-DiGilio, 1991; Remley, 1988).
<table>
<thead>
<tr>
<th>ITEM FOR COMPARISON</th>
<th>MENTAL HEALTH COUNSELING</th>
<th>MEDICAL MODEL</th>
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<tbody>
<tr>
<td>Parent discipline</td>
<td>Counseling</td>
<td>Medicine</td>
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<tr>
<td>Basic Science</td>
<td>Normal human development</td>
<td>Psychopathology</td>
</tr>
<tr>
<td>Characterization of mental health difficulties</td>
<td>Problems of living</td>
<td>Mental illness</td>
</tr>
<tr>
<td>Term used for help-seeker</td>
<td>Client</td>
<td>Patient</td>
</tr>
<tr>
<td>Desired outcome of treatment</td>
<td>Client develops ability to cope</td>
<td>Patient is cured</td>
</tr>
<tr>
<td>Treatment strategy</td>
<td>Utilize/develop assets and skills</td>
<td>Eliminate pathology</td>
</tr>
<tr>
<td>Diagnostic labeling</td>
<td>Largely irrelevant to treatment method</td>
<td>Central to choice of treatment method</td>
</tr>
<tr>
<td>Emphasis on environmental modification</td>
<td>Equal to client change</td>
<td>Secondary to patient change</td>
</tr>
<tr>
<td>Use of empirically evaluated techniques</td>
<td>Important</td>
<td>Important</td>
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</tbody>
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Figure 1. Comparison of mental health counseling and medical model.--From Hershenson & Power (1987, p. 6).
Hershenson and Power (1987, p. 21) wrote that mental health counselors are: "... professionals who apply the knowledge and skills of counseling to assist individuals, groups, organizations, and communities to determine and to attain their optimal level of psychosocial functioning."

Mental health counselors follow an educational-developmental model of counseling and keep a balanced perspective between the prevention, psychoeducational, and developmental approaches to counseling (Seiler et al., 1987). Ivey and Van Hesteren (1990, p. 534) described the educational-developmental model as one that:

... is holistic and considers both the physical (medical) and the mental (psychological) as important to education. Education (Latin educare) is about drawing out what is already there in the person or system. Development (Latin dis plus villuppare) concerns the gradual unfolding of what is in the "germ" of a person. The educational-developmental model attempts to heal the mind/body split and recognizes that individuals live and grow in families, groups, organizations, and cultures.

A 1986 survey of how Australians view counselors, social workers, psychologists, and psychiatrists, found that Australians would seek a counselor when needing a warm and empathic listener (Sharpley, 1986). While many counselors follow in the tradition of Carl Rogers, the importance of being versed in the medical model of diagnosing mental illness is also recognized (Hershenson & Power, 1987) because "normal populations contain many elements of psychopathology" (Ivey & Rigazio-DiGilio, 1991, p. 30; Remley, 1990).

Mental Health Counselors in Private Practice

In the late 1960s and early 1970s, counselors began leaving the schools to join the ranks of other mental health professionals in agencies around the country. In those days counselors had a variety of job titles: psyche tech, mental health specialist II, and psychiatric aide. Weikel & Palmo (1989, p. 7) wrote that: "[the] mental health counselor (MHC) is a hybrid, born from an uneasy relationship between psychology and educational counseling, but with family ties to all of the core mental health care disciplines."
Today, as more counselors are entering private practice (Figure 1), they will be involved in counseling services, consultation, supervision, and community involvement and public relations (Palmo, 1986). The counselor who wants to succeed in private practice, however, needs to come to terms with three potential areas of difficulty: identity, confidence and commitment (Weikel & Palmo, 1989).

1. **Identity.** Counselors who try to imitate the practices of other mental health professionals will have difficulty succeeding. The counselor cannot be all things to all people and needs to develop an area of expertise.

2. **Confidence.** Confidence comes from believing in the mental health counseling model, and that one's own skills and expertise are equal to those of other core providers. Confidence also comes with certification and licensure.

3. **Commitment.** Counselors need to commit time and energy to build their practice and not "play at private practice." Part of the commitment includes following the mental health model and not trying to follow the medical model.

**Future of Mental Health Counseling**

The future of mental health counseling includes extended public relations to expand recognition of the counselor as a core mental health provider, increased research to show counselors' efficacy, and continued political involvement to further counseling as a profession (Weikel & Palmo, 1989).

**Counselor Credentialing**

Credentialing by professionals can occur through certification by one's professional organization and through state licensure or certification. Credentialing usually requires that an individual complete prescribed training, demonstrated professional knowledge and skills on an examination, and have no history of legal or moral turpitude (Hershenson & Power, 1987).
Licensure

Licensure is defined as "the statutory process by which an agency of the government, usually a state, grants permission to a person meeting predetermined qualifications to engage in a given occupation and/or to use a particular title and to perform specified functions" (Corey, Corey, & Callanan, 1988, p. 147). State licensing boards usually have the authority to regulate the use of the professional title, and the scope of practice of members of that profession (Brooks, 1986). "State licensing acts are clear about areas of practice that belong to that professional group (Rinas & Clyne-Jackson, 1988, p. 42).

In 1976, Virginia was the first state to license counselors. According to Carol Vroman, head of the Arizona counselor credentialing committee, there are presently 34 states that regulate counselors; 25 that license counselors; 7 that certify counselors; and 2 that have a registration process.

Arizona licenses psychiatrists and nurses and not counselors, social workers or psychologists (Miller & Sales, 1986; ARS §32-3302).

Certification

Certification, like licensure, ensures that certain qualifications are met before individuals can use a restricted title. However, unlike licensure, certification only protects the professional title and does not regulate the scope of practice. As a result, uncertified practitioners can legally offer the same services as the certified professional; they are only prohibited from using the protected title; i.e., certified professional counselor.

Under Arizona law, psychologists and behavioral health professionals are certified (ARS §32-3302):

1. Behavioral Health Professionals. ARS §32-3302 identifies the following as behavioral health professionals:

Certified Baccalaureate Social Workers
Certified Master Social Workers
Certified Counselors
Certified Marriage and Family Therapists
Certified Substance Abuse Counselors

2. **ARS §32-3302.** This statute outlines the duties of the behavioral health board as well as the limitations and privileges of behavioral health professionals. See Appendix A of this handbook.

3. **Counselor Certification in Arizona.** Counselors who seek Arizona certification may contact the Board of Behavioral Health Examiners for information.

   Board of Behavioral Health Examiners
   1624 West Adams, Room 100-A
   Phoenix, AZ 85007
   602-542-1882

National certification for mental health counselors is possible through the American Association of Counseling and Development (Aacd) and the American Mental Health Counselors Association (AMHCA).

1. **American Association of Counseling and Development.** Aacd offers certification through the National Board for Certified Counselors (NBCC), an affiliate of Aacd. NBCC offers a general counseling certificate (Brooks, 1985) through its National Counselor Examination (NCE) (Loesch & Vacc, 1988).

   The NCE is increasingly used by states in their certification and licensure processes. Study guides for the NCE are advertised in Aacd's Guidepost, a newspaper sent to all Aacd members.

2. **American Mental Health Counselors Association.** The second exam is through the National Academy of Certified Clinical Mental Health Counselors (NACCMHC), an affiliate of AMHCA. NACCMHA began certifying counselors in 1979. Because of the stiffer requirements of the NACCMHA, however, fewer counselors have become
certified as mental health counselors (Brooks, 1986). AMHCA certification requirements include:

a. Masters degree,

b. Forty-five semester hours in a mental health field,

c. Minimum 2 years post-masters experience,

d. Minimum 3,000 hours experience,

e. 100 hours face-to-face supervision,

f. Demonstrated clinical skills.

Counselors certified through NACCMHC are listed in a national register made available to mental health centers, and consumer, insurance and medical organizations.

To contact AACD and AMHCA write or call:

AACD
5999 Stevenson Avenue
Alexandria, VA 22304
1-800-326-2642

Membership in AACD is a prerequisite for membership in AMHCA.

The Arizona affiliate of AACD is the Arizona Counselor's Association (ACA). For membership information write to:

Arizona Counselors Association
Robert Rencken, Executive Director
Arizona Counselors Association
1200 North El Dorado Place, Bldg. F, Suite 600
Tucson, AZ 85715

Certified Counselors and Third-party Payments

History

The migration of counselors into private practice about a decade ago has brought the issue of third-party reimbursements into the forefront. Originally, only psychiatrists received such payments because they qualified as medical doctors and were included under medical
insurance plans. Psychologists and social workers lobbied insurance companies to be included as mental health providers because, they argued, psychiatrists do the same kind of work as we do (Hershenson & Power, 1987).

Counselors are now using the same arguments to be considered core providers of mental health care, which has met opposition by other mental health care professionals (Hershenson & Power, 1987) in light of dwindling health care dollars (Ivey & Rigazio-DiGilio, 1991).

Third-party payments to counselors are, however, becoming a reality particularly in those states that license professional counselors. A 1983 survey of Virginia counselors shows that 45% of counselors who filed claims were paid (Hershenson & Power, 1987). A 1985 survey of Alabama licensed counselors indicates that 84% of insurance claims were paid. (About half of the claims were paid when either a psychologist or psychiatrist signed-off on the insurance claims.) At least 60 insurance companies were willing to reimburse counselors in Alabama directly based on the counselor's own qualifications and own signature (Covin, 1985).

The pattern of third-party reimbursements is unpredictable and varies from state to state and within divisions of the same insurance carrier. There are no general guidelines and counselors need to become familiar with exclusions on specific insurance coverages (Richards, 1990).

A questionnaire sent to Arizona Counselor's Association members (Chapter 4), found that 29% of respondents with master degrees receive some third-party payments on their signatures alone. Another 38% receive payments through sign-offs by clinical psychologists or psychiatrists.

A telephone survey of several major health insurance carriers in Arizona to determine the status of third-party reimbursements to master-level counselors based on their own signature found the following:
1. CHAMPUS (Civilian Health and Medical Plan of the United States) reimburses master-level counselors who have received prior authorization. Counselors can call 1-800-225-4816, or write to CHAMPUS Correspondence, P.O. Box 2950202, Florence, SC 29502-0202, to request the necessary forms.

2. Blue Cross/Blue Shield accepts only the signatures of clinical psychologists, psychiatrists, and other related Ph.Ds.

3. HMOs, such as Intergroup, have their own staff counselors. Some companies, such as Partners, use a provider system, and only those on their list are reimbursed for services. Partners claims that master-level counselors do qualify as providers.

Private health insurance carriers were reluctant to provide general information about third-party reimbursements. Most responded that each plan could be different and the counselor needs to inquire when a specific client is in the office with a specific policy.

Sign-offs

Master-level counselors can sometimes receive third-party payments when either a doctorate-level psychologist or psychiatrist co-signs the client's insurance claim.

Psychologist or psychiatrist who sign-off must be "true" supervisors for those cases in which counselors seek third-party reimbursements; mentioning a case in passing once a month is not adequate supervision (Beigel & Earle, 1990).

Insurance plans usually specify who will be reimbursed for services. Some companies and plans will only reimburse the actual provider of services. Counselors are advised to become familiar with state and national laws regarding theft by deception (Richards, 1990).

Guidelines for Third-party Reimbursements

The Ridgewood Financial Institute based in Hawthorne, New Jersey (Beigel & Earle, 1990, p. 145) has "nine rules for avoiding reimbursement traps":


1. Collect fees directly from clients. Give clients the responsibility for reimbursement from their insurance company.

2. "Encourage clients to seek reimbursement." Some clients may not be aware they may have coverage for counseling.

3. Reassure clients about confidentiality.

4. Investigate third parties many clients use. For example, talk to the company's local representative to understand how their plan works.

5. "Master the details of government programs" such as CHAMPUS, Medicare, Medicaide, etc.

6. "Take extra care with claim forms." Review each form before it is sent out and try to use the Standard Health Insurance Form, which most companies accept.

7. "Review your diagnostic language." Most companies require diagnosis from the Diagnostic and Statistical Manual of Mental Disorders from the American Psychiatric Association (DSM III-R).

8. "Don't fudge on credentials." Some insurance companies will not reimburse nonmedical providers; asking another professional to sign a claim form may be illegal in some instances.

9. "File claims at the right time." Do not wait until a large bill has accrued.
Privileged Communication

Privileged communication is a concept of law (Watkins & Watkins, 1983) concerning: "... the legal right ... which protects clients from having their confidences revealed publicly from the witness stand during legal proceedings without his [sic.] permission (Mappes et al., 1985, p. 248).

"Privileged communication is established by statutory law, [i.e., state law], which is enacted by the legislative branch of government" (Herlihy & Sheeley, 1987, p. 479). Privileged communication only applies when a professional is called into court as a witness (Hopkins & Anderson, 1990) and is intended to protect a client's private communications from being "divulged within the courtroom" (Rinas & Clyne-Jackson, 1988, p. 56).

Four basic conditions set forth in the 1920s (Watkins, 1989) by John Henry Wigmore (1961, p. 52) are still applied today to determine whether the privilege should be recognized:

(1) The communications must originate in confidence that they will not be disclosed.

(2) This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.

(3) The relation must be one which in the opinion of the community ought to be sedulously fostered.

(4) The injury that would inure to the relationship by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation [emphasis in original].

Courts will generally not grant privileged communication, even when Wigmore's four conditions are met, in the absence of state legislation granting the privilege (Hopkins & Anderson, 1990).
Privileges are not absolute even when guaranteed by statute (Smith, 1986). The privilege only applies when client information was made in confidence and the client wishes it to remain so. Since the privilege belongs to the client the counselor is obligated to waive the privilege when the client requests (Hopkins & Anderson, 1990). Other common waivers of privileged communication are (Watkins, 1989, p. 134):

- Client introduces privileged material into litigation.
- A client sues his/her counselor.
- A client commits or threatens a criminal act.
- A patient threatens suicide.
- A client threatens to harm his/her therapist.
- Child abuse or neglect is suspected.
- The court orders a professional examination.
- The client dies.
- A treating professional needs to collect fees for services rendered.
- Information is shared in the presence of a third person.

Privileged communication generally does not apply to individuals who participate in group counseling unless there is a statutory exception (Hopkins & Anderson, 1990).

States regulate who will be granted privileged communication (Corey, 1991; Rinas & Clyne-Jackson, 1988). Until recently, Arizona only granted the privilege to psychiatrists and psychologists. Under the new counselor certification law (Appendix A), certified professional counselors are also granted privileged communication.

Confidentiality

Butz (1985, p. 84) defined confidentiality as: "... an ethical standard of conduct that requires professionals to prevent disclosure to third parties of any information communicated by patients or clients in the course of the professional relationship. ..." Confidentiality, an ethical concept, is often confused with privileged communication, a legal concept.

The protection of mental health care information by statute, regulation and case law began less than two decades ago (Turkington, 1987). The concept of confidentiality in professional relationships has, however, existed since the time of Hippocrates who wrote: ". . .
whatever in connection with my profession or not in connection with it, I may see or hear in the lives of men which ought not to be spoken about abroad, I will not divulge as reckoning that all should be kept secret" (Siegel, 1986, p. 77).

A study (Bernard & O’Laughlin, 1990) on confidentiality and professional behavior found that 39% of surveyed practitioners did not inform clients about confidentiality at the beginning of treatment. Sixty percent (60%) who did inform clients did so inadequately. For example, 19% told clients that all of their information will be held in strictest confidence in disregard of the well-established exceptions.

A survey of Arizona counselors (Chapter 4) shows that 53% of the counselors report giving clients written confidentiality statements when they first enter therapy. Another 12% discuss confidentiality with their clients. And about 34% apparently do neither. The Bernard and O’Laughlin (1990) study found that clients do not always understand the issue of confidentiality, yet that this issue is important to them. Ninety-six percent (96%) of the clients wanted information on confidentiality; 47% wanted to know about specific exceptions to confidentiality; and 76% believed there are no exceptions.

Some clients believe their counselor will reveal confidential information about them without their permission or knowledge (VandeCreek, Miars, & Herzog, 1987), and others believe that all confidences will be held in strictest confidence (Simon, 1988). In a 1987 survey of psychologists, 61.9% reported they had unintentionally disclosed confidential information (Pope, Tabachnick, & Keith-Spiegel, 1987).

Generally the privilege to waive confidentiality belongs to the client and not to the professional. To relinquish the right, a client may do so orally; however, safer practice requires a written release in case the client forgets having granted the authority (Schwartz, 1989). Counselors are also advised to get the client’s approval before putting information about the client on an insurance form (VandeCreek et al., 1987).
Insurance claims are one threat to confidentiality, other threats include the use of collection agencies; the use of computer systems; the courts (Simon, 1988); discussing clients with others, even if the client's name is withheld; and responding to phone requests for information about clients from other professionals (Whittington, 1988). Nondisclosure laws hold that the counselor cannot divulge the fact that a particular person is a client (Everstine & Everstine, 1986).

Confidentiality is considered an important component of the counseling relationship. Without it, clients may not trust their counselor and, therefore, be unwilling to reveal personal matters believed beneficial to the counseling process (VandeCreek et al, 1987). This concern, however, may be outweighed by the responsibility of the professional to prevent serious harm either to the client or to a member of the community (Taylor & Adelman, 1989; Siegel, 1986; Simon, 1988). Situations in which the practitioner may need to break confidentiality without consent include child abuse, elder abuse, and when clients threaten to harm themselves or others (Butz, 1985).

The complexities of different reporting requirements seem to overwhelm some professionals whose concern for reporting dominates their thinking to the exclusion of protecting the client's privacy (Taylor & Adelman, 1989).

All 50 states now require that known or suspected child abuse be reported by professionals who come in contact with children or their caretakers (Butz, 1985). The advent of the mandatory reporting laws has witnessed a substantial increase in child abuse reports (Faller, 1985; Bulkley, 1988), however, professionals are not always clear about when to report (Everstine & Everstine, 1986).

A 1981 study found that 60% of reported cases could not be substantiated and other cases that fell within the guidelines were not reported (Smith, 1986). Part of the confusion may result from unclear and conflicting regulations between state and federal laws (Fader, 1987; Everstine & Everstine, 1986).
Counselors who do not report suspected child abuse may believe: abusive parents will not seek counseling without guarantee of confidentiality; abusive parents who seek counseling may not fully disclose without assurance of complete confidentiality; and a trusting relationship will be destroyed and the client will feel betrayed when professionals report to proper authorities (Butz, 1985).

According to Butz (1985), professionals may respond to mandatory child abuse reporting laws in a number of ways:

1. The counselor can ignore the duty to report when the need arises and risk legal liability. This approach is least acceptable because it leaves children unprotected.

2. The counselor can ignore the potential conflict until it actually arises—"do nothing until necessary"—which may be the most prevalent approach. This approach runs the risk of alienating the client and destroying the therapeutic relationship.

3. The counselor obtains informed consent prior to treatment, providing the client explicit information about confidentiality and its limitations. This approach may inhibit the client and adversely affect the relationship.

4. The counselor provides general information about confidentiality at the outset of counseling and when the actual need to disclose information arises, the counselor establishes a cooperative relationship with the local child protection caseworker to reduce the trauma of the investigation to the client. This solution involves the collaborative efforts between the counselor and caseworker and may be difficult to achieve because caseworkers are often overworked.

When the child is the client the counselor can minimize negative consequences of disclosure by telling the child generally about confidentiality at beginning of the relationship; give the child an explanation of the reason for the need to disclose when it arises; involve the child in a discussion about the need to disclose; discuss the likely repercussions of disclosing
information; and discuss how to best proceed; for example, does the child want to disclose, or be present when the counselor discloses? (Taylor & Adelman, 1989).

Arizona law addresses the reporting of child abuse in ARS, Chapter 36, §13-3620 (Appendix A). In summary, the law states that professionals, like counselors, have a duty to report child abuse if they see physical evidence of the abuse or the child reports having been abused. According to Child Protective Services (CPS), some professionals report potential abuse, heard second hand, if they believe a child may be in danger. In such cases, the professional may be obligated to report under the duty to warn doctrine.

Professionals can call CPS anonymously to learn if a particular case falls within the reporting requirement. Anonymous reporting of child abuse, however, is illegal because the law requires that a professional report. Without proof of the report, the professional is not protected legally.

The duty to report adult abuse is required by state law under ARS §46-451 to 46-454 and ARS §13-3620 (Marshall, 1985). According to Adult Protective Services, few reports are made by counselors, who generally do not counsel incapacitated adults (Appendix A). Counselors with questions should contact one of the 30 Adult Protective Service offices around the state. Telephone numbers are listed in the BLUE pages of the phone directory under Department of Economic Security--Adult Protective Services.

Duty to Warn

Three landmark cases (Hedlund v. Superior Court, Tarasoff v. Regents of University of California, and Landeros v. Flood) led to the conclusion that mental health professionals may be liable for malpractice when clients threaten harm to themselves or others; practitioners fail to report such information to appropriate authorities; and a child suffers further injury as a result of a professional's failure to report (Butz, 1985).
The Tarasoff case set legal precedence in 1974 by ruling that therapists are to exercise reasonable care to protect potential victims (Givelber, Bowers, & Blitch, 1984). The court ruled that while confidentiality is to be valued highly, it is not to be regarded as an absolute: "... the protective privilege ends where the public peril begins" (Knapp & VandeCreek, 1990, p. 162). Tarasoff has been interpreted both by California health professionals and others across the country as a legal duty to warn potential victims (Givelber et al., 1984).

Since Tarasoff, similar court rulings in other states have complicated therapists' legal responsibilities (Mappes et al., 1985; Greenberg, 1984; Herlihy & Sheeley, 1988; Miller & Weinstock, 1987; Corey et al., 1988). In some cases the therapist's duty to warn only exists when a specific victim is named; in others, the therapist has an obligation to act if the client makes general threats against individuals or property, as in the case of threatened arson (Greenberg, 1984; Herlihy & Sheeley, 1988).

Court rulings are sometimes in direct conflict with state laws. For example, Maryland's privileged communication statute prohibits psychotherapists from breaching confidentiality under any condition (Herlihy & Sheeley, 1988). Some states have incorporated exceptions to their privileged communication statutes such as requiring therapists to warn potential victims (Herlihy & Sheeley, 1987). According to Herlihy and Sheeley (1988, p. 210), only California, Colorado, Kentucky, and New Hampshire provide statutes "with clear guidelines for dealing with potentially dangerous clients."

In 1987, in Hamman v. County of Maricopa, 161 Ariz. 53, the Arizona Court ruled that a psychiatrist had a duty to protect potential victims even though there had been no specific threat against them.

The Arizona State Legislature, in its 1989 session, responded to the Court's decision by enacting a law that limits the liability to mental health providers who breach confidentiality in carrying out their duty "to prevent harm to a person caused by a patient. . . ." The duty to take "reasonable precaution" exists when there is both a "clearly identified" and "identifiable
victim." Reasonable precaution may include, warning identifiable victims, notifying a law enforcement agency, taking steps for voluntary or involuntary hospitalization of the patient, and "[taking] any other precautions that a reasonable and prudent mental health provider would take under the circumstances" (ARS §36-509).

Mental health providers are defined by state law as psychiatrists, clinical psychologists, and social workers who are experienced in mental health (ARS §36-509). Counselors are classified as behavioral health professionals (ARS §32-3301) and are not accorded the same legal protection when the duty to breach confidentiality is present. Counselors are put in a difficult position because the National Board for Certified Counselors Code of Ethics (§B, amended February 21, 1987) states that: "When a client's condition indicates that there is a clear and imminent danger to the client or others the certified counselor must take reasonable personal action or inform responsible authorities." The ethical guidelines for the American Association for Counseling and Development include a similar provision.

Does a counselor or therapist have the duty to warn identifiable, potential victims when a client discloses having tested HIV-positive? One study found that 12% of bisexual and homosexual men obtaining HIV testing would not tell primary sexual partners if the test was positive; 27% would not contact nonprimary partners; 35% of sexually active single men said they had lied to female partners about their past sexual history; and 20% said they would lie about having tested HIV positive (Knapp & Vande Creek, 1990).

Counselors seem reluctant to warn potential victims because the identifiability of victims is more complicated in AIDS-related therapy. One factor is the variable incubation period of the AIDS virus. Does one warn all past, present, and future sexual and/or intravenous drug partners? (Totten, Lamb, & Reeder, 1990).

Some believe that keeping confidentiality may do more good than breaking confidentiality by warning a third party. Preserving the therapeutic relationship may provide the
counselor an opportunity to help bring about behavior change in the client. Breaking confidentiality may result in the client terminating therapy (Knapp & VandeCreek, 1990).

States have responded to the AIDS epidemic by enacting reporting requirement laws (Hopkins & Anderson, 1990). The laws generally require that the identity of individuals who have tested HIV-positive be kept confidential (Knapp & VandeCreek, 1990). Washington State requires AIDS education as a condition of counselor licensure (State of Washington, Department of Health, 1990). Colleges and Universities throughout Washington provide this training; several of them offer correspondence courses:

<table>
<thead>
<tr>
<th>Institution</th>
<th>City</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.C.N.E.</td>
<td>Spokane</td>
<td>509-325-6146</td>
</tr>
<tr>
<td>Bellevue Community College</td>
<td>Bellevue</td>
<td>206-641-2012</td>
</tr>
<tr>
<td>AIDS Impact/WSNA</td>
<td>Seattle</td>
<td>206-284-3865</td>
</tr>
</tbody>
</table>

The Arizona Legislature in its 39th Session, 1990, passed Omnibus Bill 2173, which requires the Health Department to notify partners of individuals who have tested HIV-positive. Counselors with clients who have tested HIV-positive are advised to contact either an attorney or the Aids Hotline in their locality to understand their reporting obligations, which may fall under the duty to warn, and their reporting limitations, which require that names of HIV-positive clients be held in confidence.

Knapp and VandeCreek (1990) offered general guidelines for professionals who are likely to counsel clients with AIDS:

1. Avoid indiscriminate reporting, either premature or inaccurate.
2. If risk of transmission is high, turn the focus of therapy to client's voluntary disclosure; make warnings, if at all possible, with client's consent and presence.
3. Provide potential victims with information about HIV testing places and with sources of information.
4. Document all treatment decisions.
5. Consult with knowledgeable colleagues.
6. Consult legal authority in your own state for updates on state law in regard to legal status of the duty to protect when counseling HIV-positive clients.

A general rule for mental health professionals who counsel clients with any contagious or fatal disease such as AIDs is to always inform the client before breaching confidentiality (Cohen, 1990).

**Informed Consent**

The informed consent doctrine dates back to a medical malpractice suit in 1767 England (Bray, Shepherd, & Hays, 1985). Corey et al. (1988, p. 168) wrote that informed consent involves a process whereby clients are given adequate information in order to become "active participants in the therapeutic relationship."

Informed consent includes four elements (Corey et al., 1988; Slovenko, 1987; Hendrickson, 1982):

1. **Competence.** Does the individual have the legal capacity to make decisions?;
2. **Voluntarism.** Did the individual freely decide to participate without undue pressure?;
3. **Full Information.** Was the individual fully informed about all potential risks and benefits of participation?;
4. **Comprehension.** Is the consent form written in easy to understand language?"

Bray et al. (1985, p. 57) recommended that clients be given the following information on which to base their informed choice: "(1) Knowledge of goals, procedures, and side effects of psychotherapy; (2) Therapist's qualifications; and (3) Alternatives to psychotherapy."

A client cannot consent to treatment that is illegal or professionally unacceptable. In such situations, the counselor may be held liable for misconduct even though the client gave consent (Leesfield, 1987).
Informed consent is based "on the philosophy of individual freedom and choice" and relates to the rights of an individual (Bray et al., 1985, p. 51). In couple counseling, each partner needs to consent (Bray et al., 1985). If only one spouse is seen does the absent spouse need to be informed of potential risks to the relationship? To avoid civil liability, some professionals recommend sending consent forms and waivers to the absent spouse about their failure to participate in the counseling (Paquin, 1988).

Clients' Bill of Rights

Clients are not always aware of what to expect when they see a counselor, and may, therefore, not be aware of their rights. Corey et al. (1988) believed that it is the therapist's duty to protect clients' rights and to inform clients of them. Principle 12 of the Code of Ethics For Mental Health Counselors lists nine rights accorded clients (Appendix A).

A number of states require counselors and other mental health professionals to provide clients, prior to treatment, a client bill of rights. The Mental Health Association of Colorado (1989) devised a pamphlet for clients that includes a Bill of Therapy Rights and Responsibilities. Colorado law requires such disclosure by professional counselors, psychologists, social workers, and marriage and family therapists.

The State of Minnesota likewise requires that most licensed and unlicensed mental health service providers give clients, prior to treatment, a client bill of rights. The client's signature is required attesting that he or she received the bill of rights; a copy of the bill of rights is to be posted in a prominent location in the office.

Arizona law does not require counselors to provide clients with a client's rights statement (ARS §32-3251). A survey of Arizona counselors (Chapter 4) found that 37% give clients written information concerning their rights; another 4% do so orally.
Clients' Rights and Group Therapy

Corey (1990, p. 25) wrote that clients have a right to the following information before joining a group:

1. purpose of the group,
2. group format, procedures, and ground rules,
3. a pregroup interview to determine whether this particular group with this particular leader is at this time appropriate to one's needs,
4. an opportunity to seek information about the group, to pose questions, and to explore concerns,
5. education, training, and qualifications of the group leader,
6. information concerning fees and expenses and whether the fee includes a follow-up session; also information about the length of the group, frequency and duration of meetings, group goals, and types of techniques being employed,
7. psychological risks involved in group participation,
8. limitations of the confidential character of the group,
9. clarification of what services can and cannot be provided within the group,
10. help from the group leader in developing personal goals,
11. a clear understanding of the division of responsibility between the leader and participants,
12. a discussion of the rights and responsibilities of group members.

During the course of the group, clients have the right to expect (Corey, 1990, p. 26):

1. instructions concerning what is expected of the participants,
2. the freedom to leave the group,
3. notice of any research and tape or video recording; and the right to stop the recording if it restricts member participation,
4. an opportunity to discuss what one has learned in the group and to bring some closure to the group experience, so that the participant is not left with unnecessary unfinished business,

5. freedom from undue group pressure concerning participation in the group exercises, decision making, disclosure of private matters, or acceptance of suggestions from other group members,

6. observance of confidentiality on the part of the leader and other group members,

7. the right to be treated as an individual.

Professional Disclosure Statement

Corey et al. (1988, p. 150) described professional disclosure as "a process of informing prospective clients about the qualifications of a practitioner, the nature of the psychotherapeutic process, and the details of the services provided." They contend that such information benefits the counselor, through a process of thorough self-evaluation, as well as providing information for the client. Such information can help the consumer make an informed decision about which counselor to see.

Bloom et al. (1990, p. 517) have proposed model legislation for licensed professional counselors that includes a requirement that clients be furnished with a Professional Disclosure Statement. The Professional Disclosure Statement shall contain:

1. The name, title, business address, and business telephone number of the professional counselor performing the services.

2. The formal professional education of the professional counselor, including the institutions attended and the degrees received from them.

3. The professional counselor's philosophy of counseling, areas of specialization, and the services provided.
4. In the case of a person licensed under this act who is engaged in a private individual practice, partnership, or group practice, the person's fee schedule listed by type of service or hourly rate.

5. At the bottom of the first page of the disclosure statement, the words "This information is required by The Professional Counselors Licensure Board which regulates all Licensed Professional Counselors and Licensed Associated Counselors."

6. Immediately beneath the statement required by Item 5 of this subsection shall appear the name, address, and telephone numbers of the Board.

7. In the case of Licensed Associate Counselors, the name, title, business address, and business telephone number of the supervisor shall also appear on the Professional Disclosure Statement.

Several states presently require such disclosure. Arizona has no statutory requirement that counselors give each client a disclosure statement or clients' rights information.

A survey of Arizona counselors (Chapter 4) found that 37.6% of respondents provide clients with a professional disclosure statement.

**Clinical Records**

**Introduction**

Clinical records are the personal notes the counselor takes during or after sessions with a client, and are to be distinguished from business records. The business records include information such as dates of sessions, payment of fees, and health insurance reimbursements. On the other hand, the clinical records reflect the needs and personal taste of the practitioner (Piazza & Baruth, 1990).

Little is written in the counseling literature on documentation and record keeping (Snider, 1987). Two articles, one appearing in the *Journal of Counseling and Development* (Piazza & Baruth, 1990) and the other in the *Journal of Mental Health Counseling* (Snider,
1987), rely heavily on literature from the medical and legal fields. Doctors and psychiatrists have known the importance of adequate records for years, what mental health professionals are now beginning to learn (Siegel & Fischer, 1981). The mental health profession seems to agree that adequate client records benefit both the client and the counselor (Piazza & Baruth, 1990).

**Regulation of Clinical Notes**

Counselors are not required by law to write clinical notes (Remley, 1990) and ethical guidelines address the safe keeping and destruction of records but not the content.

**Clinical Notes and the Practice of Counseling**

The professional counseling literature espousing the view that clinical notes contribute to good practice. Counselors sometimes cite the chance of subpoena as their reason for keeping no notes (Chapter 4), as Watkins and Watkins (1983, p. 68) wrote: "Although some clinicians are loath to memorialize anything in writing, lest these writings perchance be subject to subpoena or be otherwise divulged, it is, nonetheless, quite prudent to record all treatment decisions, and, where appropriate, the reasons therefor."

Inadequate records usually count against the counselor and in favor of the client in the case of a malpractice suit (Snider, 1987; Beahrs, 1990). There is a saying that "... the weakest ink lasts longer than the strongest memory" (Snider, 1987, p. 136). Since malpractice suits generally take an average of five years between the time of the alleged incident until the time of trial, (Wills, 1987) "the record is often the most reliable evidence of proper diagnosis and treatment" (Soisson, VandeCreek, & Knapp, 1987, p. 499).

Most guidelines for counselors on how to keep "adequate" record were derived from guidelines developed in the medical field (Battista, 1985; Siegel & Fischer, 1981). Some believe that the counselor/client relationship is similar to the doctor/patient relationship and, therefore, counselors are advised to follow similar record-keeping procedures. Snider (1987, p. 135) wrote
that counselors are becoming increasingly involved as defendants in civil suits and are discovering what doctors have known for years: "Work not written is work not done."

A survey of psychologists (Fulero & Wilbert, 1988) found that 53.9% had changed their record-keeping practices as a result of the threat of malpractice litigation and as a result they now keep more thorough records. Only 7.6% reported keeping either none or minimal records.

Counselors who keep no clinical notes may be acting unprofessionally if that practice is contrary to the standards of the profession. A court of law could rule that a counselor breached professional responsibility to a client if that client was in any way harmed by the counselor's absence of note keeping and the court determined that the usual practice for counselors is to keep notes (Remley, 1990). An absence of adequate records may be seen by a court as an absence of care (Soisson et al., 1987).

Fear of lawsuits are not the only reasons cited for keeping good records; the record is also a part of counselor accountability (Snider, 1987). Records can show the justification for a counselor's actions (Siegel & Fischer, 1981). The record-keeping process, if done correctly, can help counselors think about the effectiveness of their therapeutic interventions and help them develop individual treatment plans for their clients (Ryback, Longabaugh, & Fowler, 1981). Soisson et al. (1987, p. 501) wrote that: "The primary purpose of the record ... is not only to document that treatment occurred but also to facilitate the coordination and continuity of services, to assist in evaluation of the client's condition and progress, and to evaluate the success or failure of treatment. Ultimately, the record should exist to serve the client.

Guidelines for "Adequate" Clinical Notes

With an absence of state laws or ethical codes to regulate record keeping, (Remley, 1990; Soisson et al., 1987) clinical notes in private practice are generally governed "more by
the idiosyncratic experiences of the clinician (Ryback et al., 1981, p. 87) who may haphazardly decide what to write down depending on the purpose of the records (Siegel & Fischer, 1981).

Snider (1987, p. 138) offered general suggestions that such notes be "unambiguous and precise," conservative, include no "abstract diagnosis" or "jargon," and consist of "clear behavioral descriptions, complete with concrete vignettes that support his or her conclusions." The professional should record relevant facts and leave out judgments (Smith, 1986; Glass, 1984; Battista, 1985).

Piazza and Baruth (1990, p. 315) offered more specific guidelines. They write that case notes should document client progress toward achieving treatment plan goals and should include the following four elements:

1. A statement of counselor's goals for the session which is to show a logical connection to previous sessions with the client. Goals need to be flexible to allow for pressing, immediate client concerns;
2. An evaluation of goal attainment for the session to show what techniques or interventions worked and/or failed, and what could have been done differently;
3. Clinical impressions that are based on client behavior or statements and not unsupported clinical impressions; and
4. An action plan for the next session which "ensures continuity of care over time and sessions."

The action plan becomes the statement of counselor's goals in the next session.

Soisson et al. (1987, p. 500) listed nine minimum inclusions in clinical notes:

1. Descriptive summary of all contacts,
2. Regular summaries of progress,
3. Available psychological test data,
4. Notations of informed consent to all aspects of treatment,
5. Notes concerning phone contacts and conversations with significant others in client's file,
6. Copies of all correspondence with the client,
7. When friends or relatives provided information,
8. When any corrections are made and why,

They listed six areas of information that should not be included in the record:
1. No guarantee of results,
2. No over optimism for treatment outcome,
3. No hunches or value judgments,
4. No emotional statements,
5. No personal opinions,
6. No information about illegal behavior, sex practices or other sensitive information that may embarrass or harm the client or others.

DePauw (1986, p. 305) summarized the record-keeping recommendations of the American Psychological Association in its "Specialty Guidelines for the Delivery of Services by Counseling Psychologists." The following are minimum inclusions: identifying data, data of services, types of services, significant actions taken, and outcome at termination. The guidelines also specify that: "(a) records be completed within a reasonable time, (b) records be retained for the length of time specified, (c) a system be established to protect confidentiality, (d) special safeguards be used when electronic data systems are involved."

There is general agreement that clinical notes be written extemporaneously; i.e., as soon after the session as possible. The counselor who sets time aside at the end of the week to update clinical notes will find those notes to be less helpful in court than ones written immediately or very shortly after a session (Greenlaw, 1982). If notes are done at the end of
the week, an attorney could argue that the counselor is maintaining the chart "in a manner reflecting an interest in personal convenience instead of the client's best interest" (Snider, 1987, p. 139).

One common format for recording client sessions is SOAP. It was developed by L. L. Weed (Siegel & Fischer, 1981) as a method of record keeping in the medical field and stands for Subjective, Objective, Assessment, and Plans (Ryback et al., 1981; Siegel & Fischer, 1981) 67% of surveyed Arizona counselors (Chapter 4), who use a specific method of record keeping, use the SOAP or modified SOAP method. One modified version is DAGP: Data, Assessment, Goals, and Plans (Siegel & Fischer, 1981); another is DAP: Data, Assessment, and Plans (Chapter 4).

There are no hard or fast rules about what information to include using the SOAP format. Typically, the following is recorded after each session (Siegel & Fischer, 1981):

1. Subjective (S): Client's reporting, i.e., what does the client say and feel; what does the client consider the problem to be; what does the client think would be helpful; what physical symptoms, if any, does the client report.

2. Objective (O): Observed behavior, i.e., what tone of voice did client use; did client show any emotion during the session; what was the client's physical appearance. Some professionals record test results in this section.

3. Assessment (A): Impressions of the counselor based on the subjective and objective; assessment of client's strengths and defenses based on supportable conclusions.

4. Plan (P): Interventions used in the session; homework assigned; interventions that might be useful in future sessions; agreements between counselor and client.

"Official" v. Private Records

Some counselors keep a set of "official" client records in their office file cabinet and "unofficial" ones in their desks or some other secret place. When a counselor is subpoenaed
to produce all of a client's records, that may include "official" as well as "unofficial" notes (Remley, 1990; Beigel & Earle, 1990). Refusal to submit such notes may result either in a fine or imprisonment. The counselor who lies on the witness stand, saying there are no "unofficial" files, when there are, may be found guilty of perjury, a criminal offense (Remley, 1990).

**Client Access to File**

Do clients have a right to see their own file upon request? VandeCreek et al. (1987) found that clients expect to be able to see most information in their files when they asked to see them. Nationally, there has been a growing trend to allow clients access to their own records (Turkington, 1987; Fulero & Wilbert, 1988). Counselors are admonished to keep records with the assumption that clients may eventually see them (Soisson et al., 1987).

A 1986 British study (Doel & Lawson, 1986) of a team of social workers who opened their clinical records to a select group of clients found a number of positive results: clients seemed to feel empowered by sharing the process of deciding what should be written in their files; and keeping records was no longer a "worker-centered diagnostic judgement" and became instead a "client-focused problem assessment" (p. 425).

One worker summed her experience:

There are lots of things which don't go down now which would have gone down in the past. I tended to record interviews from the moment I walked through the door to the moment I walked out again, whereas now it's much more of a case of "what actually happened?", "what were the problems?", "how have they been handled and what are the future plans?" It has actually made me sit down and think what I'm doing in a case and where I'm going with it (p. 423).

A study (Soisson et al., 1987) of psychiatric inpatients found that both patients and staff thought treatment had improved when patients could see their own records and thereby participate in the treatment process.

From a legal standpoint, clients have the right in most cases to view their own records (Remley, 1990; Bennett, Bryant, Vandenbos, & Greenwood, 1990; Miller & Sales, 1986). Mental health professionals have argued that records may contain interpretations, mannerisms,
statements, overt actions, etc., which, if seen by the client, may adversely affect the client and the client/therapist relationship (Rinas & Clyne-Jackson, 1988). Others have not found any hard evidence for such a claim (Turkington, 1987). A social worker in the British study (Doel & Lawson, 1986, p. 425) opined: "If you can’t confront the client with what you think about them, you certainly shouldn’t be hiding it away in a record."

Arizona law regulates the records of psychologists and psychiatrists and does not speak to behavioral health professionals (Miller & Sales, 1986). The Arizona Administrative Code R4-26-150 states that psychologists are acting unprofessionally when:

Failing to make available to a client or to his designated representative, upon the client’s written request, copies of records or documents which have been prepared for and paid for by the client. The psychologist may withhold such information from the client if in his professional judgement the release of such information clearly would adversely and substantially affect the client’s mental health.

Under state law, "unprofessional practices" of counselors includes "any conduct or practice which is contrary to recognized standards of ethics" (ARS §32-3251). The ethical codes for counselors address the safekeeping and ownership of records and not the content or client access (Herlihy & Golden, 1990).

Safekeeping and Retention of Records

All client records need to be filed in a secure place to protect the clients’ confidentiality (Remley, 1990). Snider (1987) recommended: they be in a locked file cabinet, as an "absolute minimum system"; they be kept for at least ten years; they never be sold to another practitioner; the original chart or records stay with the writer; and only a summary or copy of the record be forwarded to another professional at the client’s request.

Others (Soisson et al., 1987; Bennett et al., 1990) follow the recommendations of the "Specialty Guidelines for the Delivery of Services" of the American Psychological Association which states: retain full records for 3 years after termination; keep full records or a summary
for another 12 years; and do not destroyed records sooner than 15 years after last client contact.

**Sexual Conduct with Clients**

AACD’s Ethical Standards (Herlihy & Golden, 1990, p. 4) states: "The member will avoid any type of sexual intimacies with clients. Sexual relationships with clients are unethical."

The National Board for Certified Counselor’s Code of Ethics (Herlihy & Golden, 1990, p. 220) states: "Certified counselors do not condone or engage in sexual harassment which is defined as deliberate or repeated comments, gestures, or physical contact of a sexual nature.

The Code of Ethics for Mental Health Counselors (Herlihy & Golden, 1990, p. 195) states: "Sexual conduct, not limited to sexual intercourse, between mental health counselors and clients is specifically in violation of this code of ethics. This does not however, prohibit the use of explicit instructional aids including films and videotapes. Such use is within accepted practices of trained and competent sex therapists."

Arizona law states that "unprofessional practice" for behavioral health professionals includes: "... any conduct or practice which is contrary to recognized standards of ethics in the behavioral health profession. . ." (ARS §32-3251, Sec.9.i). In some states, Wisconsin, Minnesota, and Colorado, such conduct is considered a criminal offense (Hopkins & Anderson, 1990; Siegel, 1988).

Sexual contact with clients does not occur frequently (Pope et al., 1987); however, it has been the number one complaint of clients since 1980 according to the American Psychological Association (Gabbard, 1989). One survey found that only 4% of clients who reported sexual relationships with therapists filed formal complaints; half pursued the complaints to completion; and few formal complaints resulted in convictions (Hotelling, 1988).
A number of states have campaigns to educate clients about counselor/therapist sexual exploitation. California has developed a booklet entitled *Professional Therapy Never Includes Sex* (Quinn, 1990), and Minnesota has both a booklet and a pamphlet entitled *It's Never O.K.* (Public Education Work Group, 1990).

Despite the publicity, clients and counselors may not always be aware what behavior constitutes professional sexual misconduct, and what avenues are open to clients who are victims of such conduct (Hotelling, 1988).

**Misconceptions about Sex with Clients**

Pope and Bouhoutsos (1986) described four misconceptions about client/counselor sexual contact. Some counselors contend that sexual contact is acceptable if: (1) it does not occur during the session; (2) it occurs after therapy has terminated; (3) it is initiated by the client; and (4) one's colleague/supervisor was sexually involved with a student and/or client without being disciplined.

A national survey of psychologists (Pope et al., 1987, p. 996) found that 96.1% of respondents believed sexual contact with a client is never ethical; 95% believed erotic contact is never ethical; 85.1% believed sex with a clinical supervisee is never ethical and 50.2% believed sexual contact with a former client is never ethical.

The area of least agreement is sexual contact with a "former" client. According to Corey et al. (1988, p. 226), "state licensing boards and ethics committees have tended to rule against psychologists who use that defense." Confusion exists because most ethical guidelines do not address the issue of sex with former clients. The American Association for Marriage and Family therapy (1988) has adopted the rule that sex with former clients up to two years after therapy has ended is unethical.
Professionals would like all ethical guidelines to include provision about sexual contact with former clients. The question is, when does the therapeutic relationship end (Corey et al., 1988)?

Ethical committees and courts also have not accepted the defense that the client initiated and fully participated in the sexual contact (Corey et al., 1988; Hopkins & Anderson, 1990). The professional is always to prevent sexual contact with a client (Gabbard, 1989; Siegel, 1988).

Minnesota, which has criminalized sexual contact with clients, informs consumers: "It makes no difference even if you agreed and actively participated in the sex. It is still a crime committed by the therapist" (Public Education Work Group, 1990). Michigan law considers sexual misconduct by therapists as rape (Hotelling, 1988).

Counseling the Sexually Exploited Client

Counselors may see clients who have been sexually involved with a previous counselor or therapist. Gabbard (1989) recommended that counselors be alert to the possibility that each new client who has been in therapy previously may have had sexual contact with that therapist, even when the presenting problem is something else; clients may not initially admit to such contact. Pope and Bouhoutsos (1986, p. 47) described the characteristics of clients who are at low-risk, middle-risk, or high-risk for sexual involvement with a counselor or therapist.

1. **Low-risk group:** Highly stressed patients who have no history of prior hospitalization, are normally high functioning, come from a stable family background, and who have had previous long-term fulfilling intimate emotional and sexual relationships.

2. **Middle-risk group:** Patients who give a history of prior relationship problems, appear to be somewhat dependent and needy, and may fall into the personality disorder category.
3. **High-risk group:** Patients who have a history of previous hospitalization, suicide attempts, major psychiatric illnesses, and drug or alcohol addiction problems.

The professional who becomes involved with clients is most likely male, isolated from other professionals, overly self-confident in own abilities, charismatic, older than the client, and well established in practice (Gabbard, 1989; Pope & Bouhoutsos, 1986). Often such a practitioner may feel superior to other practitioners and may consider the use of sex to be an innovative technique (Gabbard, 1989). Others believe such professionals have psychological problems they act out with their clients (Pope & Bouhoutsos, 1986).

How does a counselor best help a client who discloses sexual involvement with a former counselor or therapist? The counselor needs to listen openly and refrain from interjecting personal reactions; needs to be aware that such clients may have suicidal tendencies; and should not practice lawyer, which could aggravate the client's condition (Gabbard, 1989).

The counselor also needs to respect the client's decisions and not attempt to convince the client to file a complaint (Gabbard, 1989). Clients may exhibit symptoms similar to post traumatic stress disorder (Pope & Bouhoutsos, 1986), and cajoling the client to file a complaint may add to the client's sense of victimization (Hotelling, 1988).

The counselor who wishes to treat a client who has been sexually exploited by another professional needs to be experienced and adequately trained. Competence includes familiarity with current theory, research, and treatment techniques in that area (Gabbard, 1989).

Hotelling (1988) described the three avenues open to the client who wants to file a complaint: ethical, administrative, and legal.

1. **Ethical.** The first step is to determine of which professional associations, the practitioner is a member (some practitioners have no professional affiliations); next write and obtain the association's policies and procedures for filing complaints.
The Arizona Counselors Association does not have its own policies and procedures for ethical complaints; members must contact AACD and request AACD's Policies and Procedures for Processing Complaints of Ethical Violations (Herlihy & Golden, 1990).

A complaint to a professional organization could result in the practitioner's expulsion from that organization. This approach is limited in that the professional association cannot revoke a license, curtail or stop practice, or award monetary compensation to the victim. On the other hand, a loss of association membership may cause a loss of insurance coverage, public embarrassment, and may be used as evidence in a lawsuit.

Some associations have no statutes of limitation in filing a complaint; in other words, it does not matter how long ago the incident occurred, a complaint can still be filed.

2. Administrative. To file an administrative complaint contact either the state licensing or certification board under which the practitioner is regulated; another avenue is to contact the agency or institution that may employ the practitioner. Not all professionals offering counseling services are licensed or certified.

A successful administrative complaint may cause the practitioner to lose state credentialing and a loss of a job, if employed by an agency or institution; some financial settlement may be possible.

3. Legal. Sexual misconduct may be tried as a civil and as a criminal action. Contact an attorney who is familiar with professional malpractice. Civil suits charge the professional with malpractice. This may be the avenue to take when the counselor is not licensed. Criminal suits are brought by the state for behavior "that the state has defined as illegal and thus punishable by law" (Hotelling, 1988, p. 235). Criminal suits have traditionally not included the award of damages to the victim.
The civil suit seeks compensation for the "cost of treatment, subsequent cost of healing, and/or pain and suffering" (Hotelling, 1988, p. 235). Compensation depends on the practitioner's insurance coverage. Some insurance policies, however, do not cover or limit payment for sexual misconduct. Insurance companies generally are reluctant to have such cases go to court and will try to settle. Practitioners who want to avoid publicity will offer to settle in exchange for client's written agreement not to file complaints with licensing boards and not to make any public statements.

A criminal suit may result in the professional being found guilty and punishable by law. An individual may be charged both civilly and criminally for the same wrongful act.

Some disadvantages of legal action are: the suit has to be filed within a specific time period determined by the statute of limitations of one's state (the statute of limitations for minors does not begin until they reach the age of 18); juries are less sympathetic to clients who have had sexual contact with their counselors; the extensive time involvement; the expense and emotional drain; and the loss of confidentiality. On the positive side, a successful legal suit may empower the client and have a healing effect. The errant professional may be put out of business.

Levenson (1986) wrote that professionals sometimes do not report a colleague because they are not certain of the colleague's guilt. Reporting a colleague is difficult. However, it is not the professional's job to "be detective, judge, and jury" (p. 317). A counselor may learn of potential sexual abuse in one of three ways: The client reports the abuse; another colleague tells of the abuse; or the professional learns directly from the errant colleague or through observation.
Levenson (1986) suggested the following interventions:

1. Explore the client's feelings about reporting. If client wants to report, obtain the client's written consent before speaking to anyone else.

2. Contact the accused professional to discuss the allegations directly.

3. Make a formal report if, after talking to the accused professional, there is a sense that the allegations may be true.

4. File a report with the state or national ethical committee of which the professional is a member; if no member of any professional organization, contact his/her supervisor.

AACD Policies and Procedures for Processing Complaints of Violations (Herlihy & Golden, 1990, p. 227) include the following procedures for submitting complaints:

1. If feasible, the complainant should discuss with utmost confidentiality the nature of the complaint with a colleague to see if he/she views the situation as an ethical violation.

2. Whenever feasible, the complainant is to approach the accused directly to discuss and resolve the complaint.

3. In cases where a resolution is not forthcoming at the personal level, the complainant shall prepare a formal written statement of the complaint, stating the details of the alleged violation and shall submit it to the AACD Ethics Committee.

Mail all complaints, directed to the AACD Ethics Committee, to:

The Ethics Committee  
c/o The Executive Director  
American Association for Counseling and Development  
5999 Stevenson Avenue  
Alexandria, Virginia 22304

The envelope must be marked "CONFIDENTIAL" to ensure confidentiality both for the individual sending the complaint and the individual accused of the complaint.

The counselor who hears of misconduct and who reports a colleague, may not be the best professional to treat the client further (Levenson, 1986).
RELATED LITERATURE TO SECTION III:  
COUNSELOR AND THE LAW

Since the mid-1970s, mental health professions have increasingly become involved in the American legal system. There are many areas of involvement: friends of the court (amicus curiae), expert witnesses, witnesses of fact, defendants, and plaintiffs (Krieshok, 1987). The counselor may appear in four different settings: criminal court, juvenile court, civil court, and family court (Bennett et al., 1990). The licensed professional counselor has a "high probability of going to court at least once during a lifetime of service" (Wills, 1987, p. 101).

The Counselor in Court

Fact Witness

The counselor, like any other citizen, may be called to testify about any pertinent fact about which he or she has first-hand, nonprivileged, information (Krieshok, 1987). Such testimony may be elicited in a number of ways, including by deposition and by appearance in court (Bennett et al., 1990). The counselor may be compelled to appear at a deposition or in court by a subpoena.

Miller and Sales (1986, p. 94) defined subpoena as "... a written order of the court compelling a witness to appear and give testimony." The subpoena, of itself, does not vitiate the certified counselor-client privilege, which continues until the client waives it or until a court determines that it no longer exists. A failure to appear in court at the specified time may result in contempt of court charges and possible incarceration until the counselor is willing to comply by the order.

A counselor may also be served a subpoena duces tecum which requires that he or she bring specific physical evidence, such as client records, to court (Miller & Sales, 1986). When files are subpoenaed, everything in the file, unabridged, must be turned over (Whittington, 1988). The counselor may protest such orders to the judge but may not refuse to comply (Hopkins & Anderson, 1990).
When a counselor is asked to testify about a client, the client's attorney may ask the judge for a motion for a protective order. This protects the information the counselor has about the client which is deemed by the judge irrelevant to the case (Krieshok, 1987).

Expert Witness

An expert witness is someone who knows more about trade, art or science or other area than the average, lay person would know, and whose "expert opinion" comes from three spheres of knowledge: formal education and training, experience, and state of knowledge in a discipline. Opinion is expected to be made with "reasonable certainty." "Reasonable" typically means "the average standard of the profession" (Krieshok, 1987, p. 95). An expert witness can base opinion on observation, tests, calculations, etc.; whereas, other witnesses can testify only to what they heard or saw (Moloney, 1986).

An expert witness is not required to have any particular level of experience. Even a relatively inexperienced expert may be called upon to give opinion testimony (Moloney, 1986). Under the rules of evidence, expert witnesses are allowed to give opinion testimony that is "helpful" to the judge or jury; experts are not required to have "special" or "complete" knowledge in their areas of expertise (Slovenko, 1987).

The expert's knowledge is given to assist in understanding the evidence before the judge or jury (Evans, 1983; Bulkley, 1988; Krieshok, 1987). Experts generally do not give opinions about the ultimate issue before the court, such as guilt or innocence, or the credibility of a witness, which is the province of the jury or judge (Krieshok, 1987; Bulkley, 1988). State law determines the evidence expert witnesses may present. In Arizona, expert witnesses can be asked to state an opinion or inference about the ultimate issue before the court (Arizona Rules of Evidence, Article VII, Rule 704, Opinion on Ultimate Issue, 1988). Counselors are offered the following advice when called upon to provide expert testimony (Krieshok, 1987; Slovenko, 1987; Rinas & Clyne-Jackson, 1988; Wills, 1987; Weikel, 1986):
Before the court date:

1. **Do not work for careless attorneys.** Those are the ones who will not allow you the information and access to their client which you need to feel comfortable about your opinion.

2. **Avoid attorneys who try to change your opinion.**

3. **Be aware that a good psychological assessment takes about 8 hours.** Refuse to testify if you are given substantially less time; your credibility is on the line.

4. **Know the legal issues covered by the case and the area** to which your testimony will be addressed.

5. **Get a release before talking to anyone or making an appearance.** Asking for a subpoena or judicial order may be an alternative.

6. **Give criminal defendants a Miranda warning before starting the examination.**

7. **When assessing the defendant, do not ask questions about areas that are unrelated to the question under study.** For example, if the question is: Is the defendant competent to stand trial? Do not ask: "What was the defendant's state of mind or behavior at the time of the crime?"

8. **Avoid putting labels on the defendants.** Labels are notoriously unreliable and the public, i.e., a jury, may regard labels as absolutes. Instead use clear behavioral descriptions. Include no absolute statements about state of mind at a time other than the present.

9. **Ask the referring attorney to make every effort to furnish all relevant material on which to base an opinion.**

10. **Do work very carefully:** Score tests twice; prepare a written report even if not required; let the attorney know what you will say.

11. **Maintain a very accurate and detailed file on each case.**
12. **Develop a cue book** to take to court for very accurate responses to questions. Keep in mind that whatever you take to the witness stand to help you testify, the other side gets to see.

13. **Critique and staff the case with a skilled forensic colleague** in order to highlight areas where research and knowledge may be taken for granted.

14. **Put yourself in the role of devil’s advocate.**

15. **Insist on a conference with the attorney** who requested your testimony to walk you through direct examination. This gives you an idea of what might be asked and where the weak spots in your testimony are.

16. **Learn the rules of the court.** Know where to stand, how to raise your hand, when to keep quiet, and so on.

17. **Be aware that experts who testify frequently in front of the same judge may lose their credibility** as certain judges get to know their credibility.

**In Court:**

1. **Dress, demeanor, and appearance should be of a conservative nature**, suitable for the locale.

2. **Arrive on time** or shortly before the scheduled appearance, sit quietly outside the courtroom, avoid conversation with the litigants and leave after making your appearance.

3. **Be yourself.** When some clinicians get into the witness box, former modest claims of professional objectives go out the window, and the expert makes outrageous claims of certainty.

4. **Testify only within the area where expertise is clear.** Be prepared to justify all conclusions and opinions.
5. **Maintain the impartiality of a disinterested third party** and avoid being lured into an advocate position.

7. **Refrain from using pompous mental health jargon** because it does not communicate.

8. **Maintain an even temperament and professional style** even when the challenge is ungracious.

9. **Avoid over-elaboration as well as bombastic and flamboyant comments.**

10. **Comfortably concede the necessary issue** in order to maintain an honest and creditable posture in spite of any damage to your testimony.

11. **Do not make personal, social or moral statements in the guise of scientific judgments and opinions.**

12. **Leave after making your appearance.** Avoid further contact with the litigants.

After your appearance:

If you would like to evaluate and critique your testimony, you can buy a copy of your testimony from the court reporter.

During court testimony, the expert can expect to be questioned about three different areas:

1. **Professional Training and Experience:** The expert must always be up front about his or her expertise and experience (Moloney, 1986; Glass, 1984).

2. **The Work Product:** The expert must expect questions about methods, theories, principles, assessments, and reliability and validity of tests used to form opinion (Glass, 1984). If using tests, the expert needs to be knowledgeable of their evaluations in Buro's Mental Measurements Yearbook (Wills, 1987). If using the DSM-III-R for diagnosing a client, the expert needs to be aware that the DSM-III-R could be questioned as a reliable source because the methods used to include or exclude items are not always based on sound scientific data. For example, in 1973 the trustees of
the American Psychiatric Association decided to remove the classification of homosexuality from the Manual based on a vote of the membership (Wills, 1987).

3. Professional Credentials: The expert must never misrepresent his or her credentials and keep in mind that anything in one's curriculum vitae is fair game for cross examination. Professional credentials may be questioned if licensure or certification was received under a "grandfather" clause and did not require a proficiency exam. Upon cross examination, the attorney is likely to ask if licensing involved a test and a demonstration of competency or just filling out an application and sending in some money (Wills, 1987; Glass, 1984).

Professional Standard of Care and Malpractice

Negligence

Legally, all adults are expected to behave the way any "ordinary and reasonable" person would act in the same or similar circumstances (Cohen, 1983; Everstine & Everstine, 1986). When a person's actions unintentionally fall below this standard, the behavior is described as negligent. Negligence is defined as "conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm" (Cohen, 1983, p. 10).

Malpractice

Members of professions, like counseling, are held to a higher standard of conduct which is measured by the actions of ordinary and reasonable persons in their profession. If a professional falls below this higher standard, the term "malpractice" applies (Cohen, 1983, p. 10). Malpractice is defined as: "The failure of one rendering professional services to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession with the result of injury, loss, or damage to the recipient of those services or to those entitled to rely upon them" (Beis, 1984, p. 24).
That higher standard of care, however, does not imply perfection. Chief Justice Tindal in the 1832 case of *Lamphier v. Phipus* stated that the professional "is not charged by law to be brilliant. "Others have stated that counselors, as well as other professionals are not "guarantors of good results" (Cohen, 1983, p. 11).

Cases in which the client fails to completely and accurately disclose important personal information, the counselor may not be held negligent in treatment of the client. This duty was defined in 1979 in *Mackey v. Greenview Hospital, Inc.*, in which a patient was found to have a duty to reveal information known to be relevant and whose omission was known to be risky. Clients' liability for their own actions does not, however, absolve the professional's possible liability in failing to warn a third party of potential injury (Beahrs, 1990).

**Professional Standard of Care**

State law regulates who may be considered a "professional" (Bennett et al., 1990). However, unregulated practitioners may be held to the same higher standard of care as are professionals (Cohen & Mariano, 1982). Individuals who falsely represent themselves as professionals may also be held to the higher standard of care (Cohen, 1983).

How does a professional counselor determine what constitutes ordinary and prudent behavior? The standard is not clearly defined (Soisson et al., 1987), and the practitioner may encounter conflicts of interest when statutory (state) law, case law and ethical guidelines require different behavior (Schopp & Wexler, 1989). Generally, the professional is expected to perform with the same care and competence as members of that profession in good standing (Schopp & Wexler, 1989).

The standard of care is usually measured by other professionals practicing in the same philosophical school (Cohen, 1983) and is determined in a court of law either through expert testimony (Paquin, 1988; Schopp & Wexler, 1989), by requirements set forth in applicable state statutes (Bennett et al., 1990), or by the ethical guidelines of professional associations (Hopkins...
The form of treatment needs to be supported "by at least a 'respectable minority' of the members of the profession. If treatment is unorthodox, the practitioner may be required to justify its application (Cohen, 1983).

The courts used to adhere to a "locality rule" to determine standard of care, which held that a professional's conduct was measured by the conduct of other similar professionals in one's "local" community. The community that defines the standard of care is now the entire state. However, standards in other states may also influence the standard in Arizona (Bennett et al., 1990; Soisson et al., 1987; Fulero & Wilbert, 1988).

What is a reasonable standard of care? Sheldon-Wildgen (1982) described a general standard of care for mental health professionals that reflects the opinion of most counseling professionals and is summarized as follows.

The "reasonable" counselor:

1. **Provides information to the client and obtains consent for therapy.**

   Areas that should be addressed in writing and signed before therapy begins:
   - description of services, goals, procedures,
   - behavior required of client (i.e., active or passive),
   - negatively and positively anticipated results,
   - length and frequency of treatment,
   - timetable for review of progress and client recourse if not satisfied,
   - cost of services,
   - statement about confidential and privileged information.

2. **Provides Appropriate Treatment.**

   Appropriate treatment includes:
   - proper diagnosis of problem,
   - use of instruments with proven validity and reliability,
knowledge and reliance on current published literature for professional justification of treatment,
consultation with other professionals,
discussion of alternate treatments with client,
written record of agreed upon goals and treatment procedure.

3. Ensures Appropriate Qualifications and Referrals.

Appropriate qualifications and referrals include:
determining an area of specialty,
keeping abreast of research and developments in that specialty,
recognizing one professional limitations,
referring client to qualified professional if no progress is evident,

4. Balances Confidentiality with "The Duty to Warn".

This includes:
telling the client at the outset of therapy that all confidential information will only be disclosed with the client's permission,
telling the client situations in which confidentiality may be legally breached.

Standard of Care and Minority Group/Crosscultural Clients

Many mental health professionals believe that counselors need special training before counseling minority group/cross-cultural clients (Atkinson, Morten, & Sue, 1989; Corey, 1990, 1991; Corey et al., 1988; Ibrahim & Arreydondo, 1990). Some consider counseling such populations without training as unethical (Corey, 1991). A culturally skilled counselor needs to adhere to the basic standard of care mentioned above as well as the following specialized beliefs/attitudes, knowledge, and skills (Sue, Bernier, Feinberg, Pederson, Smith, & Vasquez-Nuttall, 1981, p. 305):
1. Awareness and sensitivity about one's own cultural heritage, with an understanding and appreciation for other cultures;

2. Awareness of one's own values and biases and how they may affect counseling minority clients;

3. Comfort with differences between oneself and the client in terms of race and beliefs;

4. Sensitivity to personal biases, stage of ethnic identity, sociopolitical influences, etc., that may dictate referral of the minority client to a member of his/her own race/culture;

5. Understanding of the sociopolitical history of the United States with respect to its treatment of minorities and an understanding of institutional barriers that may prevent minority members from seeking counseling;

6. Knowledge and information about the particular client or group whom one is counseling;

7. Familiarity and working knowledge of a wide variety of verbal and nonverbal responses;

8. Ability to exercise institutional intervention skills on behalf of one’s client when appropriate.

Lawsuits

Litigaphobia

One American in four is estimated to have some personal experience with counseling or therapy due to the fact, there is less stigma attached to counseling today, counselors are more readily available, and health plans are increasingly covering mental health care. Some counseling professionals believe that an increase in clients has also brought an increase in the number of lawsuits (Bernard & O’Laughlin, 1990; Sheldon-Wildgen, 1982; Siegel, 1988). Adding to the risk of lawsuits may be an increased clientele which does not want to be treated but is mandated to receive counseling by orders of a court (Watkins & Watkins, 1983).
Some counselors have developed a phobia about being sued, called litigaphobia (Brodsky, 1988), although that fear is neither warranted (Brodsky, 1988) nor epidemic (Wilbert & Fulero, 1988). However, when a law suit is filed, it may have a lasting impact on the affected professional (Cavanaugh & Rogers, 1983).

How high is the risk of being sued? Among psychologists, the estimated risk of being sued is about 0.5%, and the actual number of suits/year was 153 between 1982-1984 (Wilbert & Fulero, 1988). Figures for 1987 indicate that mental health professionals were winning up to 70% of their cases, however, the price for winning may range upward to $50,000 for legal fees (Schopp & Wexler, 1989; Wills, 1987).

Proof of Harm

Successful malpractice claims against mental health professionals may be relatively low because proof of harm is more difficult to gauge. When suing a counselor, the plaintiff needs to demonstrate that (Soisson et al., 1987, p. 498; Bennett et al., 1990, p. 35):

1. The practitioner owed a duty to the plaintiff that was based on an established therapeutic relationship;

2. The quality of care provided by the practitioner fell below the standard of care expected of the average practitioner;

3. The [client] suffered or was caused harm or injury;

4. The practitioner's dereliction of duty was the direct cause of the harm or injury.

All four elements need to be proved in order for the plaintiff to win. Successful suits have generally involved clients who inflicted some tangible physical injury either to themselves or to others. However, courts are recognizing and awarding damages more frequently when the injury is emotional distress (Cohen, 1983). If the plaintiff prevails, three types of damages are commonly awarded in personal injury cases (civil suits): lost earnings, expenses for past, present and future care, and pain and suffering (Paquin, 1988).
Common Causes of Lawsuits

Lawsuits are usually brought when clients feel they have been treated negligently; that the therapist has not acted in a reasonably professional manner (Sheldon-Wildgen, 1982; Wills, 1987; Kermani, 1989; Hendrickson, 1982; Schopp & Wexler, 1989). Many areas of conduct may result in the counselor being sued.

Frequently, a fee dispute triggers a malpractice claim against private practitioners. The dispute usually is not listed as the cause of the complaint. The client sues when the professional tries to collect a large unpaid bill (Cohen, 1983; Wilbert & Fulero, 1988; Bennett et al., 1990).

Sexual misconduct is one of the most common causes of malpractice suits (Hendrickson, 1982; Leesfield, 1987; Siegel, 1988; Cohen, 1983). Some courts will consider any "physical invasion of the patient as improper practice per se" precluding the need for expert testimony to determine a standard of care (Schopp & Wexler, 1989; Cohen, 1983; Leesfield, 1987; Bennett et al., 1990).

Another common complaint results from a breach of confidentiality. Difficulty ensues when a professional fails to properly disguise a client's identity in published reports (Whittington, 1988), in conversations with others (Bennett et al., 1990), and in poorly secured records (Hendrickson, 1982). Conversely, neglecting to breach confidentiality in cases that warrant a duty to warn or to report, as in child abuse, may also result in a lawsuit (Leesfield, 1987; Watkins & Watkins, 1983).

The interpretation of psychological tests, particularly through the use of computer-generated assessment instruments is another area of potential liability. (Cohen, 1983; Meier & Geiger, 1986). The professional who is untrained in assessment and testing may perceive the computer-generated printout as "hard science" (Meier & Geiger, 1986). However, conducting any psychological evaluation without proper skill is fraught with danger (Cohen, 1983).
Watkins and Watkins (1983, p. 68) consider "the lack of adequate records to substantiate clinical choices as fertile ground for malpractice claims." Others agree (Snider, 1987; Hendrickson, 1982; Fulero & Wilbert, 1988; Soisson et al., 1988; Bennett et al., 1990). No records, or poorly-kept records, are likely to tip the scale against the professional who is involved in a lawsuit (Glass, 1984).

Other areas of potential difficulty include any "radical" treatment that produces unwanted effects (Watkins & Watkins, 1983), improper termination of treatment (Leesfield, 1987), custody evaluations (Wilbert & Fulero, 1988), referral to professionals who act negligently (Cohen, 1983), disgruntled spouses or parents of the client (Wilbert & Fulero, 1988); and a professional partner's negligent behavior (Cohen, 1983).

How To Avoid a Lawsuit

The opposite of malpractice is good practice (Wills, 1987). Preventative measures for malpractice are seen as "positive changes that work to promote sound and ethical practice" (Wilbert & Fulero, 1988, p. 381). To reduce the risk of malpractice the counselor is advised to:

1. Never allow a client to run up a high bill that one intends to collect (Wright, 1981).
2. Know the law—keep up with changes in both case law and state laws through professional literature, other counselors and attorneys (Wills, 1987; Cohen, 1983).
3. Contact the malpractice insurance broker immediately after a client commits either suicide or homicide: the broker who may be able to provide valuable information and assistance in obtaining help before any legal action is taken (Wright, 1981).
4. Obtain the client's written consent preceding any "radical" treatment; include in writing information about all the expected, positive and negative, effects of the treatment, and
provide the client a reasonable amounts of time to consider the treatment (Watkins & Watkins, 1983). A client cannot consent to improper or illegal treatment such as sexual misconduct (Gabbard, 1989).

5. Avoid abandonment charges when terminating treatment of an uncooperative or abusive client by giving written notice to the client and by providing alternate treatment choices (Beahrs, 1990).

6. Consult a Peer Review or Human Rights committee before implementing a controversial method of treatment (Sheldon-Wildgen, 1982).


8. Treat children and adolescents with special care (Wills, 1987).

What To Do If Sued

When the process server shows up on the door step and delivers a summons to appear in court, the professional is likely to experience an immediate high level of anxiety, followed by feelings of righteous indignation, anger, vindictiveness and lowered self-esteem (Wilbert & Fulero, 1988).

The following are some basic guidelines of what do if sued (Cohen, 1983; Wright, 1981; Bennett et al., 1990).

1. "Do not panic" and under no circumstances call your client "to reconcile [sic], berate or apologize and beg for mercy" (Cohen, 1983, p. 19).

2. Do not write any letters to the client.

3. Promptly notify your malpractice insurance carrier. Failing to do so may negate the coverage. The carrier is responsible for your defense and will appoint an attorney. Some carriers will allow you to select your own attorney. If you are not satisfied with the appointed attorney, you may want to retain your own attorney who will work in
cooperation with the carrier's attorney. Once retained, the insurance company appointed attorney may only represent your interests and not those of the insurance carrier (A. R. Christensen, attorney, personal communication, February, 1991).

4. Only discuss the case with your attorney unless directed to do otherwise by the attorney. Do not discuss the case with your friends and family; only your spouse is immune from having to testify against you.

5. If you consult another mental health professional about the case, do so only with your attorney's knowledge and permission, and only discuss the case in hypothetical terms, because "professional case consultation is generally not considered privileged information" (Wright, 1981, p. 1541).

6. Collect all personal written documents that may pertain to the case. Do not make any additions or deletions to any files or notes, and do not destroy them. Consider that the plaintiff, your ex-client, could have the following corroborating evidence against you: journals, diaries, calendars, letters or notes from you, overheard phone calls by family members, confessions to friends, and knowledge of physical marks on intimate parts of your body.

7. The plaintiff, plaintiff's attorney and court may request documents; only make them available through your attorney and always keep the originals.

8. If you and your place of employment have been named in the suit, you may not want to agree to joint legal representation by one attorney; it is important to have your own who will represent only your interests.

9. Your attorney should be a specialist in malpractice cases.

10. If your insurance carrier wants to settle and you want to "go the distance" you will need to do so at your own cost and expense.

11. Write summaries of all events pertinent to your case.
12. Anytime the plaintiff and plaintiff's attorney contact you, say nothing and immediately inform your own attorney. In our legal system the plaintiff's attorney may not contact you directly (A. R. Christensen, personal communication, February, 1991).

13. Immediately stop treating a client who is suing you.

14. Prepare yourself for a long involvement with the case, maybe years.

How Do I Find My Own Attorney?

In the event of a lawsuit, the insurance company will appoint an attorney (Wright, 1981). To consult with an attorney on mental health issues, the best way to find an attorney may be by word of mouth (Richards, 1990).

Professional Liability Insurance

Insurance companies generally refer to malpractice insurance as "professional liability" insurance (Cohen & Mariano, 1982). All counselors are advised to carry professional liability insurance (Hendrickson, 1982) because "any practitioner who undertakes a duty of care" may be sued even if no wrongful deed was ever done (Bennett et al., 1990, p. 99). Professional liability insurance should cover two different types of liability: malpractice and injury to another. The first covers unprofessional conduct and the latter, any physical injury (Hopkins & Anderson, 1990). When choosing insurance coverage the following factors should be considered:

Types of Policies

There are two basic types of policies: claims-made policies and occurrence-based policies.

The claims-made policy requires that you are insured with the company when the alleged act occurred and that you are continuously insured with the same company up to the time the claim is filed. This kind of coverage is usually less expensive, but has limitations that may cost money to overcome. You could be sued after you retire because the statute of
limitations for children, for example, does not begin until they reach eighteen. Companies offer "tails", "riders", or "reporting endorsements" for such situations (Bennett et al., 1990, p. 107).

Occurrence-based policies cover any claims against acts that occurred during the policy period regardless of how long afterwards the claim is filed. This type of coverage is more expensive, but it, in effect, protects forever. An advantage under this type of plan is the freedom to switch insurance companies or policies when the need arises (Bennett et al., 1990).

Coverage

In 1981, a 25-year review of insurance claims against psychologists showed that three fourths of the claims settled for less than $5,000 (Wright, 1981). Figures in 1987 showed that mental health professionals were winning up to 70% of their cases, however, the price for winning ranged upward to $50,000 for legal fees (Wills, 1987). More recent figures suggest that coverage in the low hundred thousand range may be sufficient protection even for a "catastrophic claim" (Bennett et al., 1990). Counseling professionals consider coverage of one million to be more realistic (Advisory Panel Members, Chapter 4).

Some policies cover only from the time a "formal legal complaint" is filed and not from the time the first warning signs of an impending suit may appear (Bennett et al., 1990, p. 110). Insurance carriers generally select the attorney to represent the professional in a malpractice suit; some plans allow the professional to chose their own attorney (Hopkins & Anderson, 1990; Bennett et al., 1990).

The following acts are either never covered or variously covered (Siegel, 1988; Bennett et al., 1990):

1. Criminal acts are never covered.
2. Sexual misconduct is variously covered. Some companies cover everything; others cover legal expenses only; others cover legal expenses with a lid on settlements or damages; and some cover nothing.

3. Fee disputes are variously covered by insurance carriers.

4. Taking action against another insurance plan member is generally not covered. Counselors who step outside of their professional boundaries by giving legal, financial, medical or other noncounseling advice, and are sued for such advice, may not be covered under their professional liability insurance; professionals need to know how narrowly the insurance carrier defines the practice of counseling.

The counselor who is in partnership with others, or employed in an agency, or just shares an office with nonmental health professions, needs personal coverage in the event a claim is filed against one of the others. Likewise, an individual who is employed in a large corporation, like a hospital, cannot assume immunity from personal liability (Bennett et al., 1990).

Rating the Insurance Carrier

Not all insurance companies are solvent when it comes time to pay a claim because the business of professional liability insurance tends to be volatile. All companies are regulated by state government through the state insurance commissioner. One can learn from the commissioner's office if one's present or intended carrier protects its policy holders by a state-backed guarantee in the event of bankruptcy. One can also gauge a company's financial stability by looking at the A. M. Best Company's rating guide, found in all public libraries. One wants a company with either an A+ or A rating (Bennett et al., 1990).
RELATED LITERATURE TO SECTION IV: ETHICS AND THE COUNSELOR

When Ethical Issues Arise

Ethics may be defined as "the science of moral obligation and duty." The Latin root of science, "scio", means to know. Ethics then is "to know duty" (Lindenberg, 1981, p. 255).

Determining what is ethical behavior is "often a perplexing dilemma" (Gross & Robinson, 1987, p. 5), may involve difficult decisions (Robinson & Gross, 1986, 1989), and is "usually not clear-cut" (Corey et al., 1988, p. 4). Corey et al. (1988) talked of "aspirational ethics" which comes from an "inner quality" that goes beyond the adherence to laws and ethical codes of one's profession. The latter they call "mandatory ethics." Robinson and Gross (1989, p. 310) wrote that: "At the core of all ethical behavior is the personal responsibility [of counselors] to determine what ethical conduct means both philosophically and behaviorally and to incorporate this meaning into their professional practice."

Tennyson and Strom (1986, p. 299) talked of responsibility and responsibleness. "Responsibility" is that part of professional conduct which is "imposed by some authority," and "responsibleness" "... comes from within, and the person responds not out of duty alone, but because he or she decides a certain response is right." Most professional decisions seem to be made intuitively and automatically and "ethical dilemmas arise ... when two or more values, principles, or obligations conflict; and uncertainty prevents the intuitive response" (Woody, 1990, p. 133).

Codes of Ethics

Ethical codes are one form of authority imposing rules on the counselor. Woody (1990, p. 137) wrote that: "Professional codes of ethics appear to offer "absolute" rules and principles for proper conduct; but the terms used are, in fact, general and subject to definition and interpretation."
Codes are variably believed to be the beacon that lights the way towards the highest standards (Herlihy & Golden, 1990), the ideal and not the minimum (Bray, Shepherd et al., 1985), the profession's way of self-regulation to avoid governmental regulation (Wylie, 1989), and by their conservative nature not a reflection of "ideal practice" (Corey et al., 1988, p. 5).

Wylie (1989, p. 24) opined that "ethical codes are not moral rules themselves [and that] 'ethics' refers only to the study of what constitutes moral conduct, not the conduct itself."

Mabe and Rollins (1986, p. 294) reflected a widely held view: "Although [a code's] primary function is to establish a framework for professional behavior and responsibility, the code also serves as a vehicle for professional identity and a mark of the maturity of the profession. . . . The code is clearly a central part, but only a part, of the basis for the explication of professional responsibility."

Wylie (1989) found that the "welfare of the client" is basic to all ethical codes, but that it is unclear what it means to consider the welfare of the client. Does this mean the client leaves therapy happy and cured? She reasoned that "the most scrupulously ethical therapist may not be the most effective one" (p. 24).

Wylie (1989) considered therapy as an ethical balancing act with the ethics of the counselor and not the ethics of the therapy in question. Blind adherence to a theoretical framework and disregard for what clients say they need and want becomes an "ethical failing." She wrote that the ethical counselor is "honest, trustworthy, sensitive, knowledgeable, courageous, open-minded, modest, and rigorously self-reflective" (p. 33).

The professional literature expresses the importance for practitioners to recognize the limitations of codes. Rinas and Clyne-Jackson (1988, p. 4) reflected the commonly expressed view that ethical codes "may be too general to be of help in specific instances and are often subject to interpretation." Herlihy and Golden (1990, p. 122) believed that thorough knowledge of one's professional code of ethics is important, but that "in the face-to-face counseling situation counselors must grapple with their own values."
Mabe and Rollin (1986, p. 294) admonished professionals who rely solely on a code of ethics, and suggested that professionals become familiar with the following limitations inherent in all codes:

1. Not all issues can be covered.
2. Codes are generally not at the "cutting edge" of issues; codes are generally reactive to issues developed elsewhere.
3. Because codes are reactive, they may at times be in conflict with state statutes and case law.
4. The counselor who is a member of several professional organizations may find conflicting guidelines in some areas.

Since codes cannot provide specific answers to all ethical questions how does a professional make ethical decisions? Hillerbrand and Stone (1986) wrote that counselors have traditionally employed a "paternal model" of decision making in which the counselor is the expert who sets up the ethical standards. In this model clients are assumed to be naive about their rights and responsibilities and entrust the counselor to know best.

Cayleff (1986, p. 346) summarized that:

Paternalistic behavior reflects the counselor's belief that he or she is acting in the client's best interest; to this end the counselor may withhold or distort information. This behavior, in turn, compromises (a) the autonomy of clients, their ability to act in their own best interest in keeping with their cultural self-definition, and (b) rational decision making based on informed consent and awareness of viable options and likely outcomes.

The paternal model is widely followed in the mental health profession as evidenced by the almost universally-held belief that "the welfare of the client rests squarely on the counselor" (Gross & Robinson, 1987, p. 10). However, while the counselor, as a professional, is held to a higher standard of conduct than the lay public (Palmo & Weikel, 1986), the concept of therapy as a "joint venture" (Corey et al., p. 114) is a right that clients are taught...
Gross and Robinson (1987) described four components that deal with direct client services inherent in all ethical codes: counselor responsibility, counselor competence, confidentiality, and client welfare.

1. **Responsibility.** The counselor is found to be responsible not only to the client, but may also be responsible to society, the community in which the counselor practices, the employing institution, the referral agency, minor clients' parents or legal guardians, colleagues, and professional associations, the state as required by state statutes, professional boards, and to oneself.

2. **Competence.** Competence includes accurate representation of professional qualifications, professional growth through involvement in continuing education, provisions of only those services for which one is qualified, maintenance of accurate knowledge and expertise in specialized areas, and assistance in solving personal issues which impede effectiveness.

3. **Confidentiality.** Confidentiality insures clients access to their official record and subsequent decision about who else may view the file; client anonymity and counselor disclosure to the client if confidentiality needs to be breached; notations in client records and communications with third parties contain accurate, unbiased, and verifiable information; proper safe-keeping and disposition of client records; all client testing and evaluation is preceded by a thorough explanation of the purpose for and the ways in which the information will be used; audio and video recording of sessions is done only with the permission of the client; and the counselor sets norms for confidentiality in a group counseling setting.

4. **Client Welfare.** To ensure client welfare the counselor determines if clients are currently involved in other counseling relationships, develops a Professional Disclosure...
Statement, is aware of limits of expertise and refers when appropriate, applies
approaches and techniques appropriate to the client, and avoids dual relationships.

Rinas and Clyne-Jackson (1988) included several other areas for counselor sensitivity
and awareness when determining ethical behavior. The following have not been covered
elsewhere in this study:

1. **Public Behavior.** The counselor's personal behavior in public reflects on the profession.
   The authors consider mental health professionals "as role models to the rest of the
   community, revealing a 'healthy' approach to life and other people.

2. **Service Provisions.** The counselor respects the clients by avoiding overbooking, by
   keeping the client's waiting time before a scheduled session to 15 minutes or less, by
   charging reasonable fees, and by referring when appropriate.

3. **Protection.** Protection of the adult client, society, and children. One aspect of
   protection is professional monitoring.

When difficult ethical issues arise, Wright (1981) advised counselors to contact the
state or national ethics committees of their professional associations; to talk to a competent
legal advisor; and to consult with experienced colleagues. Moral responsibleness can be
developed through "collegial networks" which consist of peers who are all committed to seeking
"rational consensus on meanings and norms of professional conduct" (Tennyson & Strom, 1986,
p. 301).

**Ethical Decisions**

The first rule of the healing professions is: "Primum non nocere;" "first do no
harm" (Wylie, 1989, p. 33).
Much of the professional literature provides general guidelines for ethical decision-making. Tennyson and Strom (1986, p. 300) suggested counselors consider the following questions when faced with an ethical dilemma:

- Why take this approach?
- What is it for?
- What difference will it make?
- How does it contribute to client growth?
- Who benefits from this service?
- What ends are being served?
- Whose interests are being served?
- To what extent do my beliefs, values, and practices have a limiting or distorting effect on the possibilities open to clients?

Ethics and Theories

Some mental health professionals regard counseling as an ethical balancing act with the ethics of the counselor and not the ethics of the counseling in question (Wylie, 1989). Blind adherence to a theoretical framework and disregard for what clients say they need and want becomes an "ethical failing." While theories influence the practitioner's ethical decision making, problems may arise when the theories are applied as though they embodied the "truth of the human condition" (Woody, 1990, p. 139). Counselors may be practicing unprofessionally if they adhere to only one or two traditional theories (Kelly, 1991).

What some consider ethical dilemmas, others consider treatment issues and differences of theoretical orientation (Green & Hansen, 1989).

One example, the use of paradoxical injunctions in marital and family therapy is quite controversial and raises questions about "honesty" in the counseling relationship (Ryder & Hepworth, 1990). Some professionals consider the use of this technique a questionable manipulation of the client (Paquin, 1988; Glick, Clarkin, & Kessler, 1987). A 1989 study of family therapists found that a great majority of the therapists are, however, "willing to manipulate the family for therapeutic benefit, even if this means being dishonest" (Green & Hansen, 1989, p. 157).
Another example involves Gestalt theory and the client's therapeutic release of anger. Certain Gestalt techniques which are used to facilitate such a release can result in "heightened verbal expression" (Daldrup, Beutler, Engle, & Greenberg, 1988, p. 132). Eager therapists who may believe that only vociferous catharsis of emotion is beneficial, may manipulate the client to express anger in that manner. By complying, clients risk losing their confidentiality especially if the work is completed in a crowded office which lacks soundproofed walls (M. Holiman, Ph.D, Counselor, personal communication, March, 1991).

Dual Relationships

A dual, or dual role, relationship exists when "one person simultaneously or sequentially plays two or more roles with another person" (Kitchener & Harding, 1990, p. 147). The Ethical Standards of AACD state: "Dual relationships with clients that might impair the member's objectivity and professional judgement (e.g., as with close friends or relatives) must be avoided and/or the counseling relationship terminated through referral to another competent professional."

The Code of Ethics for Mental Health Counselors, 1987, addresses dual relationships more specifically: "Examples of such dual relationships include treating an employee or supervisor, treating a close friend or family relative and sexual relationships with clients."

Other dual relationships may include "combining the roles of teacher and therapist, trading therapy for goods or services, bartering with needy clients, providing therapy to a friend's relative, socializing outside therapy sessions, becoming emotionally or sexually involved with a client or former client, and combining the roles of supervisor and therapist" (Corey et al., 1988, p. 214).

Dual relationships are not always considered unethical. The boundary between unethical and ethical relationships is not easily defined (Beigel & Earle, 1990), with the
exception of client/counselor sexual contact (Herlihy & Golden, 1990). In some cases, dual relationships may be difficult to avoid (Kitchener & Harding, 1990).

Dual relationships are considered harmful to the client when three conditions exist (Kitchener & Harding, 1990, p. 147; Kitchener, 1988, p. 219):

1. The expectations for the two roles the counselor plays may not be compatible; an example is the individual who is both counselor and supervisor. As counselor, the individual is expected to act in the best interests of the client and keep all communications confidential; as supervisor, the individual is expected to serve the best interests of the public and confidentiality is not a factor.

2. The obligations of the different roles may diverge; an example is the individual who acts as both counselor and as close friend. In the counseling relationship, the counselor's primary concern is the need of the client; in a personal relationship both individuals expect to have their needs met. Objectivity in the counseling relationship may be lost is divergent needs are being met.

3. The potential power and prestige of the professional increases the risk of exploitation. Consumers, i.e., clients, come to professionals seeking help and are thereby in a dependent, less powerful position. Emotional turmoil may increase client vulnerability with the resultant asymmetrical relationship leaving the client open to potential manipulation by the professional.

Two kinds of dual relationships may have legal ramifications: sexual relationships and bartering with clients (Beigel & Earle, 1990). Sexual relationships are discussed in Section II, Chapter 6. Bartering can be problematical legally because bartered services or goods need to be declared as income; failing to do so can result in charges of tax fraud (Beigel & Earle, 1990).
Minority Group and Multicultural Counseling

The counseling profession took little interest in or concern for the status of racial, ethnic, or other minority groups until the mid 1960s (Atkinson et al., 1989). Twenty-five years later the profession is still being criticized for its lack of sensitivity and skills in counseling such clients (Atkinson et al., 1989; Corey, 1991; Corey et al., 1988; Ibrahim & Arredondo, 1990).

Ibrahim and Arredondo (1990, p. 138) wrote that the profession is filled with "good intentions" but has failed "to expand the cultural pluralism of psychological theories to make them relevant to culturally diverse groups." They see this problem perpetuated in the profession's ethical codes, which they believe are not relevant to all clients. Ibrahim and Arredondo (1990, p. 141) recommended that AACC's Ethical Standards include the following:

1. Counselors need to "enhance their own multiculturalism" whether they consider themselves members of the mainstream culture or a minority group.

2. Competence in multicultural/minority counseling includes awareness, knowledge, and skills gained through appropriate education and training.

3. The belief of some counselors that "people are people" and that as a competent counselor I can work effectively with any population is not considered competent or ethical practice with minority and cross-cultural clients.

4. The "language of communication", both written and spoken, is an important component of the counseling relationship.

5. Client "freedom of choice" may have different meanings in other cultures; i.e., the client who comes from a lineal-hierarchical social system may not have the same freedom of choice to refuse a specific treatment because the refusal may involve confronting an authority, the counselor.

6. Cultures have varying views and practices regarding self-disclosure.
7. "Counseling theories were developed in a specific context and may not apply to individuals who do not live within that context."

8. "People from diverse backgrounds may send and receive verbal and nonverbal messages differently."

9. Moral-ethical assumptions and beliefs vary across sociocultural groups.

10. Cultural differences are not equal to "personal limitations."

AACD's Ethical Standards address minority and multicultural clients under A.10, B.19, C.1 and C.12 (Appendix A). The Code of Ethics for Mental Health Counselors addresses such populations under 1.a, 2.c, 2.h, and 8.c (Appendix A).

Cayleff (1986) wrote of "beneficience" as a principle governing counselor-client relationships. She defined beneficience as "doing good' by preventing harm to the patient and, furthermore, acting in such a way as to benefit the patient" (p. 34). This "doing good" applies especially to cross-cultural counseling in that the counselor does not harm the client "through a disregard for his or her belief system" (p. 346).

Multiple Client Systems

Counselors who work with multiple client systems, such as families and couples (Gross & Robinson, 1987), face some of the same ethical issues as counselors who work with individuals, with added ethical issues unique to such systems (Glick et al., 1987). Some graduate programs in marital and family therapy "require a separate course in ethics and law pertaining to this specialization" (Corey et al., 1988, p. 295). Marriage and family therapy is presently embroiled in controversy between AACD and one of its affiliates, the American Association for Marriage and Family Therapy (AAMFT), as to who should be able to conduct marriage and family therapy (Everett, 1990; Brooks & Gerstein, 1990a; Brooks & Gerstein, 1990b). Both sides advocate collaboration.
Not all counselors choose to specialize in this area, yet mental health counselors eventually will counsel couples and families in different settings (Corey et al., 1988). The AACD Ethical Principles do not seem to address nondyadic counseling (Strein & Hershenson, 1991) and counselors are directed to AAMFT’s Ethical Principles for Family Therapists (Herlihy & Golden, 1990).

The AAMFT Ethical Principles have been criticized for being incomplete (Green & Hansen, 1989; Palmo & Weikel, 1986) and for dealing only superficially with multiple client systems (Gross & Robinson, 1987). Green and Hansen (1989, p. 149) described nine common dilemmas faced in family counseling which are either not covered or only briefly covered in the Principles:

1. Treating the entire family if one member does not want to participate;
2. The training and qualifications of family therapists;
3. Seeing one family member without the others present;
4. Informing clients of values implicit in the mode of therapy;
5. Dealing with requests for information from family members;
6. Sharing values with clients;
7. Manipulating a family for therapeutic reasons;
8. Obtaining the informed consent of children; and
9. Preserving the family.

Glick et al. (1987, p. 572) considered three ethical issues important in family therapy:

1. Whose interest should the family therapist serve;
2. What position should the family therapist take regarding secrets; and
3. What position should the therapist take regarding harmful effects of one member on another in the family when individual’s in a family begin to change due to the therapy.
Identifying the client in family counseling is not always clear (Glick et al., 1987). One concern is the possible disregard for the needs and problems of the individual (Wylie, 1989) when the presenting problem, i.e., the problem of an individual in a family, is ignored and the focus is put on the family (Paquin, 1988; Doherty, 1989).

Marriage and family therapy, as espoused by AAMFT, is essentially a systems approach to treating the family (Everett, 1990). Following a strict system’s approach may suggest "that the individuals of the family are less important than the system" (Wylie, 1989, p. 26). On the other hand, treating only one member of a family may have adverse affects on the rest of the family (Wylie, 1989).

**Summary**

This chapter reviewed the literature in four areas of study: the profession of counseling, the practice of counseling, the counselor and the law, and ethics and the counselor. The following conclusions can be drawn from this review:

First, there are virtually no studies that deal with the behavior of counselors; articles in the professional counseling literature rely heavily on research about other professionals, such as psychologists and social workers.

Second, most of the literature interchanges the terms "counseling" and "therapy" and the terms "counselor" and "therapist," often within the same article. The reader is left with the impression that these terms are synonymous.

Third, many of the articles address the importance of practicing defensively to avoid lawsuits, yet there is little discussion about whether lawsuits are a problem to most mental health practitioners or whether counselors are practicing unprofessionally, i.e., negligently.

Fourth, the concept of duty to warn is covered voluminously, while the concept of dual relationships receives little coverage. This seems somewhat incongruous since counselors, who
generally do not treat individuals with serious pathology, will be more likely to grapple with problems of dual relationships than to encounter violent clients.
CHAPTER 3

METHODS AND PROCEDURES

... [Knowledge] is never steady and is in fluctuation. It is altered as different and more diversified information infiltrates these knowledge systems, rendering them antiquated and no longer pertinent or relevant (Rich, 1988, p. 6).

The primary purpose of this study is to further knowledge. The basic creed of scientific and academic disciplines holds that academic inquiry, or research, seeks to improve knowledge (Maxwell, 1984). Mauch and Birch (1989, p. 9) distinguished between "academic discipline research" and "professional discipline research." Through professional discipline research "knowledge is accrued to validate or to bring into question aspects of professional practice, to create better practices, and, generally, to foster and guide the improvement of the profession and its services."

This study uses a handbook to impart knowledge. The handbook content is a compilation of past and present practices in the counseling profession.

Thus, this study contains elements from two different methods of research: historical and descriptive. According to Gay (1987), "historical research involves studying, understanding, and explaining past events" (p. 9) and "a descriptive study determines and reports the way things are" (p. 10). While past and present events are not analyzed in the handbook, information about the events is synthesized to further knowledge.

Survey of Need

A search was conducted for any similar handbooks in Arizona or elsewhere. This search included contacts with state and national counselors' associations by mail and telephone, a review of resources at the University of Arizona Main Library, an informal poll of 14 counselors in private practice in Tucson, and a review of references from recent professional
journal articles on ethics and law. The search uncovered no handbook that addressed both ethics and law as they pertain to counselors in Arizona.

In 1986, Miller and Sales published *Law and Mental Health Professionals: Arizona*, a comprehensive study of Arizona law as of 1985. However, that work did not specifically address counselors, probably because at that time counselors were not certified by the State of Arizona and no existing Arizona laws specifically addressed counselor behavior.

The American Association for Counseling and Development (AACD) has published two recent books that address issues of ethics and law from a national perspective. One of them, the *Ethical Standards Casebook* (Herlihy & Golden, 1990), provides practical interpretations of AACD's ethical guidelines. The other, Hopkins and Anderson's (1990) *The Counselor and the Law*, is an overview of laws that apply to counselors. Both books provided valuable information for the handbook.

The review of journal articles disclosed handbooks directed towards clients in Colorado and Minnesota. These handbooks concern client rights and were useful sources of information for the subject handbook.

Finally, need for the subject handbook was specifically assessed by sending a questionnaire and the handbook's proposed table of contents to members of the Arizona Counselors Association throughout the state. Those members were asked if they would find the proposed handbook useful. Their response was an overwhelming yes (Chapter 4).

**Handbook Development**

The handbook was developed through both descriptive and historical research methods. It answers the following questions: who is a mental health counselor; what does Arizona's new state certification law require of counselors; what rights do counselors' clients have; what legal issues do counselors face today generally and specifically in Arizona; and of what ethical
issues do counselors need to be most aware. The handbook is included below as Appendix A. Development of the handbook began with a proposed table of contents, which provided a guideline for an initial search of the literature. From that search, emerged general themes of relevant information for counselors.

The table of contents was revised several times. One revision resulted from the literature search, another from the suggestions of a 14-member advisory panel, and a third from a questionnaire sent to members of the Arizona Counselors Association. (The advisory panel include 13 counselors in private practice in Tucson and one faculty member from the University of Arizona Psychology Department.)

The body of the handbook contains information from the professional literature, questionnaires from members of the Arizona Counselors Association, Arizona attorneys, the Arizona State board of behavioral health examiners, insurance companies, counselor educators, counselor practitioners, handbooks from other states, Arizona state statutes, professional associations, and Arizona state agencies. The handbook includes general principles, practical suggestions and examples for the practitioner.

**Evaluation Procedures**

The first, revised draft of the handbook was reviewed by an attorney, a counselor educator, eight members of the advisory panel, and five students in the University of Arizona’s Counseling and Guidance graduate program. Each reviewer received a copy of the handbook (Chapter 4), a cover letter (Appendix B), and an evaluation form (Appendix C), which was to be completed and returned within two weeks.

**Summary**

The result of this study is the production of a handbook. Both historical and descriptive research methods were used to produce the handbook. An advisory panel of
counselors and a group of Counseling and Guidance graduate students reviewed and critiqued
the handbook upon completion.
CHAPTER 4

RESULTS AND EVALUATIONS

Introduction

The purpose of this thesis is to develop a handbook for mental health counselors on ethics and law specifically as they apply in Arizona. The expected benefit of the handbook is an increase in counselor competence through awareness of common and usual practices of counselors in Arizona. Included, as part of the handbook, is a questionnaire which was developed to help determine some common practices of counselors in Arizona. The handbook was first evaluated by twelve advisory panel members who reviewed the questionnaire and table of contents before the questionnaire was mailed. A second evaluation came from the questionnaire respondents who were asked to comment on the handbook's contents and its potential usefulness to them in their practice. A third evaluation, a review and critique of the second draft of the handbook, was completed by advisory board members and graduate students majoring in counseling. This chapter presents both the findings of the questionnaire and the results of the handbook evaluations.

Questionnaire

The handbook was partly developed from information obtained from a questionnaire sent to Arizona Counselors Association (ACA) members. A total of 286 questionnaires were sent out; 121 were returned by the deadline of which, 4 were not completed because the recipient ACA members are not practicing counselors. Three returns arrived after the deadline and 7 were returned by the post office as undeliverable. The resulting 117 timely returns represent 41.9% of the delivered questionnaires.
Counselor Profile

Questionnaires were timely returned from all parts of the state by counselors with doctorate, master and bachelor degrees who are employed in private practice, agencies, institutions, hospitals, and schools (Table 2). Most questionnaire respondents are employed in private practice, either alone or in partnerships. About 36% are employed by agencies or other institutions. A number of respondents work part time in private practice and part time in an agency. Some are in a private practice but do contract work for public institutions.

Respondents' time in practice ranges from less than 1 to 35 years (Table 3). Counselors with doctorate degrees average 14.9 years in practice; those with master and bachelor degrees average 9.3 years.

Table 2. Settings in which Arizona counselors practice

<table>
<thead>
<tr>
<th>Type of Practice</th>
<th>Number of Responses</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>66</td>
<td>56.4</td>
</tr>
<tr>
<td>In partnership</td>
<td>19</td>
<td>16.2</td>
</tr>
<tr>
<td>Agency, institution, hospital</td>
<td>43</td>
<td>36.8</td>
</tr>
<tr>
<td>School, university, college</td>
<td>10</td>
<td>8.5</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>4.3</td>
</tr>
<tr>
<td>Retired</td>
<td>2</td>
<td>1.7</td>
</tr>
</tbody>
</table>

n = 117  Percentage exceeds 100 because some respondents marked more than one category.
Table 3. Number of years in practice

<table>
<thead>
<tr>
<th>Years Practiced</th>
<th>Number of Responses</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 5</td>
<td>31</td>
<td>26.5</td>
</tr>
<tr>
<td>6 to 10</td>
<td>38</td>
<td>32.5</td>
</tr>
<tr>
<td>11 to 15</td>
<td>24</td>
<td>20.5</td>
</tr>
<tr>
<td>16 to 20</td>
<td>14</td>
<td>12.0</td>
</tr>
<tr>
<td>21 to 25</td>
<td>6</td>
<td>5.1</td>
</tr>
<tr>
<td>26 to 35</td>
<td>4</td>
<td>3.4</td>
</tr>
</tbody>
</table>

n = 117

Table 4 identifies the highest counseling degree achieved by the respondents; 81.2% have a master as their highest degree. One study in 1985 found that 89.5% of mental health services were provided by master-level counselors (Weikel & Palmo, 1989). One counselor holds a master in social work (MSW); another holds a master of theology. The latter two were not included in data that compared master-level counselors and doctorate-level counselors.

Table 5 shows the communities where respondents practice. In the Phoenix area, which includes Phoenix, Tempe, Glendale, Mesa, Scottsdale, and Chandler, 46.2% practice. The next largest group practices in Tucson; the third largest group practices in Flagstaff. The rest practice in smaller communities around the state. Three respondents did not indicate where they practice. Two are employed outside Arizona. One practices in both Phoenix and Flagstaff.
Table 4. Highest counseling degree

<table>
<thead>
<tr>
<th>Degree</th>
<th>Number of Responses</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Master</td>
<td>95</td>
<td>81.2</td>
</tr>
<tr>
<td>Doctorate</td>
<td>18</td>
<td>15.4</td>
</tr>
<tr>
<td>Bachelor</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>.9</td>
</tr>
</tbody>
</table>

n = 117

Table 5. Practice in what area or city

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of Responses</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phoenix Area</td>
<td>54</td>
<td>46.2</td>
</tr>
<tr>
<td>Tucson</td>
<td>35</td>
<td>29.9</td>
</tr>
<tr>
<td>Flagstaff</td>
<td>11</td>
<td>9.4</td>
</tr>
<tr>
<td>Other Arizona cities:</td>
<td>11</td>
<td>9.4</td>
</tr>
<tr>
<td>Bisbee (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patagonia/Nogales (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescott (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cottonwood (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casa Grande (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ajo (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Show Low (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kingman/Bullhead City (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td>Out of State</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Phoenix and Flagstaff</td>
<td>1</td>
<td>.9</td>
</tr>
</tbody>
</table>

n = 117
Purpose of Questionnaire
1. Do the practices of counselors differ substantially from one part of the state to another?
2. How do counselors respond to ethical and legal questions in their practice?
3. Do counselors typically generate and retain clinical notes?
4. Do counselors disclose file material to clients on request?
5. Are clients informed of the scope and limits of confidentiality and other clients' rights issues at the beginning of counseling?
6. Do master-level counselors in Arizona receive third-party payments?
7. Would the handbook, as proposed, be useful to counselors?

Practices of Counselors
1. Do the practices of counselors differ substantially from one area of the state to another?

Table 5 shows the different Arizona communities in which respondents practice. Counselors generally practice in ways not significantly different from one area of the state to another. A one-way analysis of variance across location of practice revealed significant differences ($F = 3.56, 3.107$ df, $p < .05$) in extent to which counselors sought consultation with colleagues when legal issues arise. A post hoc analysis (Scheffe) revealed that Tucson counselors reported seeking consultation more frequently ($p < .05$) than counselors in "Other Arizona Cities."

Ethical And Legal Dilemmas
2. How do counselors commonly handle ethical and legal dilemmas?

When faced with legal issues (Table 6), counselors most frequently consult with other counselors (Table 7). About half call attorneys. Counselors with doctorates were much more
Table 6. Have legal issues arisen in past 12 months?

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Responses</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>80</td>
<td>68.4</td>
</tr>
<tr>
<td>No</td>
<td>36</td>
<td>30.8</td>
</tr>
<tr>
<td>Unmarked</td>
<td>1</td>
<td>.9</td>
</tr>
</tbody>
</table>

Table 7. How answers to legal questions are commonly found

<table>
<thead>
<tr>
<th>Sources</th>
<th>Number of Responses</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other counselors</td>
<td>84</td>
<td>71.8</td>
</tr>
<tr>
<td>Attorneys</td>
<td>61</td>
<td>52.1</td>
</tr>
<tr>
<td>Professional Literature</td>
<td>56</td>
<td>47.9</td>
</tr>
<tr>
<td>State Laws</td>
<td>45</td>
<td>38.5</td>
</tr>
<tr>
<td>Professional Organization</td>
<td>29</td>
<td>24.8</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>17.9</td>
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<tr>
<td>State AG's Office</td>
<td>16</td>
<td>13.7</td>
</tr>
<tr>
<td>Libraries</td>
<td>8</td>
<td>6.8</td>
</tr>
</tbody>
</table>

n = 117  Respondents could mark more than one source.
likely to consult attorneys than were master-level counselors, 72% vs. 46% (t = 2.31, p < .05) (Table 8). About half of the respondents consider the clients' best interest to be the most important factor and the possibility of a complaint to their professional organization to be the least important factor when making decisions about legal issues (Table 9).

Respondents most frequently answered ethical questions by referring to professional ethical guidelines (Table 10). Respondents consult attorneys less frequently about ethical questions than about legal questions. However, they consult other counselors on ethical issues about as often as on legal issues. When making a decision on a matter of ethics, respondents' paramount concern is the client's best interest (Table 9).

Significant differences exist between counselors with master degrees and those with doctorates. Counselors with doctorates contact attorneys more often when legal issues arise. They are also more concerned about the possibility of complaints to their professional organizations (t = 2.64, p < .05) (Table 8). Master's-level counselors consult other counselors more frequently on ethical issues than do counselors with doctorates. When asked to list the book(s) they found most useful when ethical and legal problems arise, over half of the respondents left the item blank (Table 11). Forty-one (41%) responded by identifying either books, journals, or professional ethical guidelines; some of those counselors, however, identified only parts of book titles or authors. Two percent (2%) of the respondents say they have had no need for such books because no ethical or legal issues have arisen in their practice. Another 4% prefer to obtain information about legal and ethical matters by talking to other professionals.
Table 8. T-test analysis of masters-level counselors vs. doctorate-level counselors

<table>
<thead>
<tr>
<th>Variable</th>
<th>Cases</th>
<th>Number of</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call Attorney</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters</td>
<td>93</td>
<td>.47</td>
<td>.05</td>
<td></td>
<td>2.07*</td>
</tr>
<tr>
<td>Doctorate</td>
<td>18</td>
<td>.72</td>
<td>.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consult Counselor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters</td>
<td>93</td>
<td>.76</td>
<td>.04</td>
<td></td>
<td>2.31*</td>
</tr>
<tr>
<td>Doctorate</td>
<td>18</td>
<td>.50</td>
<td>.12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaint to Professional Organization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters</td>
<td>93</td>
<td>.11</td>
<td>.16</td>
<td></td>
<td>2.64*</td>
</tr>
<tr>
<td>Doctorate</td>
<td>18</td>
<td>.83</td>
<td>.45</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* (p < .05)
Table 9. Factors taken into consideration when ethical and legal decisions are made (ranked in order of importance)

<table>
<thead>
<tr>
<th>Factors</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st</td>
</tr>
<tr>
<td>Client’s best interest</td>
<td>48.7</td>
</tr>
<tr>
<td>Personal ethics and values</td>
<td>41.9</td>
</tr>
<tr>
<td>Workplace standards and philosophy</td>
<td>11.1</td>
</tr>
<tr>
<td>Possibility of lawsuit</td>
<td>7.7</td>
</tr>
<tr>
<td>Complaint to professional organization</td>
<td>1.7</td>
</tr>
</tbody>
</table>

n = 117  Not all factors were ranked by each respondent.

Table 10. How ethical dilemmas are commonly handled

<table>
<thead>
<tr>
<th>Sources</th>
<th>Number of Cases</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow Ethical Guidelines</td>
<td>92</td>
<td>78.6</td>
</tr>
<tr>
<td>Consult Other Counselors</td>
<td>82</td>
<td>70.1</td>
</tr>
<tr>
<td>Trust My Own Judgement</td>
<td>50</td>
<td>42.7</td>
</tr>
<tr>
<td>Call An Attorney</td>
<td>42</td>
<td>35.9</td>
</tr>
<tr>
<td>Review Literature</td>
<td>32</td>
<td>27.4</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>12.0</td>
</tr>
</tbody>
</table>

n = 117  Some subjects made more than one response.
Table 11. Do counselors have books they use most often when solving ethical and legal problems?

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Cases</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>60</td>
<td>51.0</td>
</tr>
<tr>
<td>Books</td>
<td>31</td>
<td>26.5</td>
</tr>
<tr>
<td>Ethical guidelines</td>
<td>16</td>
<td>13.7</td>
</tr>
<tr>
<td>Prefer personal contact</td>
<td>5</td>
<td>4.0</td>
</tr>
<tr>
<td>Journals</td>
<td>4</td>
<td>3.4</td>
</tr>
<tr>
<td>Arizona statutes</td>
<td>4</td>
<td>3.4</td>
</tr>
<tr>
<td>Never needed one</td>
<td>3</td>
<td>2.0</td>
</tr>
<tr>
<td>Educator once</td>
<td>1</td>
<td>.9</td>
</tr>
</tbody>
</table>

n = 117 Some subjects made more than one response.

Clinical Notes

3. Do counselors typically generate and retain clinical notes?

Arizona counselors typically keep some kind of clinical notes on client sessions. However, 6.8% keep no notes. The reason this group cites for this practice is that, if they kept notes, those notes could be subpoenaed, presumably to the client's detriment (Table 12).

Almost half of the respondents, 47.9%, have created their own systems of note taking (Table 13). Counselors in private practice are significantly more likely to create their own record-keeping systems than are counselors employed by agencies (Table 14). Generally, the longer a counselor has been in practice, the more likely he or she is to be using a system personally created (Table 15).
### Table 12. Record-keeping practices of Arizona counselors

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Responses</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Notes</td>
<td>66</td>
<td>56.4</td>
</tr>
<tr>
<td>SOAP</td>
<td>24</td>
<td>20.5</td>
</tr>
<tr>
<td>Detailed Notes</td>
<td>12</td>
<td>10.3</td>
</tr>
<tr>
<td>Varies</td>
<td>11</td>
<td>9.4</td>
</tr>
<tr>
<td>None</td>
<td>8</td>
<td>6.8</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>4.4</td>
</tr>
<tr>
<td>DAP</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td>SOAP or DAP</td>
<td>1</td>
<td>.9</td>
</tr>
</tbody>
</table>

n = 117  * Some respondents marked more than one response.

### Table 13. Sources of counselor's record-keeping systems

<table>
<thead>
<tr>
<th>Responses</th>
<th>Number of Responses</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Made Up My Own System</td>
<td>56</td>
<td>47.9</td>
</tr>
<tr>
<td>Agencies</td>
<td>44</td>
<td>37.6</td>
</tr>
<tr>
<td>Other Professionals</td>
<td>40</td>
<td>34.2</td>
</tr>
<tr>
<td>Graduate School</td>
<td>34</td>
<td>29.1</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>12.0</td>
</tr>
<tr>
<td>Professional Literature</td>
<td>10</td>
<td>8.5</td>
</tr>
</tbody>
</table>

n = 117  * Some respondents marked more than one source.
Table 14. T-test analysis of record-keeping practices of counselors in private practice vs. in agencies (probability of using their own system)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number of Cases</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>64</td>
<td>.60</td>
<td>49</td>
<td>4.27</td>
</tr>
<tr>
<td>Agency</td>
<td>37</td>
<td>.21</td>
<td>41</td>
<td></td>
</tr>
</tbody>
</table>

Table 15. T-test analysis of record-keeping practices vs. number of years practiced

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of Cases</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9 years average)</td>
<td>61</td>
<td>.08</td>
<td>5.54</td>
<td>2.34</td>
</tr>
<tr>
<td>More years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(12 years average)</td>
<td>56</td>
<td>.05</td>
<td>7.88</td>
<td></td>
</tr>
</tbody>
</table>
Client Request of File

4. Do counselors show clients their files upon request?

Almost 40% of respondents say they would reveal all of a client's file to that client upon request. Another 46% would disclose either all of the file or part of it depending on the circumstances. Only about 8% would disclose none of it (Table 16).

Respondents cited a number of factors on which they would base their decisions to disclose a file to a client: the client's best interest, the reason and motivation for the request, agency guidelines, the client's ability to accept what is written, and the "appropriateness" of the request. Several would allow review of show the file only in their presence. One respondent stated that his or her notes are so brief that a client could not understand them without counselor interpretation.

Some respondents only disclose test results or any part of a file when required by law to do so. One respondent regularly reviews the file with the client as part of the clinical process. Another stated that if he or she had any reservations about disclosing file material, those reservations would be discussed with the client.

Table 16. Do counselors disclose file to client when requested?

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Responses</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of It</td>
<td>46</td>
<td>39.3</td>
</tr>
<tr>
<td>Part of It</td>
<td>29</td>
<td>24.8</td>
</tr>
<tr>
<td>Depends</td>
<td>25</td>
<td>21.4</td>
</tr>
<tr>
<td>None of It</td>
<td>9</td>
<td>7.7</td>
</tr>
<tr>
<td>No response</td>
<td>6</td>
<td>5.1</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.8</td>
</tr>
</tbody>
</table>
Clients' Rights

5. Are clients informed of confidentiality and its exclusions as well as other clients' rights issues at the beginning of counseling?

Fifty-three percent (53%) of respondents provide their clients with written information on confidentiality and its limitations, and 37.6% give their clients a professional disclosure statement. (It appears that not all counselors know what a disclosure statement is; as a response to this item on the questionnaire, one respondent wrote, "What's that?") Fewer than half of respondents give their clients consent to treatment forms; fewer than one third of respondents give clients information about their rights (Table 17). About 17% of respondents give clients other forms, including treatment disclaimers, routine intake forms, insurance forms, release of information forms, and other administrative forms. Of the respondents, 28.2% convey information about confidentiality, consent to treatment, client's rights, and treatment philosophy orally rather than with forms or other written materials.

<table>
<thead>
<tr>
<th>Type of Information</th>
<th>Written</th>
<th>Verbal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Cases</td>
<td>Frequency (%)</td>
</tr>
<tr>
<td>Statement on confidentiality and exclusions</td>
<td>62</td>
<td>53.0</td>
</tr>
<tr>
<td>Consent to treatment form</td>
<td>52</td>
<td>44.4</td>
</tr>
<tr>
<td>Disclosure statement</td>
<td>44</td>
<td>37.6</td>
</tr>
<tr>
<td>Client's rights pamphlet/handout</td>
<td>37</td>
<td>31.6</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>16.5</td>
</tr>
</tbody>
</table>

n = 117  Respondents marked more than one item.
Third-party Payments

6. Do master-level counselors receive third-party payments in Arizona?

About 18% of respondent master-level counselors say they obtain third-party payments on their signatures alone; another 10.2% do so with some companies. About 37% receive insurance payments through the signatures of psychologists or psychiatrists who co-sign the forms as consultants or supervisors. Of course, this question does not apply to counselors who work in school settings and do not have paying clients (Table 18).

Over 30% of respondents receive no third-party payments. One stated that he or she is not interested in third-party payments because they may be a "set-up for legal suits." Another considers sign-offs to be ethically problematical.

Of those respondents who use sign-offs, half are in private practice and half in agencies, clinics or other institutional settings.

Table 18. Third-party payments to master- and bachelor-level counselors

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Cases</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sign-offs</td>
<td>36</td>
<td>36.7</td>
</tr>
<tr>
<td>None</td>
<td>30</td>
<td>30.6</td>
</tr>
<tr>
<td>Yes</td>
<td>17</td>
<td>17.3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>10</td>
<td>10.2</td>
</tr>
<tr>
<td>Not applicable</td>
<td>5</td>
<td>5.1</td>
</tr>
</tbody>
</table>

n = 98
Usefulness of Handbook

7. Would the handbook, as proposed, be useful to counselors?

About 93% of responding counselors stated that the handbook would be useful to them in their practice (Table 19). Five percent (5%) responded that the handbook would not be useful to them, either they are sufficiently informed or because the handbook would be out of date very quickly. One respondent stated the handbook would be redundant because the Arizona Counselors Association already covers the information. Two respondents could not be sure the handbook would be of use to them without knowing its content.

Table 19. Would handbook be useful to counselors?

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Cases</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>109</td>
<td>93.2</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>5.1</td>
</tr>
<tr>
<td>Depends</td>
<td>2</td>
<td>1.7</td>
</tr>
</tbody>
</table>

n = 117
Handbook Evaluations

First Evaluation

In November, 1990, the 14 advisory panel members received the first evaluation packet, which included a cover letter (Appendix B), the proposed table of contents, on following page, and the questionnaire (Appendix C). Six members returned their comments within the 2-week response period; two more returned theirs a few days later; and three more returned theirs promptly after a reminder phone call. One member never responded and the other two returned their comments too late to be included here.

The panel members were asked to critique the table of contents and the questionnaire. Six of the panel members filled out the questionnaire and did not comment on its former content. One member wrote, "they look very good to me with all areas covered." Another wrote, "Your thesis proposal and questionnaire are very thorough and seem complete."

Four panel members made several suggestions for changes to the table of contents and the questionnaire. The following are the suggestions concerning the table of contents:

1. Part II, "adding license would be confusing."
   Part IV, privileged communication belongs under client right and not under counselor right.

   Part V, there is only one mental health counselors association.

   Part II, put Chapter 5 right after Chapter 2.

   Part III, include molest reporting under confidentiality. Child abuse needs to include both physical and emotional.

   Part IV, need to really cover the issue of expert testimony.

3. Part II, "not sure why you are including Chapters 1 and 2."
   "Not sure what client's rights would include."

   Part V, "more here about common [ethical] dilemmas—what to do about them."
The following are the suggestions concerning the questionnaire:

1. On question 1, "legal questions" should be clearer.
   
   On question 2, change "if, yes, have you tried to find an answer?" to "if, yes, do you seek an answer:"
   
   On question 5, which ethical guidelines?
   
   On question 6, "change ranking to a continuum because all items are important."
   
   On question 7, add date of publication.
   
   On question 8, change "use SOAP method" to "Specific method (SOAP, etc.).
   
   Please specify." Omit "Fairly" before brief and detailed.
   
2. On question 3, omit comma after If.
   
3. On question 10, panel member wondered if showing client file is not required by law.

Relatively few changes were made to the questionnaire; most of those changes came from the suggestions made by the advisory panel members. Appendix C is a copy of the questionnaire as sent to the Arizona Counselors Association members after changes were made.

The table of contents was revised quite extensively, both as a result of the panel's evaluation and as a result of natural evolution of the handbook.
Proposed Table of Contents
(as mailed to the advisory board members, November, 1990)

Part I: MENTAL HEALTH COUNSELORS

Chapter 1. Who is the Mental Health Counselor [MHC]?
Chapter 2. How is the [MHC] Different from Other Mental Health Professionals
Chapter 3. Legal Categories of Counselors in Arizona State
Chapter 4. Limitations of Practice

PART II: COUNSELOR CERTIFICATION

Chapter 1. Mental Health Counselor Certification
Chapter 2. Attaining State Certification/License
  a. Newly graduated counselors
  b. Practicing Arizona counselors
  c. Out-of-state counselors
Chapter 3. Certified Counselors and Third-party Payments
Chapter 4. Losing Your Certification/License
Chapter 5. National Certification
Chapter 6. Agencies and Professional Associations

PART III: CLIENTS' RIGHTS

Chapter 1. Confidentiality
  a. Child abuse
  b. Danger to self
  c. Danger to others
Chapter 2. Records
Chapter 3. Informed Consent
Chapter 4. Client's Rights
Chapter 5. Client Advocacy Groups

PART IV: COUNSELORS' RIGHTS

Chapter 1. Privileged Communication
Chapter 2. Receiving a Subpoena
Chapter 3. Depositions
Chapter 4. Testifying as Expert Witness
Chapter 5. Being Sued
Chapter 6. Finding an Attorney

PART V: WHEN ETHICAL ISSUES ARISE

Chapter 1. Do's and Don'ts
Chapter 2. Select Bibliography
Chapter 3. Ethical Guidelines of MHC Associations
PROPOSED TABLE OF CONTENTS
(as sent to ACA members, January, 1991)

Section I: MENTAL HEALTH COUNSELORS

Chapter 1. Who is the Mental Health Counselor?
Chapter 2. How is the Mental Health Counselor Different from Other Mental Health Professionals

Section II: COUNSELOR CERTIFICATION

Chapter 1. Certification vs. Licensing: What is the Difference?
Chapter 2. How Counselors become Certified in Arizona
   a. Newly graduated counselors
   b. Practicing Arizona counselors
   c. Out-of-state counselors
Chapter 3. Certified Counselors and Third-party Payments
Chapter 4. Losing Your Certification
Chapter 5. National Certification
Chapter 6. State Agencies and Professional Associations

Section III: CLIENTS’ RIGHTS

Chapter 1. Privileged Communication
Chapter 2. Confidentiality
   a. Child abuse reporting
   b. Duty to warn
   c. Duty to warn and AIDS
Chapter 3. Informed Consent
Chapter 4. Clinical Records
Chapter 5. Client’s Bill of Rights
Chapter 6. Sexual Contact with Clients
Chapter 7. Client Advocacy Groups

Section IV: COUNSELOR AND THE LAW

Chapter 1. Malpractice
Chapter 2. Receiving a Subpoena
Chapter 3. Depositions
Chapter 4. Testifying as Expert Witness
Chapter 5. Minimizing Legal Risks
Chapter 6. Finding an Attorney

Section V: WHEN ETHICAL ISSUES ARISE

Chapter 1. Do’s and Don’ts
Chapter 2. Select Bibliography
Chapter 3. Ethical Guidelines of MHC Association
Second Evaluation

In early January, 1991, Arizona Counselors Association members were sent a cover letter (Appendix B), a questionnaire (Appendix C), and a proposed table of contents to the handbook; see previous page. Items 14, 15, and 16 on the questionnaire requested an evaluation of the usefulness of the proposed handbook as presented in the table of contents, and suggestions for additional information.

Of the respondents, 93.2% indicated the handbook would be useful as proposed. Several wrote that it, "looks great" and is definitely needed. Most respondents made no suggestions for additional information. About a third of the respondents requested the addition of some or all of the following information:

1. Include summaries of legal cases and specific laws/statutes that affect counselors.
2. How to report information about children, like sexually active teenagers, to their parents.
3. Issue of legal interest to clients, such as divorce, custody and property. Dual relationships, in detail.
4. Malpractice insurance information.
5. "When do I need to report adult abuse?"
6. "Please cover involuntary hospitalization."
7. Client abandonment.
8. Confidentiality and minors, members in groups and court-ordered clients.
9. Include specific vignettes on ethical dilemmas and ethics of counseling cross-cultural clients.
10. "How does one deal with psychiatrists?"
11. What will the influence of HMOs be on counselors?
12. Information for all counseling specialties and not just for mental health counselors.

"The certification for addictions counselors seems particularly confusing."
Other respondent suggestions included the expansion of information already covered. One respondent wrote, "Put emphasis on sections 3, 4, and 5." Another opined that the information on certification does not belong in a handbook on ethics and law. Others requested more detail about the counselor certification process in Arizona.

In response to the second evaluation, several topics were added to the handbook: elder abuse reporting, dual relationships, the ethics of multiple-client and crosscultural counseling, malpractice insurance, and clients' rights in group counseling. Many of the other suggestions were outside the scope of the handbook. The final table of contents appears in Appendix A.

Third Evaluation

Of the 14 panel members, 11 were able to participate in the third evaluation. Five graduate students agreed to participate. Of those, five advisory panel members and all five graduate students returned completed evaluations by the deadline; three additional panel members responded shortly after the deadline.

Eight panel member and five student evaluations are included in this study. Three other panel members returned their evaluations too late for inclusion in the study; however, their responses will be considered for inclusion in the handbook before publication.

The evaluations were generally favorable, and included many suggestions, some of which were included in this study. Some suggestions were beyond the scope of the present study and will be included in the final copy of the handbook before publication. Each chapter evaluation will be discussed separately. Following the discussions are tables illustrating both student and panel member responses to each chapter.
Chapter 1. Mental Health Counselors.

Students and panel members generally considered Chapter 1 easy to read, fairly clear, and informative. Respondents suggested several format changes and the clarification of some sections.

One responded thought that the section on social workers did not accurately reflect current practices. Another suggested expanding the mental health counselor section to include more history and specific functions needed in private practice. The section on the core providers was judged incomplete by some who requested additional information on the overlapping functions of the different mental health professionals as well as a distinction between counseling and therapy.

The format will be changed to help clarify the content and the section on social workers will be rewritten to reflect their increasing involvement in counseling. It is beyond the scope of this study to include additional information about mental health counselors as they relate to other core providers; such information is, however, appropriate for the handbook and will be incorporated before publication.

Chapter 2. Counselor Certification.

Most respondents found this chapter easy to read, informative, fairly clear, and easy to follow. Both the students and the panel agreed that some sections needed more information, and one student suggested several format changes. Favorable comments included, "Great information! It really clarified some points for me." "This chapter was to the point. Gave me the info I wanted to know."

Four respondents wanted additional information on the certification process in Arizona. That section will be expanded after Senate Bill (S.B.) 1138 is either passed or defeated by the Arizona legislature. S.B. 1138 was introduced February 6, 1991, with proposed
changes in ARS §§32-3251, 32-3301, and 32-3302. Passage of the bill is not expected prior to the completion of this study.

Chapter 3. Certified Counselors and Third-party Reimbursements.

Both the panel and students thought the information is fairly clear, easy to read, informative and easy to follow. One member commented, "This is a good chapter. It should be helpful to all of us."

Three panel members wanted more information about "signing-off," and one asked about insurance fraud in cases in which counselors deliberately misdiagnose clients for insurance purposes. Another panel member suggested that information on specific insurance companies, except C.H.A.M.P.U.S., be excluded because "all third-party rules change constantly" (Robert Rencken, ACA Head). Many respondents particularly liked the "nine rules for avoiding reimbursement traps"; although, one thought the title did not match the narrative.

The information on specific companies will be deleted and several suggested format changes will be incorporated. Expanding the section on "signing-off" is beyond the scope of the present study but will be completed for the handbook prior to publication. One panel member had asked how Arizona counselors who receive third-party payments on their signatures alone are able to do that. Because the survey of ACA members (Chapter 4) did not include such a question, that question cannot be answered.

Chapter 4. Client's Rights.

Panel members and students generally liked this chapter. They wrote, "Excellent chapter." "Helpful content--I'd buy the handbook just for this chapter." "This chapter is excellent. Very important information not easily available elsewhere."

Two students found the use of numbers and letters in section headings confusing. One panel member recommended that a list of "client's rights" head the chapter. Others
requested more information on the options a counselor has when a client does not want the insurance company to learn "sensitive" information about him or her; the information a counselor is obligated to tell a parent when the child or teen is the client; the statute of limitation, if any, on reporting child abuse; counselor obligations to an absent spouse in couples counseling.

One panel member found the section on Professional Disclosure Statements very useful and a student wrote that the section on child abuse reporting included "good step by step instructions. "For this study, the format of Chapter 4 will be modified to eliminate the confusing numbering system. Requests for additional information all fall within the scope of the handbook and will be included in the final draft before publication.


This chapter received the most favorable response from both the panel and students. They wrote, "Best section so far"; "Good chapter—clear and informative." "Excellent inclusion in the handbook about notetaking—guidelines for adequate clinical records!!" "Very good."

Several respondents request either clarification or information about the following: record keeping in child custody cases; an example using the SOAP or DAP format of record keeping; the possible protection of clinical records under the privileged communication clause of the new counselor certification law; the disposition of client files when one counselor buys another counselor's business; and total length of time records need to be kept.

All suggestions for information and clarification will be included in the final copy of the handbook before publication. They are beyond the scope of the present study.

Chapter 6. Sexual Contact with Clients.

This chapter received few comments by either the panel or the students. Favorable remarks include, "Good treatment of a tricky subject." "OK the way it is." One wrote, "Seems a bit abbreviated."
One panel member recommended that the chapter title be changed from "sexual contact with clients" to "sexual conduct with clients." One student questioned whether a counselor could ever fall in love with a former client and wondered when the professional relationship end. One student suggested changing the format in the section, "the client who wants to file a complaint," by replacing the "pros" and "cons" with recommendations from the author.

The title will be changed as will the format in specific sections. A further discussion of sexual relations with former clients is beyond the scope of this study and will be included in the handbook before publication. The handbook will also include a section on nonsexual touching which has not been covered before but seems appropriate.

Chapter 7. The Counselor as Expert Witness.

Both the panel and students considered this chapter easy to follow; however, several respondents thought the information somewhat difficult to read, confusing in parts, and not always informative. Overall, the chapter did receive some favorable comments: "Very helpful." "Excellent." "Good coverage." "Very Good."

Several students and panel members wanted clarification of the differences between expert opinion witnesses and fact witnesses and suggested that examples be used to illustrate their different functions. One respondent wanted to know what a "cue book" is and another what "the rules of the court" are. The bold print used to highlight "Suggestions for appearing as expert witness" was distracting to one student.

The section on expert witnesses will be expanded and clarified; however, such a task is beyond the scope of the present study and will be completed before the handbook is published. Recommended format changes will be included in this study.
Chapter 8. Malpractice.

Respondents considered Chapter 8 to be mostly informative and the format easy to follow. The content was judged by three respondents to be somewhat difficult to read and confusing in parts. One panel member thought the chapter was definitely too long and another thought it a little too short. A student commented, "Good chapter, very important and useful."

Suggestions included a change in the title from "Malpractice" to "General Standard of Care and Malpractice"; additional information on "appropriate treatment" and crosscultural clients. One panel member asked, "When am I not qualified to provide service?" One of the students considered the format cumbersome. Corrections for this study will include a change in the title and in the format. It is beyond the scope of this as well as the handbook to expand the discussion of crosscultural clients; however, book titles for further reading will be included in the final copy of the handbook before publication.

Chapter 9. Lawsuits.

This chapter was favorably evaluated with 75% of the panel members recommending that it be longer. Respondents wrote, "Very detailed and helpful information." "Very good chapter--very informative and useful." "Good job here."

Respondents wanted additional information about the outcome of lawsuits, the proper way to terminate a client who runs up a large bill, how counselors can find emotional support when sued, how counselors recover from a lawsuit, and what "any physical invasion" includes.

Several of the suggestions will be included in this study such as defining "physical invasion" and outcomes of lawsuits as reported in the professional literature. How to terminate a client is beyond the present study and will be covered in the handbook before
publication. The issues of counselor emotional support and recovery when sued, while important, are beyond the scope of the handbook.

Chapter 10. Liability Insurance.

Respondents found the material in this chapter generally easy to read, fairly clear and informative. Two wanted more information and one wanted less. One panel member found the format a little confusing and suggested that several sections be combined into one. Favorable comments included, "Good info." "Good chapter." "Well written."

One student commented that this chapter has some overlap with Chapter 8 on malpractice. Several respondents wanted the section on "What does the policy not cover" expanded to explain why fee disputes and suing another plan member may not be covered under liability insurance. The figure for minimum liability coverage was considered too low and was believed to inaccurately reflect the current trends in liability coverage. One panel member requested information on the cost of insurance coverage. Several format changes will be incorporated in this study to help clarify the content. The section on what the policy may not cover will be expanded to include additional information on fee disputes and suing another plan member. A more accurate figure for minimum liability coverage will be included in the handbook prior to publication. Information on the cost of premiums is beyond the scope of the handbook.

Chapter 11. When Ethical Issues Arise.

Respondents' comments dwindled in the last few chapters and noticeably diminished in this chapter; only five of the eight panel members evaluated the format. Both the students and panel judged the content as informative, fairly clear and relatively easy to read. Two panel members thought the chapter somewhat too long and one somewhat too short. General comments included, "Very thorough." "Good about cultural minorities." "Good sections on dual relationships, crosscultural and multiple family systems."
One student suggested that the section on influences of ethical behavior be omitted; another wrote that the section which illustrates how some Arizona counselors deal with ethical dilemmas "does not add to the impact of your message"; a third student suggested omitting the recommendations by Ibrahim and Arredondo. One panel member thought the section on ethics and theories very important and recommended additional information be included. One respondents wanted more information about "who is the client" and one requested that the section on "honesty" be expanded. A panel member thought the "honesty" section to be incomplete and thought it may be more appropriate under "ethics and theories." One of the students was confused by the placement of "the timeline for ethical behavior."

The section on "What influences ethical behavior" will be omitted; the recommendations by Ibrahim and Arredondo will not. "Timeline for ethical decisions" will be relocated at the beginning of the chapter and several other minor format changes will be incorporated. Expanding the sections on "ethics and theories," "honesty," and "who is the client" is beyond the scope of this study and will be included in the final copy of the handbook before publication.

**Summary**

Results of the questionnaires indicate there is a need for the handbook. The evaluations were quite favorable and provided many useful suggestions, some of which were included in this study and others which will be incorporated before publication.
Table 20. Tabulations of third evaluation (Chapters 1-11)

Chapter 1. Mental Health Counselors

1. Generally I found the information: (Please circle your response)

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<thead>
<tr>
<th>Percentage of Respondents</th>
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</table>

| Too Long                   | 1  | 2  | 3  | 4  | 5  | 6  | 7  |
| Students                   | -  | -  | -  | 80 | 20 | -  | -  |
| Panel                      | -  | 12.5 | - | 75 | -  | 12.5 | -  |

| Fairly Clear               | 1  | 2  | 3  | 4  | 5  | 6  | 7  |
| Students                   | 60 | 20 | 20 | -  | -  | -  | -  |
| Panel                      | 50 | 37.5 | - | 12.5 | - | -  | -  |

| Informative                | 1  | 2  | 3  | 4  | 5  | 6  | 7  |
| Students                   | 80 | 20 | -  | -  | -  | -  | -  |
| Panel                      | 62.5 | 11.5 | 12.5 | 12.5 | - | -  | -  |

2. The format is:

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Students (n = 5)
Panel (n = 8)
Table 20.--Continued

Chapter 2. Counselor Certification

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<td>Panel</td>
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<tr>
<td>62.5 37.5</td>
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</table>

| Too Long                   | Too Short        |
| 1  2  3  4  5  6  7        |                  |
| Students                   |                  |
|                          80  20 |                  |
| Panel                     |                  |
|                          50  37.5 12.5 |                  |

| Fairly Clear               | Confusing in Parts |
| 1  2  3  4  5  6  7        |                  |
| Students                   |                  |
| 60  - 20                   |                  |
| Panel                      |                  |
| 50  37.5 12.5              |                  |

| Informative                | Not Informative  |
| 1  2  3  4  5  6  7        |                  |
| Students                   |                  |
| 100 -                       |                  |
| Panel                      |                  |
| 37.5 37.5 12.5 12.5         |                  |

2. The format is:

| Easy to Follow             | Difficult to Follow |
| 1  2  3  4  5  6  7        |                  |
| Students                   |                  |
| 60  40                      |                  |
| Panel                      |                  |
| 50  25 25                   |                  |

Students (n = 5)
Panel    (n = 8)
Table 20—Continued

Chapter 3. Third-party Payments

1. Generally I found the information: (Please circle your response)

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Students (n = 5) * Not all panel members responded to each item.
Panel (n = 8)
Table 20.—Continued

Chapter 4. Clients’ Rights

1. Generally I found the information: (Please circle your response)

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Students (n = 5) Panel (n = 8) * Not all panel members responded to each item.
Table 20.—Continued

Chapter 5. Clinical Records

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Table 20. Tabulations of third evaluation (Chapters 1-11).—Continued

Chapter 6. Sexual Conduct with Clients

1. Generally I found the information: (Please circle your response)

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Students (n = 5) * Not all panel members responded to each item.
Panel (n = 8)
Table 20.—Continued

Chapter 7. The Counselor as Expert Witness

1. Generally I found the information: (Please circle your response)

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Students (n = 5) Panel (n = 8)

* Not all panel members responded to each item.
Table 20.--Continued

Chapter 8. Malpractice

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Students (n = 5)
Panel (n = 8)
### Table 20.—Continued

#### Chapter 9. Lawsuits

1. Generally I found the information: (Please circle your response)

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<thead>
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<th>Percentage of Respondents</th>
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<th>Difficult to Read</th>
</tr>
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<td></td>
</tr>
<tr>
<td>Panel</td>
<td>50 37.5 12.5 - -</td>
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<table>
<thead>
<tr>
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<th>Too Short</th>
</tr>
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<td>- - - 25 75 -</td>
<td></td>
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<table>
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<th>Confusing in Parts</th>
</tr>
</thead>
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</tr>
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<td>Panel</td>
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Students (n = 5)
Panel (n = 8)


Table 20.--Continued

Chapter 10. Liability Insurance

1. Generally I found the information: (Please circle your response)

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</tr>
</thead>
<tbody>
<tr>
<td>Students</td>
<td>80</td>
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</tr>
<tr>
<td>Panel</td>
<td>50 37.5</td>
<td>12.5 - - - - - -</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of Respondents</th>
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<th>Too Short</th>
</tr>
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<td>75 12.5 -</td>
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<th>Confusing in Parts</th>
</tr>
</thead>
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<td>- - - - - - - -</td>
</tr>
<tr>
<td>Panel</td>
<td>50 25 12.5 12.5</td>
<td>- - - - - -</td>
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</table>

<table>
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<td>12.5 - - -</td>
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2. The format is:

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<td>Students</td>
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<td>- - - - - - -</td>
</tr>
<tr>
<td>Panel</td>
<td>50 12.5 12.5 12.5</td>
<td>12.5 - - -</td>
</tr>
</tbody>
</table>

Students (n = 5)
Panel (n = 8)
Table 20--Continued

Chapter 11. When Ethical Issues Arise

1. Generally I found the information: (Please circle your response)

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<tbody>
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</tr>
<tr>
<td>Panel*</td>
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</tr>
<tr>
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<td>Students</td>
<td>- - - 100 - -</td>
</tr>
<tr>
<td>Panel*</td>
<td>- 14.3 14.3 57.1 -</td>
</tr>
<tr>
<td><strong>Fairly Clear</strong></td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Students</td>
<td>60 - 40 - - -</td>
</tr>
<tr>
<td>Panel*</td>
<td>14.3 42.8 28.6 14.3 -</td>
</tr>
<tr>
<td><strong>Informative</strong></td>
<td>1 2 3 4 5 6 7</td>
</tr>
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<td>Students</td>
<td>80 20 - - - - -</td>
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<tr>
<td>Panel*</td>
<td>57.1 42.8 - - - - -</td>
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</table>

2. The format is:

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<tr>
<th></th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
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<td><strong>Easy to Follow</strong></td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Students</td>
<td>80 - 20 - - -</td>
</tr>
<tr>
<td>Panel*</td>
<td>40 20 - - - -</td>
</tr>
</tbody>
</table>

Students (n = 5)  Panel (n = 8) * Not all panel members responded to each item.
CHAPTER 5

CONCLUSIONS, USES, AND RECOMMENDATIONS

The purpose of this thesis is the production of a handbook on ethics and law for mental health counselors practicing in Arizona. The handbook is the result of information from many different sources: a questionnaire sent to Arizona Counselors Association members, professional literature; state laws and regulations; interviews with various noncounseling professionals who practice in Arizona and other states; evaluations and suggestions from counselors practicing in Tucson; and evaluations and suggestions from graduate students in Counseling and Guidance at the University of Arizona.

Questionnaire Sample Group

A total of 286 questionnaires were sent to members of the Arizona Counselors Association. 124 were returned, of which 117 were useable. The questionnaire respondents practice in 11 or more different Arizona metropolitan areas. Their experience as counselors ranges from less than 1 year to more than 35 years. They hold baccalaureate, master, or doctorate degrees in counseling or related areas of study.

Not known about any respondent is gender, length of practice in Arizona, and counseling specialty, if any. Gender was considered unimportant because the concern of the handbook is the typical practices of all counselors. Length of practice in Arizona and counseling specialty may affect typical practice, but analysis of any such effect is beyond the scope of this work.

Measurement

A 20-item questionnaire was developed to identify typical practices of counselors in Arizona and to assess the usefulness of the proposed handbook. Items in the questionnaire
reflect subjects of ethics and law which the professional counseling literature considers important. In order to limit the questionnaire to two pages, each subject area was covered fairly broadly.

The questionnaire was evaluated by 12 advisory panel members who are experienced counselors. Certain of the questionnaire inadequacies were not discovered until after the responses were received. For example:

1. The term "disclosure statement" should have been defined; it appears that not all respondents were familiar with that term.

2. Questionnaire item 12 which asks, "Do you get third-party payments on your own signature?" should have included a section which asked, "Do you have clients who are covered by insurance?" The added question would have allowed a more accurate count of respondents who unsuccessful or successful obtain third-party payments.

3. Item 17 is unclear: "Private" should have read "Sole practitioner in private practice" and "In partnership with others" should have read "In partnership with others in private practice." For data analysis, "Private" was interpreted to mean that the respondent works alone in private practice and "In partnership with others" was interpreted to mean that the respondent is associated with other counselors in private practice and not in a public agency or institution.

Generally, it appears that the questionnaire was uniformly intelligible and meaningful to respondents; there was a consistency among respondents and no surprises surfaced.

**Questionnaire Findings**

1. Do the practices of counselors differ substantially from one part of the state to another?

The first question was answered, "No." The questionnaire revealed no significant geographical differences in counselor practices except in one area: Tucson counselors are
more likely to consult with other counselors when legal issues arise than are counselors who live in smaller communities in Arizona.

One explanation for this difference may be that, since smaller metropolitan areas have fewer counselors, respondent counselors in those areas simply have less opportunity to consult with colleagues. If that explanation is valid, one would expect counselors in the Phoenix area to consult most frequently with each other. There may, however, be an optimum city size conducive to this kind of counselor interaction. Phoenix's magnitude in population and land area may actually inhibit such counselor interaction. Counselors are probably most likely to consult with colleagues they know well and counselors in Tucson may do more networking and cooperative work than counselors in the Phoenix area.

2. How do counselors respond to ethical and legal questions in their practice?

Respondent counselors most frequently consult with other counselors when legal questions arise and most frequently consult professional codes of ethics to resolve ethical dilemmas. However, doctorate-level counselors are significantly more likely to call an attorney for legal issues than are master-level counselors.

This is not surprising. Doctorate-level counselors typically have been in practice longer and thus have had more time to make professional contacts. [Finding an attorney who is knowledgeable about mental health issues is not easy; it appears to happen most successfully by word-of-mouth (Richards, 1990).] Further, counselors who have practiced longer have had more time to discover the importance of obtaining legal advice when certain situations arise.

When making decisions about ethical and legal issues, counselors with doctorates are also more likely to be concerned about a complaint to their professional organization than are master-level counselors. Counselors who have earned doctorate degrees may be more likely to consider themselves as professionals because of their status in the community. If that is so, they may be more likely to belong to professional organizations (VanZandt, 1990).
Overall, respondent counselors consider client welfare first when they make decisions about ethical and legal issues, complaints to their professional organizations last. Although the professional literature suggests that all mental health professionals need to practice defensively because of the litigiousness of our society, fear of lawsuits was the second least concern among respondents. Lawsuits against mental health practitioners are relatively rare, however, and counselors may judge the chances of being sued more by their own experiences and that of their colleagues' than by the professional literature. Tables 7 and 10 in Chapter 4 show that respondents consult colleagues more often than they review the professional literature.

When respondents were asked to list the books most useful to them when ethical and/or legal issues arise, over half of them made no response, only a few of the others identified books with full titles and authors. Some mentioned ethical codes, others journals and quite a few said they used their college texts, but could not remember titles or authors.

The questionnaire data suggest that fewer than a fourth of the counselors use any kind of textbook to help them answer ethical and legal questions. Several explanations for this seem likely: answers to specific questions may not be easily found in textbooks; talking to others may take less time and be more productive than reading when searching for an answer; respondents may not have wanted to take the time to write book titles on the questionnaire.

3. Do counselors typically generate and retain clinical notes?

Almost all respondents, over 90%, keep some kind of clinical notes. This is consistent with national data (Fulero & Wilbert, 1988). Counselors who keep no clinical notes are very much in the minority and may be practicing unethically.

A majority of respondents use record-keeping systems of their own devising. Respondents in private practice are significantly more likely to devise their own record-keeping systems than those employed by agencies. This is understandable because agencies usually
develop specific record-keeping guidelines, often in response to governmental requirements.

The longer respondent counselors have been in practice, the more likely they are to have devised their own system. Respondents in private practice have been counseling an average of 11.0 years and are more likely to have devised their own record-keeping systems than are agency respondents who have been counseling an average of only 8.9 years.

The professional literature identifies few guidelines for record-keeping practices specific to counselors. Most applicable guidelines arise from the practice of medicine which has a higher incidence of lawsuits. Since the fear of lawsuits seems quite muted in counselors, they may lack a compelling reason to establish guidelines for keeping "good" clinical records.

One such compelling reason could come from the counseling profession's general belief that proper records can improve counselor competence and, thereby, increase the quality of client care. In a profession that considers client welfare to be the paramount concern, it is surprising that more emphasis is not placed on the role the clinical record plays in the therapeutic process.

4. Do counselors disclose file material to clients upon request?

The majority of respondents would disclose all or part of a client's file to the client. Only about 8% would disclose none of it. The most frequently cited consideration in deciding whether to disclose a file is the client's best interest as determined by the counselor. Some respondents believe that properly written client records never affect the client adversely (Doel & Lawson, 1986).

5. Are clients informed of the scope and limits of confidentiality and other clients' rights issues at the beginning of counseling?

About two-thirds of respondents give clients either written or oral information on confidentiality and its exclusions at the beginning of counseling. However, one study found
that 96% of clients want to be informed of the limits of confidentiality at the beginning of therapy (VandeCreek et al., 1987).

Respondents seem to consider confidentiality to be the most important client right. The benefits of other client rights, such as consent to treatment and knowledge of counselor philosophy and expertise, are accorded to clients by fewer than half the respondents. In this practice, the study sample is consistent with the existing paternalistic model of counseling, in which the counselor alone decides what is in the best interest of the client. The paternalistic model is almost mandated by both the legal system and by professional codes of ethics.

6. Do master-level counselors in Arizona receive third-party payments?

Fewer than one-fourth of the respondents with master degrees report obtaining insurance payments on their signatures alone. It is unclear if their responses mean that those respondents always receive insurance payments without sign-offs from all insurance companies or only from some companies.

Ten percent of the remaining respondents indicated that they receive third-party payments on their signatures alone under some plans. Since some companies, such as Blue Cross/Blue Shield, will not reimburse master-level counselors directly, a reasonable interpretation of the questionnaire data is that about 28% of respondent master-level counselors in Arizona receive some third-party payments solely on their own signatures.

This interpretation is consistent with a study of licensed professional counselors in Alabama that found 33% of those counselors received some third-party payments on their own signatures (Covin, 1985). The Alabama study is 6 years old, however, and licensed professional counselors there may since have made more progress toward obtaining insurance reimbursement based solely on their own qualifications. The new Arizona counselor certification law, ARS §32-3302, may affect the payment of third-party reimbursements to master-level counselors.
About 37% of respondents receive some third-party payments through sign-offs. The questionnaire data do not indicate how thoroughly the respondents' client cases are staffed by clinical psychologists and/or psychiatrists; the extent of such staffing may well affect respondents' ability to obtain third-party payments. (Cursory counselor supervision by professionals who sign off on client insurance claims, may constitute insurance fraud.)

7. Would the handbook, as proposed, be useful to counselors?

This question was answered with an overwhelming "Yes." Ninety-three percent (93%) of respondents believe the handbook, as proposed, would be useful in their practices. This high positive response seems inconsistent for two reasons:

a. The handbook is written primarily for mental health counselors yet only one respondent indicated that he or she follows the ethical guidelines of AMHCA; 22 indicated that they follow APA's Guidelines; 26 indicated that they follow AADC's Principles; and 19 indicated that they follow the ethical codes of various other organizations.

b. Only about half of the respondents rely on literature for answers to legal or ethical questions.

One explanation for this strong endorsement of the handbook may be that 96% of respondents who confronted legal questions in the past 12 months reported that satisfactory answers were only sometimes easy to find. A second explanation may be that respondents do not recognize mental health counseling as a separate specialty and confuse it with mental health professions generally. A third explanation may be found in the essence of the profession of counseling: counselors are trained to empower their clients; respondents, who are all counselors, may have used a "Yes" response as a means of encouraging or empowering the author of the handbook to complete the project. A fourth explanation may be that
Respondents' counseling practices do not vary substantially from one metropolitan area to another. Respondents believe strongly in communicating with colleagues when legal and ethical issues arise. They may do so less frequently when they practice in small metropolitan areas with few counseling professionals. Their clients' best interests and confidentiality are two important components of the counseling relationship which concerned respondents. Of less concern to them is the possibility of being sued.

Possible Handbook Uses

The handbook is intended as a resource on legal and ethical issues primarily for counselors practicing in Arizona. However, it is also intended to be useful to a wider audience and is therefore written with a minimum of counseling jargon. For the counselor who is interested in further study, the handbook includes a substantial list of references. Although the handbook specifically addresses the practice of mental health counseling, the information in it also pertains to counselors in general.

The handbook may be useful as:

1. supplemental reading in a graduate counseling course on ethics and law;
2. as a primer for practicing counselors who have never taken a course in ethics or law;
3. as a resource for newly graduated counselors;
4. as a refresher for counselors who have been in practice for a number of years;
5. as an introduction to Arizona law for counselors newly arrived from another state; and
6. as information for actual and prospective clients who want to gain a better understanding of their rights in the counseling relationship.
Implications

This study has implications for further research in the areas of counselor/client relationships and of mental health counseling as a profession.

Counselor/Client Relationship

Two important aspects of the counseling relationship pervaded this study: confidentiality and the client's best interest. While both aspects are at the core of many legal and ethical issues, neither is well defined in a way that offers practical suggestions for implementation.

The definition of confidentiality is well understood. However, how to best impart information to clients about confidentiality and its limitations is not well defined. Some counselors believe that clients will be reluctant to confide "secrets" if they are given lengthy explanations at the beginning of counseling of the many possible exceptions to confidentiality. Yet clients seem to want to know about the limits of confidentiality (VandeCreek et al., 1987).

Few existing studies attempt to discover what the client wants to know about confidentiality, how that information should be presented, and when it can be presented most effectively: at the beginning of counseling, when specific issues arise, or at some other time.

The concept of "the client's best interest" is also regularly discussed among counselors, yet poorly defined. The Random House Dictionary (1966, p. 741) defines "in the interest" as: "to the advantage or advancement of; in behalf of." Is a counselor required at all times to act on behalf of a client to decide what is to the advantage or advancement of that client? Professional codes of ethics seem to say yes: the counselor is fully responsible for the client's welfare.

On the other hand, the concept of informed consent requires that the client be fully informed in order to be able to participate in making decisions about participation in certain
therapeutic endeavors. That requirement seems particularly clear where those endeavors include tests, research, or unusual treatments. A requirement to fully inform a client before any counseling procedure is less clear.

Some state laws and ethical codes require that clients be given a professional disclosure statement containing specific information. However, there is no clear evidence about what information is most useful to clients or how such information can best be presented.

Also needing further examination is how counselors decide when the best interest of the client should be determined by the client and when it should be determined by the counselor. In the present study, for example, some counselors reported they would disclose all of a client file, upon request, while others would do so only if it is in the client's best interest. Do the counselors in this latter group simply decide that best interest for the client, or do they fully inform the client about all possible benefits and risks of reviewing the contents of the file and then let the client decide what is in his or her best interest?

Mental Health Counseling as a Profession

Previous research projects generally have studied the practices of psychologists, social workers, and psychiatrists. If mental health counselors specifically and counselors generally, want to be recognized as a distinct profession, it is important their practices be studied separately from such other core providers.

Recommendations

Mental health counselors need to be recognized as a separate specialty. They need to unite with other counselors to form a professionally distinct entity capable of affecting state political processes.

One issue important to counselors, but not clearly defined under Arizona law, is indicative of this lack of recognition. Counselors who act on their ethical duty to warn
potential victims are not clearly protected from liability to their client for such warnings. Such protection is clearly accorded psychiatrists and psychologists, but not to counselors. At the same time, Arizona law requires that counselors follow their ethical guidelines, which require such warnings.

As counselors in Arizona become certified, they also need to unite and to lobby insurance companies for inclusion as third-party providers (Lambert & McGuire, 1990). If insurance companies require licensure, rather than certification, for such inclusion and for other benefits, counselors may need to lobby for a change in state law from regulation of behavioral health providers by certification to regulation by licensure.

Summary

The questionnaire results and the evaluations demonstrate a need for the information presented in the Handbook. Some of the needed information is not readily available from other sources. Further, information about current directions in counseling, such as the increasing emphasis on client involvement in the therapeutic process, does not appear to have reached all of the questionnaire respondents. The handbook will fill an information gap for both new and more experienced counselors.
APPENDIX A

HANDBOOK:  A HANDBOOK FOR MENTAL HEALTH COUNSELORS IN ARIZONA ON ETHICS AND LAW
A HANDBOOK FOR MENTAL HEALTH COUNSELORS
IN ARIZONA ON ETHICS AND LAW

by

Elizabeth Helene Christensen

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TABLE OF CONTENTS

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SECTION I. THE PROFESSION OF COUNSELING

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INTRODUCTION

Mental health counseling, as a distinct discipline, is still in its adolescence. Indeed, mental health counselors (MHCs) have gained professional status only in the last decade (VanZandt, 1990; Weikel & Palmo, 1989). A growing recognition that MHCs are separate and distinct from such other mental health professionals as psychologists, psychiatrists, social workers, and psychiatric nurses is an indication of the growth of this discipline.

Common to all MHCs is a sense of professionalism which is characterized in part by adherence to high personal standards of competence, improvement of skills through professional development, and pursuit of quality and ideals within the profession (VanZandt, 1990).

As the discipline of mental health counseling continues to mature and as its practitioners strive for competence, knowledge of the boundaries of proper practice becomes increasingly important. These boundaries are defined by ethical codes, state laws, and licensing and credentialing boards. MHCs must maintain a current awareness of all three areas of definition because boundaries can frequently change as the discipline adjusts to societal norms, expectations and practices (Schwartz, 1989; Remley, 1990; Mabe & Rollin, 1986).

Studies have shown that counselors are sometimes confused about ethical and legal aspects of their practices (Conte, et al., 1989; Smith, 1986). Part of this confusion arises because guidelines and laws do not always clearly define professional obligations. Answers to questions of law and ethics often require the mental health practitioner to rely heavily upon conscience and professional judgement (Turkington, 1987).

The need for knowledge in legal and ethical areas is heightened by the increase in lawsuits against mental health practitioners (Snider, 1987). Our society is one of the most litigious in the history of civilization. One of the important adjuncts to our freedom is the right to sue and the commensurate burden to be sued; we usually employ litigation rather than physical violence to resolve important differences (Wills, 1987).

While ethical codes apply substantially uniformly across the country, laws vary significantly from state to state (Hopkins & Anderson, 1990). MHCs, like other mental health professionals, can learn about their state laws through professional mailings from their state associations, seminars, attorneys, other counseling professionals, state statutes, and other sources. How often, and how many, MHCs utilize these different sources is unknown.

Contact with other professionals is considered to be one of the best ways to maintain and increase professional competence (Palmo & Weikel, 1986; Tennyson & Strom, 1986). Such contact is more readily available to MHCs who work in agencies; MHCs in private practice are more isolated (Richards, 1990; Jones, 1986) and often must take more initiative to become knowledgeable about legal and ethical issues.

Mental health agencies generally require all counselors on their staff to be licensed or certified. Through licensure and certification, such counselors become part of a state and national network of mental health practitioners who receive current information through mailings and professional journals. But no such requirement exists for counselors in private practice in Arizona. How do these counselors become knowledgeable about information that is a central part of a competent practice?

This handbook is written to inform counselors about specific state laws which directly apply to their practices, areas of law which may apply in less direct ways, and practical ethical considerations. The primary goals of this handbook are to help counselors untangle the sometimes confusing array of rules and regulations governing their discipline, to help them increase professionalism both in their individual practices.
and in counseling generally, and to acquaint them with some of the resources available when specific ethical and legal problems arise.

The handbook is intended as a useful guide and not as a definitive work on ethics or law. The handbook does not offer legal advice and does not replace the need for seeking the services of an attorney where appropriate and necessary.

The handbook is written primarily for mental health counselors, but it may also be of interest to clients and other counselors because many legal and ethical issues overlap various mental health professions.
SECTION I

THE PROFESSION OF COUNSELING
CHAPTER 1

MENTAL HEALTH COUNSELORS

HISTORY

The mental health professions in this country trace their beginnings back to the 1870s. The post-World War II period witnessed a dramatic increase in the perceived need for psychological treatment and to the passage of the National Mental Health Act. Until the mid-1960s, the post-war period was characterized by increased mental health spending, a burgeoning network of national mental health centers and a growing body of mental health professionals (Hershenson & Power, 1987). An important change in mental health care came when the "mechanistic-deterministic" philosophy of behaviorism gave way to the "self-determinism" of the humanistic philosophy of Carl Rogers (Palmo, 1986).

The period of the late 1960s and 1970s was a time of consolidation and reassessment during which mental health care consumers began to participate in the process of treatment, patients were more readily released from mental hospitals, "boom areas" arose, and federal funding for mental health care decreased. "Boom areas" were metropolitan centers characterized by rapid, substantial growth, primarily in minority populations. Such areas developed high needs for mental health services (Hershenson & Power, 1987).

During the late 1960s and 1970s, counselors gradually began leaving schools where they had been predominantly found, joining the ranks of other mental health professionals in agencies around the country. They were generally considered paraprofessionals and they worked under a variety of job titles: psyche tech, mental health specialist II, and psychiatric aide, to name a few. Describing the somewhat ambiguous nature of their position, Weikel & Palmo (1989, p. 7) wrote that "[the] mental health counselor (MHC) is a hybrid, born from an uneasy relationship between psychology and educational counseling, but with family ties to all of the core mental health care disciplines."

Mental health counselors finally received a kind of formal recognition in 1976 when the American Mental Health Counselor's Association (AMHCA) was founded. The AMHCA provided a home for "community" and "agency" counselors who previously had no established organization (Weikel & Palmo, 1989; Palmo, 1986). In 1977 the AMHCA joined the American Personnel and Guidance Association (APGA) which later became the American Association for Counseling and Development (AACD) (Hershenson & Power, 1987). Today AMHCA is the second largest division of AACD (Robert Rencken, head of the Arizona Counselors Association, 1991).

During the 1980s, an increasing number of mental health counselors entered private practice. By 1985, 22% of AMHCA members worked in private practice, more than in any other work setting (Hershenson & Power, 1987) (Table 1). This migration into private practice may have been due in part to the licensure and credentialing of counselors (Weikel, 1985).

The profession of mental health counseling is "in a continuous state of evolution" (Seiler et al., 1987, p. 204). MHCs are still trying to define their relationship to other mental health practitioners and to the consuming public. Some MHCs believe that professional identity may be the single most significant issue facing them today. The public often seems to assume that "counselors" are all the same, and may see little difference between psychologists, social workers, psychiatric nurses and MHCs (Weikel & Palmo, 1989; Seay, 1986).

Even professionals sometimes blur the distinction among the different mental health practitioners. Remley (1988, p. 170), in an article for the Journal of Mental Health Counseling, wrote: "All professional counselors are mental health counselors." If MHCs are to establish a true identity they must explore
similarities and differences between themselves and the other core mental health professionals: psychiatrists, psychologists, social workers and psychiatric nurses (Remley, 1988). An integral part of establishing that identity is the implementation of a concept of professionalism which embraces a personal commitment to the profession (VanZandt, 1990).

CORE PROVIDERS

The mental health profession recognizes five core mental health providers: psychiatrists, psychologists, social workers, psychiatric nurses, and counselors. These professions have some overlapping functions, their involvement in some kind of counseling or therapy, and some functions distinct to each specialty (Palmo, 1986).

Arizona law regulates psychiatrists, psychologists, counselors, social workers, marital and family therapists, and substance abuse counselors. Psychiatric nurses are not regulated as a separate specialty from the general practice of nursing (Miller & Sales, 1986). The following definitions appear in the Arizona Revised Statutes (ARS):

1. "Psychiatrist" means a licensed physician who has completed three years of graduate training in psychiatry in a program approved by the American medical association or the American osteopathic association (Mental Health Services, ARS §36-501, 1985).

2. "Psychologist" means a person who is certified as a psychologist by the board. [The board is the Board of Psychologist Examiners] (Psychologists, ARS §32-2061, 1980) [No further definition of psychologist is provided; the practice of psychology is primarily defined by the requirements for certification and by a description of unprofessional conduct (Board of Psychologist Examiners, R4-26-150, Article 3. Regulation, 1984).]

3. "Practice of social work" means professional services which are developed to effect change in human behavior, emotional responses and social conditions of individuals, couples, families, groups and communities and which involve specialized knowledge and skill related to human development, including an understanding of unconscious motivation, the potential of human growth, the availability of social resources and knowledge of social systems. Practice of social work includes: (a) The use of psychotherapy for the purpose of diagnosis, evaluation and treatment of individuals, couples, families and groups. (b) Social planning, administration and research for community social services delivery systems.

Social work practice means both private, self-employed practice on a fee for service basis by an individual social worker or as part of a group practice and autonomous self-regulated practice by a social worker under the auspices of a public or private agency or facility (Behavioral Health Professionals, ARS §32-3251, 1989).

4. "Practice of professional counseling" means the professional application of counseling principles, methods, procedures or services to assist individuals, couples, families and groups, to achieve interpersonal, intrapersonal, social, educational or vocational development and adjustment and to promote optimal mental health (ARS §32-3251, as amended under Senate Bill 1138; needs passage in the House of Representatives, 1991).

5. "Practice of marital and family therapy" means the professional application marital and family theories and techniques in the diagnosis and treatment of mental emotional conditions in individuals, couples and families and involves the presence of a diagnosed mental or physical disorder in at least one member of the couple or family being treated (Behavioral Health Professionals, ARS §32-3251, 1989).

6. Substance abuse counselors are not defined separately.
SPECIALTY OF MENTAL HEALTH COUNSELING

Mental health counselors primarily work with "normal populations" and stress prevention and mental health versus remediation and mental illness. They look at the global view of client concerns that include family and other personal associations (Palmo, 1986; Ivey & Rigazio-DiGilio, 1991; Remley, 1988). Mental health counselors follow an educational-developmental model in their practice and not the medical model (Ivey & Van Hesteren, 1990). Figure 1, following page, illustrates a comparison of the medical model and mental health counseling model.

In contrast to the medical model, the educational-developmental model considers both the physical and the mental aspects of the individual.

Education (Latin educare) is about drawing out what is already there in the person or system. Development (Latin dis plus villuppare) concerns the gradual unfolding of what is in the "germ" of a person. The educational-developmental model attempts to heal the mind/body split and recognizes that individuals live and grow in families, groups, organizations, and cultures (Ivey & Van Hesteren, 1990, p. 534).

Although MHCs do not follow the medical model, they need a working knowledge of the Diagnostic and Statistical Manual (DSM III-R) of the American Psychiatric Association because MHCs frequently collaborate with other mental health professionals (Remley, 1988).

Mental Health Counselors in Private Practice

Counselors who enter private practice need both business skills and mental health services skills. There are four components to the mental health service skills: counseling, consultation, supervision, and community involvement and public relations (Lowry, Roland, & Palmo, 1986). This handbook deals primarily with the counseling aspects of the mental health profession and the reader is directed to the following literature for on all aspects of private practice:


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<tr>
<td>Desired outcome of treatment</td>
<td>Client develops ability to cope</td>
<td>Patient is cured</td>
</tr>
<tr>
<td>Treatment strategy</td>
<td>Utilize/develop assets and skills</td>
<td>Eliminate pathology</td>
</tr>
<tr>
<td>Diagnostic labeling method</td>
<td>Largely irrelevant to</td>
<td>Central to choice of treatment method</td>
</tr>
<tr>
<td>Emphasis on environmental</td>
<td>Equal to client</td>
<td>Secondary to patient change</td>
</tr>
<tr>
<td>modification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of empirically evaluated</td>
<td>Important</td>
<td>Important</td>
</tr>
<tr>
<td>techniques</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 1. Comparison of mental health counseling and medical model.—From Hershenson & Power (1987, p. 6).
CHAPTER 2
COUNSELOR CREDENTIALING

LICENSURE

Licensure is "the statutory process by which an agency of the government, usually a state, grants permission to a person meeting predetermined qualifications to engage in a given occupation and/or to use a particular title and to perform specified functions" (Corey, et al., 1988, p. 147).

In other words, licensure protects both the title and the scope of practice.

Arizona Law

Under Arizona law psychiatrists and psychiatric nurses are the only mental health providers who are licensed.

CERTIFICATION

The process of certification ensures that certain qualifications are met before individuals can use a restricted title. However, unlike licensure, uncertified practitioners are not legally prevented from offering the same services as the certified professional.

In other words, only a certified counselor can use the title: "certified counselor." All other unregulated counselors may, however, continue to call themselves "counselor."

Arizona Law

Under Arizona law, psychologists and behavioral health professionals are certified (ARS §32-3302).

1. Behavioral Health Professionals

Arizona Revised Statutes (ARS) §32-3302 identifies the following as behavioral health professionals:

Certified Baccalaureate Social Workers
Certified Master Social Workers
Certified Independent Social Workers
Certified Counselors
Certified Marriage and Family Therapists
Certified Substance Abuse Counselors

2. ARS §32-3302

This Statute outlines the duties of the behavioral health board as well as the limitations and privileges of behavioral health professionals. See Appendix A of this handbook.
Arizona Certification

Counselors who seek Arizona certification may contact the Board of Behavioral Health Examiners for information.

Board of Behavioral Health Examiners
1624 W. Adams, Rm #100-A
Phoenix, AZ 85007
602-542-1882

National Certification

1. AACD

National certification for mental health counselors is possible through two different examinations. One is through the National Board for Certified Counselors (NBCC) an affiliate of AACD. NBCC offers a general counseling certificate (Brooks, 1986) through its National Counselor Examination (NCE) (Loesch & Vacc, 1988).

The NCE is increasingly used by states in their certification and licensure processes. Study guides for the NCE are advertised in AACD's Guidepost, a newspaper sent to all AACD members.

2. AMHCA

The second exam is through the National Academy of Certified Clinical Mental Health Counselors (NACCMHC), an affiliate of AMHCA. NACCMHA began certifying counselors in 1979. Because of the stiffer requirements of the NACCMHA, fewer counselors have become certified as mental health counselors (Brooks, 1986). AMHCA certification requirements include:

a. Master's degree,
b. 45 semester hours in a mental health field,
c. Minimum 2 years post-master's experience,
d. Minimum 3,000 hours experience,
e. 100 hours face-to-face supervision,
f. Demonstrated clinical skills.

Counselors certified through NACCMHC are listed in a register that is made available to mental health centers, and consumer, insurance and medical organizations.

3. How to Contact AACD and AMHCA

For membership in AACD and AMHCA write or call:

AACD
5999 Stevenson Avenue
Alexandria, VA 22304
1-800-326-2642

Membership in AACD is a prerequisite for membership in AMHCA.
4. Arizona affiliate of AACC

The Arizona affiliate of AACC is the Arizona Counselor's Association (ACA). For membership information write to:

Arizona Counselors Association
Robert Rencken, Executive Director
Arizona Counselors Association
1200 N. El Dorado Place, Bldg. F, Suite 600
Tucson, AZ 85715
CHAPTER 3

CERTIFIED COUNSELORS AND THIRD-PARTY REIMBURSEMENTS

HISTORY

The migration of counselors into private practice about a decade ago has brought the issue of third-party reimbursements into the forefront. Originally, only psychiatrists received insurance payments for client services because they qualified as medical doctors and were covered under medical insurance plans. Psychologists and social workers lobbied insurance companies to be included as recognized providers of health care; they argued that they perform the same services, at less cost, than psychiatrists.

Counselors are seeking provider status under health insurance plans by using a similar argument, that they provide basically the same services as psychologists and social workers, often at less cost (Hershenson & Power, 1987).

National Trends

Counselors, who are licensed or certified, are receiving some third-party payments on their own signatures. In Virginia 45% of licensed counselors who filed claims were paid (Hershenson & Power, 1987). In Alabama 33% of licensed counselors who filed claims were paid (Covin, 1985).

The pattern of third-party reimbursements is unpredictable and varies from state to state, and within divisions of the same insurance carrier. The counselor needs to be familiar with the exclusions on specific insurance coverages (Richards, 1990).

Arizona

A survey of Arizona Counselors shows that 27% of respondents with masters degrees report receiving third-party payments on their signatures alone. Another 38% of master's level counselors receive payments through sign-offs by clinical psychologists or psychiatrists (Christensen, 1991).

1. CHAMPUS (Civilian Health and Medical Plan of United States).
   CHAMPUS reimburses certified master-level counselors who meet the minimum standards of NACCMHA. All mental health professionals who seek CHAMPUS reimbursement require prior authorization. For application forms call or write:
   
   CHAMPUS Correspondence
   P. O. Box 2950202
   Florence, S.C. 29502-0202
   1-800-225-4816

2. Other Insurance Plans

Federal and state insurance plans, such as Blue Cross/Blue Shield, private carriers and HMOs are too variable in their payments to master-level counselors to be covered here.
Private insurance carriers suggest that counselors call for information when a specific client is in the office with a specific health insurance plan.

HMOs use a provider system of health care and only those professionals who have prior authorization are reimbursed for services rendered. Counselors who are interested in qualifying as an HMO provider need to contact each HMO separately for information.

SIGN-OFFS

Master-level counselors can sometimes receive third-party payments when either a doctorate-level psychologist or psychiatrist co-sign the client's insurance claim.

Psychologist or psychiatrist who sign-off must be "true" supervisors for those cases in which counselors seek third-party reimbursements; mentioning a case in passing once a month is not adequate supervision (Beigel & Earle, 1990).

Insurance plans usually specify who will be reimbursed for services. Some companies and plans will only reimburse the actual provider of services. Counselors are advised to become familiar with state and national laws regarding theft by deception (Richards, 1990).

GUIDELINES FOR THIRD-PARTY REIMBURSEMENTS

The Ridgewood Financial Institute based in Hawthorne, New Jersey (Beigel & Earle, 1990, p. 145) has "nine rules for avoiding reimbursement traps":

1. Collect fees directly from clients; give clients the responsibility for reimbursement from their insurance company.

2. Encourage clients to seek reimbursement; some may not be aware they may have coverage for counseling.

3. Reassure clients about confidentiality.

4. Investigate third parties many clients use; i.e., talk to the company's local representative to understand how their plan works.

5. Master the details of government programs such as CHAMPUS, Medicare, Medicaid, etc.

6. Take extra care with claim forms; review each form before it is sent out and try to use the Standard Health Insurance Form most companies accept.

7. Review your diagnostic language; Most companies require diagnosis from the Diagnostic and Statistical Manual of Mental Disorders from the American Psychiatric Association (DSM III-R).

8. Don't fudge on credentials; some insurance companies will not reimburse nonmedical providers; asking another professional to sign a claim form may be illegal in some instances.

9. File claims at the right time; don't wait until a large bill has accrued.
SECTION II:

THE PRACTICE OF COUNSELING
CHAPTER 4

CLIENT'S RIGHTS

Client’s Rights Statement

The Code of Ethics for Mental Health Counselors, 1987, state that the client has the right (Herlihy & Golden, 1990, p. 201):

a. to be treated with consideration and respect;

b. to expect quality service provided by concerned, competent staff;

c. to a clear statement of the purposes, goals, techniques, rules of procedure, and limitations as well as potential dangers of the services to be performed and all other information related to or likely to affect the on-going counseling relationship;

d. to obtain information about their case record and to have this information explained clearly and directly;

e. to full, knowledgeable, and responsible participation in the on-going treatment plan, to the maximum feasible extent;

f. to expect complete confidentiality and that no information will be released without written consent;

g. to see and discuss their charges and payment records;

h. to refuse any recommended services and be advised of the consequences of this action.

PRIVILEGED COMMUNICATION

Definition of

Privileged communication is a concept of law which concerns: "the legal right that protects clients from having their confidences revealed publicly from the witness stand during legal proceedings without their permission" (Mappes et al., 1985, p. 248).

Privileged communication is established by state law and only applies when a professional, who has been legally granted that privilege, is called into court as a witness (Hopkins & Anderson, 1990). It protects a client’s confidential statements made to the counselor from being disclosed during legal proceedings (Rinas, 1988).

In Arizona, privileged communication is granted only to those counselors who are certified.
Four Conditions of Privileged Communication

There are four basic conditions set forth in the 1920s by John Henry Wigmore (1961, p. 52) and are still applied today to determine whether the privilege should be recognized:

1. The communications must originate in confidence that they will not be disclosed.
2. This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.
3. The relation must be one which in the opinion of the community ought to be sedulously fostered.
4. The injury that would inure to the relationship by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation [emphasis in original].

Some Common Waivers of Privileged Communication

Courts will generally only grant privileged communication when state legislation grants the privilege, even when Wigmore's four conditions are met (Hopkins & Anderson, 1990). Privileges, however, are not absolute even when guaranteed by statute (Smith, 1986).

The privilege only applies when client information was made in confidence and the client wishes it to remain so. Since the privilege belongs to the client the counselor is obligated to waive the privilege when the client requests (Hopkins & Anderson, 1990). Some other waivers of privileged communication are (Watkins, 1989, p. 134):

Client introduces privileged material into litigation.
1. A client sues his/her counselor.
2. A client commits or threatens a criminal act.
3. A client threatens suicide.
4. A client threatens to harm his/her therapist.
5. Child abuse or neglect is suspected.
6. The court orders a professional examination.
7. The client dies.
8. Information is shared in the presence of a third person.
9. A treating professional needs to collect fees for services rendered.

Group Counseling and Privileged Communication

Privileged communication generally does not apply to individuals who participate in group counseling unless there is a statutory exception (Hopkins & Anderson, 1990).
**Arizona Law**

Until recently, Arizona only granted the privilege to a few mental health professionals: psychiatrists and psychologists. The new counselor certification law (ARS §32-3283) also grants the privilege to certified behavioral health professionals (Handbook, Appendix A).

**CONFIDENTIALITY**

**Definition**

Confidentiality is an ethical concept often confused with privileged communication, a legal concept.

Confidentiality is: "... an ethical standard of conduct that requires professionals to prevent disclosure to third parties of any information communicated by patients or clients in the course of the professional relationship. . ." (Butz, 1985, p. 84).

Confidentiality is considered an important component of the counseling relationship. Without it clients may not be unwilling to reveal personal matters believed beneficial to the counseling process (VandeCreek et al., 1987).

Confidentiality is not absolute.

**Threats to Confidentiality**

Generally, the privilege to waive confidentiality belongs to the client and not to the professional. By legal standards, a client may relinquish the privilege orally, but professional ethical guidelines require that release of information be obtain in writing (Schwartz, 1989).

Some common threats to confidentiality include:

1. Failure to receive client approval before putting information about the client on an insurance form (VandeCreek et al., 1987);
2. The use of a collection agencies to collect outstanding bills (Simon, 1988);
3. The use of a computer filing system without properly disguising client identity (Simon, 1988);
4. Legal requirements, of a court or state law, to reveal information;
5. Discussion of cases with others, even if the client's name is withheld, because details of the case may reveal client's identity, especially in a small town (Watkins & Watkins, 1983);
6. Phone requests from other professionals for information about clients, and the counselor does not assure positive identification of the professional (Whittington, 1988);
7. Ignoring nondisclosure laws, which hold that the counselor not divulge that a particular individual is a client; this breach most likely occurs when professionals or family members request information about a client (Everstine & Everstine, 1986).
When is a Breach of Confidentiality Valid?

1. Client Consent:

A breach of confidentiality is only valid when the client gives valid consent. To be valid, the client consented knowingly and voluntarily. The counselor is advised to always receive written consent before breaching confidentiality, which is a requirement under the profession's ethical codes (Butz, 1985).

2. Public Interest:

The counselor may need to break confidentiality without client consent if overriding public interest prevails, as in cases of child abuse, elder abuse, harm to self, and harm to others.

Informing a Client about Confidentiality Issues

Many mental health professionals do not inform clients at the outset of counseling about confidentiality and its limitations. While clients may not always understand the full implications of confidentiality, they overwhelmingly want to be informed. One study (Bernard & O’Laughlin, 1990) found that 39% of practitioners did not inform clients and 60% did so inadequately.

A survey (Christensen, 1991) of Arizona Counselors Association members found that 53% of respondents inform clients about confidentiality and its exclusions through written material at the beginning of counseling; 12% do so orally; about 34% provide no information.

Appendix C includes sample forms demonstrating how several counselors inform their clients of confidentiality and its exclusions.

Arizona Child Abuse Reporting Law

Arizona law mandates the reporting of child abuse in ARS §13-3620. See Appendix A in the handbook for the full text. In summary, the law states that professionals, like counselors, have a duty to report child abuse if they see physical evidence of the abuse or if the child reports having been abused.

Child abuse reporting does not apply in cases of adult clients who reveal abusing children, either their own or others; however, if the counselor has reason to believe that a child's life may be in danger, the duty to warn doctrine may apply.

1. How and When to Report:

a. Immediately inform, by phone or in person, the police or Child Protective Services (CPS). Informing only your supervisor or agency head does not meet the legal requirement.

b. Within 72 hours of the initial reporting, send a written report and include:

- The names and addresses of the minor and his parents or person or persons having custody of such minor, if known.

- The minor's age and the nature and extent of his injuries or physical neglect, including any evidence of previous injuries or physical neglect.

- Any other information that such person believes might be helpful in establishing the cause of the injury or physical neglect.
2. Anonymous Reporting

If you are unsure whether a case is reportable, you may call CPS anonymously for information to help determine if a particular case falls within the reporting requirement. Anonymous reporting of child abuse, however, is illegal because the law requires that you report. Without proof of the report, you have not fulfilled your legal requirement.

3. Why Some Professionals Don't Report?

Some professionals believe that reporting suspected child abuse will have the following adverse effects:

a. The abusive parents will not seek counseling without the guarantee of confidentiality;
b. Abusive parents who seek counseling may not fully disclose the abuse without assurance of complete confidentiality;
c. Trust in the counselor/client relationship will be destroyed and the client will feel betrayed (Butz, 1985).

4. How to Preserve the Counseling Relationship

Counselors can deal with the mandatory child abuse reporting law in a number of different ways (Butz, 1985):

a. Ignore the duty to report when the need arises and thereby risk legal liability; an unacceptable response which leaves children unprotected.
b. Ignore the potential conflict until it actually arises - "do nothing until necessary" - which may be the most prevalent approach. This approach may alienate the client and, thereby, destroy the therapeutic relationship.
c. Provide the client with detailed information about confidentiality and its exclusions at the outset of counseling. Some professionals believe such an approach may inhibit the client to disclose serious issues.
d. Give the client general information about confidentiality and its exclusions at the outset of counseling. When the need to disclose information arises, discuss the issue first with the client and second establish a cooperative relationship with the local child protection caseworker to reduce the trauma of the investigation. This ideal solution involves the collaborative efforts between the counselor and caseworker and may be difficult to achieve because caseworkers are often overworked.
e. When the child is the client, the counselor should initially tell the child generally about confidentiality and its exclusions. When the child reveals abuse, explain to the child the need to disclose the abuse and discuss the likely consequences of disclosing such information. Give the child the option to personally report the abuse or to be present when the counselor does so (Taylor & Adelman, 1989).
Arizona Elder Abuse Reporting

The duty to report adult abuse is required by state law under ARS §46-451 and is regulated by Adult Protective Services (APS) of the Department of Economic Security. The purpose of this law is to prevent or alleviate abuse, neglect or exploitation incapacitated adults (18 and over) (Arizona Family Planning Council, 1989).

According to APS, few counselors report adult abuse because they generally do not have the care of incapacitated adults. Counselors with questions should contact one of the 30 Adult Protective Service offices around the state. Telephone numbers are listed in the BLUE pages of the phone directory under Department of Economic Security--Adult Protective Services.

Duty to Warn

"The protective privilege ends where the public peril begins"
Tarasoff Court

1. Tarasoff

The court in Tarasoff v. Regents of University of California set legal precedence in 1974 by ruling that therapists are to exercise reasonable care to protect potential victims (Givelber et al., 1984). The court also ruled that while confidentiality is to be valued highly, it is not to be regarded as an absolute.

Tarasoff has been interpreted by mental health professionals both in California and other states as a legal duty to warn potential victims. Rulings vary from state to state: for example, in one state the therapist's duty to warn only exists when a specific victim is named; and in another, the therapist has an obligation to act if the client makes general threats against individuals or property, as in the case of threatened arson (Greenberg, 1984; Herlihy & Sheeley, 1988).

2. Arizona Law

a. Hamman v. County of Maricopa

In 1987 Hamman v. County of Maricopa, 161 Ariz. 53, the Arizona court ruled that a psychiatrist had a duty to protect potential victims even though there had been no specific threat against them.

The Arizona State Legislature, in its 1989 session, responded to the Court's decision in Hamman v. County of Maricopa by enacting a law that limits the liability to mental health providers who breach confidentiality in carrying out their duty "to prevent harm to a person caused by a patient..."

Under the law mental health providers have the duty to take "reasonable precaution" when there is both a "clearly identified" and "identifiable victim." Reasonable precaution may include warning identifiable victims, notifying the police, taking steps for voluntary or involuntary hospitalize the patient, and "[taking] any other precautions that a reasonable and prudent mental health provider would take under the circumstances" (ARS §36-509).

b. Mental Health Providers

are defined by state law as psychiatrists, clinical psychologists, and social workers who are experienced in mental health (ARS §36-509).
c. Behavioral Health Professionals

Counselors are classified as behavioral health professionals (ARS §32-3301), and are not accorded the same legal protection when the duty to breach confidentiality is present. Counselors are put in a difficult position because the National Board for Certified Counselors Code of Ethics states:

When a client's condition indicates that there is a clear and imminent danger to the client or others the certified counselor must take reasonable personal action or inform responsible authorities (Section B., amended February 21, 1987).

The Duty to Warn and AIDS

A 1990 study (Knapp & VandeCreek, 1990) found: 12% of bisexual and homosexual men obtaining HIV testing would not tell their primary sexual partners if they tested HIV-positive; 27% would not contact nonprimary partners; 35% of sexually active single men reported lying to their female partners about past sexual activities; and 20% would lie about having tested HIV-positive.

Does a counselor have the duty to warn sexual partners of clients who test HIV-positive and who exhibit high-risk sexual behavior?

Some mental health professionals believe that counselors have an obligation to warn such sexual partners; others believe preserving the therapeutic relationship is more important. Counselors need to be aware of their state laws which may regulate who and under what circumstances the sexual partners of HIV-positive individuals are to be informed (Totten et al., 1990).

1. Arizona Law

The Arizona Legislature in its 39th Session, 1990, passed H.B. 2173 which requires the health department to notify known partners of individuals who have tested HIV-positive.

Under H.B. 2173 only the health department is required to notify partners and they must do so without revealing identifying information about the infected person.

Physicians and clinics automatically report the names of individuals who test positive to the health department. However, the health department only receives those names of individuals who were tested in Arizona by a physician or clinic.

2. Guidelines for Counselors

The following guidelines are a combination of general recommendations offered by Knapp (1990) and more specific recommendations of the Tucson AIDS Hotline. Counselors are advised to:

a. Avoid indiscriminate reporting, either premature or inaccurate. Only report names to the health department if you believe a client's behavior is risky, and do so, if possible, with the client's consent and presence.

b. If the risk of transmission appears high, turn the focus of therapy to the client's voluntary disclosure.

c. Document all treatment decisions.

d. Consult with knowledgeable colleagues.
e. Contact either an attorney or the Aids Hotline in your locality to understand your reporting obligations. The counselor's obligations to report may fall under the duty to warn, yet counselors must also abide by the reporting limitations, which require that names of HIV-positive clients be held in confidence, even from potential victims.

3. Educational Opportunities

Washington State has initiated a mandatory AIDS training and education requirement as a prerequisite to licensing for all professionals who have diagnostic or treatment responsibilities to persons with AIDS. Counselors fall under this requirement and must show proof they completed a minimum of 4 hours of AIDS education. Colleges and Universities throughout Washington provide this training and several of them offer correspondence courses.

<table>
<thead>
<tr>
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<th>Phone Number</th>
</tr>
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<tbody>
<tr>
<td>LC.N.E.</td>
<td>Spokane</td>
<td>509-325-6146</td>
</tr>
<tr>
<td>Bellevue Community College</td>
<td>Bellevue</td>
<td>206-641-2012</td>
</tr>
<tr>
<td>AIDS Impact/WSNA</td>
<td>Seattle</td>
<td>206-284-3865</td>
</tr>
</tbody>
</table>

INFORMED CONSENT

Four Elements of Informed Consent

Informed consent is based "on the philosophy of individual freedom and choice" and relates to the rights of an individual (Bray et al., 1985, p 51). The informed consent doctrine holds that clients be given adequate information in order to become "active participants in the therapeutic relationship" (Corey et al., 1988, p. 168), and includes four elements (Corey et al., 1988, p. 128):

1. Competence: Does the individual have the legal capacity to make decisions?
2. Voluntarism: Did the individual freely decide to participate without undue pressure?
3. Full Information: Was the individual fully informed about all potential risks and benefits of participation?
4. Comprehension: Is the consent form written in easy to understand language?

Even if all four elements are met, a client cannot consent to illegal or professionally unacceptable treatment. In such situations, the counselor may be held liable for misconduct even though the client gave consent (Leesfield, 1987). See Chapter 6, Sexual Misconduct.

Required Pretreatment Information

To help clients make informed decisions, counselors need to provide them the following information before any new treatment begins (Bray et al., 1985):

1. Description of goals, procedures, and side effects of counseling;
2. Information about counselor's qualifications; and
3. Alternatives to counseling.
Informed Consent and Couple Counseling

In couple counseling, each partner needs to consent (Bray et al., 1985). However, if only one partner is seen, does the absent partner need to be informed of potential risks to the relationship? To avoid civil liability, some professionals recommend sending written consent forms and waivers to absent partners regarding their failure to be present and participate (Paquin, 1988).

CLIENTS' BILL OF RIGHTS

Clients are generally not knowledgeable about their rights in a counseling relationship. It is therefore the counselor's duty to protect the clients' rights and to inform them of such rights (Corey et al., 1988).

States' Regulation of Counselors

A number of states require counselors and other mental health professionals to give clients, prior to treatment, a client bill of rights. For example, Minnesota requires that both licensed and unlicensed mental health service providers give clients, prior to treatment, a client bill of rights. Client must sign a statement attesting that they received and read the bill of rights. A copy of the rights must be posted in a prominent location in the office.

The Arizona behavioral health board does not have statutory authority to require counselors to give clients a client bill of rights (ARS §32-3251). The law, however, will often step in when professions do not adequately regulate themselves. A survey of Arizona Counselors Association members (Christensen, 1991) found that only about 37% of respondents give clients written information about clients' rights; another 5% do so orally.

Ethical Guidelines and Clients' Rights

Principle 12 of the Code of Ethics for Mental Health Counselors, 1987, has a list of client rights, see Appendix B, but the code does not specify that the counselor inform clients of those rights.

Principle 6.e addresses the client's right to information about the counseling relationship and recommends that the counselor develop a Professional Disclosure Statement (see below).

AACD's Ethical Standards do not directly state that counselors inform clients of their rights except as they relate to "the purposes, goals, techniques, rules of procedure, and limitations that may affect the relationship at or before the time that the counseling relationship is entered" (Section B:8).

Clients' Rights and Group Therapy

According to Corey (1990, p. 25), clients have the right to the following information before joining a group:

1. purpose of the group,
2. group format, procedures, and ground rules,
3. a pregroup interview to determine whether this particular group with this particular leader is at this time appropriate to one's needs,
4. an opportunity to seek information about the group, to pose questions, and to explore concerns,

5. education, training, and qualifications of the group leader,

6. information concerning fees and expenses and whether the fee includes a follow-up session; also information about the length of the group, frequency and duration of meetings, group goals, and types of techniques being employed,

7. psychological risks involved in group participation,

8. limitations of the confidential character of the group,

9. clarification of what services can and cannot be provided within the group,

10. help from the group leader in developing personal goals,

11. a clear understanding of the division of responsibility between the leader and participants,

12. a discussion of the rights and responsibilities of group members.

During the course of the group, clients have the right to expect the following (Corey, 1990, p. 26):

1. instructions concerning what is expected of the participants,

2. the freedom to leave the group,

3. notice of any research and tape or video recording; and the right to stop the recording if it restricts member participation,

4. an opportunity to discuss what one has learned in the group and to bring some closure to the group experience, so that the participant is not left with unnecessary unfinished business,

5. freedom from undue group pressure concerning participation in the group exercises, decision making, disclosure of private matters, or acceptance of suggestions from other group members,

6. observance of confidentiality on the part of the leader and other group members,

7. the right to be treated as an individual.

Counselors who lead groups are directed to become familiar with the Ethical Guidelines for Group Counselors (Herlihy & Golden, 1990).

**Consumer Information**

The Mental Health Association of Colorado (1989) has published an excellent guide, *Reaching Out For Mental Health*, for consumers on finding and using mental health professionals. Copies may be obtained by writing or calling:
PROFESSIONAL DISCLOSURE STATEMENT

Definition of

Professional disclosure is a process of informing prospective clients about one's qualifications, about the nature of the counseling process, and about the services provided. Such information is beneficial to the counselor, through a process of thorough self-evaluation, and to the client, who will be able to make an informed decision about which counselor to see (Corey et al., 1988).

Elements of

Professional Disclosure Statements typically include the following minimum elements (Bloom et al., 1990):

1. Name, title, business address, and business telephone number;

2. Formal professional education, including the institutions attended and the degrees received from them;

3. One's philosophy of counseling, areas of specialization, and the services provided;

4. If in private practice, one's fee schedule listed by type of service or hourly rate.

See Appendix C for an example of a professional disclosure statement.
CHAPTER 5

CLINICAL RECORDS

"The weakest ink lasts longer than the strongest memory."

"Work not written is work not done."

(Snider, 1987, pp 135, 136)

INTRODUCTION

Clinical records are the personal notes the counselor takes during or after sessions with a client, and are distinguished from business records. Business records include dates of sessions, payment of fees, and health insurance reimbursements, and other information.

The mental health practitioners generally believe records to be a vital part of any practice, yet the professional counseling literature has sparsely addressed this issue. It is not surprising that the profession of counseling has not developed its own guidelines on documentation and record keeping, instead, has adapted guidelines developed in the medical profession.

REGULATION OF CLINICAL NOTES

Legal Requirements

Counselors are not required by law to write clinical notes.

Ethical Requirements

Ethical guidelines address the safe keeping and destruction of records but not the content.

CLINICAL NOTES AND THE PRACTICE OF COUNSELING

Arizona Counselors' Practices

A survey of Arizona Counselors Association members (Christensen, 1991) found that about 93% of respondents keep some kind of clinical records, although in some cases quite minimal. Over half of them take brief notes and only about 10% said they take detailed notes; 6.8% reported taking no notes at all. Similar findings in an Ohio survey (Fulero & Wilbert, 1988) show that 7.6% keep either no notes or minimal notes.
Why Keep Clinical Notes?

1. Counselor Accountability:

Many mental health professionals consider clinical records an important part of counselor accountability (Snider, 1987). Records can show the justification for a counselor's actions (Siegel & Fischer, 1981). The record-keeping process, if done correctly, can help counselors think about the effectiveness of their therapeutic interventions and help them develop individual treatment plans for their clients (Ryback et al., 1981).

The primary purpose of the record...is not only to document that treatment occurred but also to facilitate the coordination and continuity of services, to assist in evaluation of the client's condition and progress, and to evaluate the success or failure of treatment. Ultimately, the record should exist to serve the client (Soisson et al., 1987, p. 501).

2. Professional Responsibility:

Counselors who do not keep clinical notes may be acting unprofessionally if that practice is contrary to the standards of the profession. A court of law could rule that a counselor breached professional responsibility to a client if that client was in any way harmed by the counselor's absence of note keeping and the court determined that the usual practice for counselors is to keep notes (Remley, 1990). An absence of adequate records may be seen by a court as an absence of care (Soisson et al., 1987).

3. Legal Protection:

Inadequate records usually count against the counselor and in favor of the client in the case of a malpractice suit (Snider, 1987; Beahrs, 1990). "There is a saying that ... the weakest ink lasts longer than the strongest memory" (Snider, 1987, p. 136). Since malpractice suits generally take an average of five years between the time of the alleged incident until the time of trial, (Wills, 1987) "the record is often the most reliable evidence of proper diagnosis and treatment" (Soisson et al., 1987, p. 499).

Why Not Keep Clinical Notes?

The minority of mental health professionals who keep no clinical notes do so to avoid subpoena of those records. They believe they are acting in the best interest of the client. There is no indication in the professional literature that "adequately" written clinical notes harm a client.

According to the ethical codes of the profession, see Chapter 11, counselors have a responsibility to society as well as to individuals. Keeping information from a court of law through an absence of clinical notes may serve in the best interest of that individual client, but may not serve in the best interest of society.

GUIDELINES FOR "ADEQUATE" CLINICAL NOTES

General Characteristics

Clinical records should be:

1. unambiguous
2. precise
3. conservative

And consist of:
4. clear behavioral descriptions
5. concrete vignettes that support any conclusions and relevant facts

And should not include:
6. guarantee of results
7. over optimism for treatment outcome
8. hunches or value judgments
9. emotional statements
10. personal opinions
11. information about illegal behavior, sex practices or other sensitive information that may embarrass or harm the client or others
12. jargon
13. abstract diagnosis

Nine Minimum Inclusions (Soisson et al., 1987, p. 500):
1. descriptive summary of all contacts
2. regular summaries of progress
3. available psychological test data
4. notations of informed consent to all aspects of treatment
5. notes concerning phone contacts and conversations with significant others
6. copies of all correspondence with the client
7. when friends or relatives provided information,
8. when any corrections are made and why
9. acknowledgment of limitations of treatment
Specific Methods of Record Keeping

1. A Goal-oriented Plan

The goal-oriented plan helps document client progress toward achieving treatment plan goals and includes four elements (Piazza & Baruth, 1990).

a. A statement of the goal(s) for the session which shows a logical connection to the previous session. Any goal needs to be flexible to allow for pressing, immediate client concerns.

b. An evaluation of goal attainment for the session to show what techniques or interventions worked or failed and what could have been done differently.

c. Clinical impressions that are based on client behavior or statements and not on unsupported clinical impressions.

d. An action plan for the next session which becomes the statement of goals for that session.

2. SOAP and DAP

One common format for recording client sessions is SOAP. It was developed by L.L. Weed as a method of record keeping in the medical field (Siegel & Fischer, 1981) and stands for Subjective, Objective, Assessment, and Plan (Ryback et al., 1981; Siegel & Fischer, 1981). About 23% of surveyed Arizona Counselors Association members indicated that they use SOAP or a modified SOAP method (Christensen, 1991).

One modified version of SOAP is DAP, which stands for Data, Assessment, and Plan. "Data" combines the Subjective and Objective categories of the SOAP method.

There are no hard and fast rules about what to include in the four categories of the SOAP method. Typically, the following information is recorded after each session (Siegel & Fischer, 1981):

a. Subjective: Client’s reporting, i.e., what does the client say and feel; what does the client consider the problem to be; what does the client think would be helpful; what physical symptoms, if any, does the client report.

b. Objective: Observed behavior, i.e., what tone of voice did client use; did client show any emotion during the session; what was the client’s physical appearance. Some professionals record test results in this section.

c. Assessment: Impressions of the counselor based on the subjective and objective; assessment of client’s strengths and defenses based on supportable conclusions.

d. Plan: Interventions used in the session; homework assigned; interventions which might be useful in future sessions; any agreements between counselor and client.

Appendix C includes a copy of a form for progress notes using the SOAP format. This form includes a fifth category, Treatment, which can be used to record recommendations for future treatment.
When to Write Clinical Notes

Clinical notes must be written extemporaneously, i.e., as soon after the session as possible; hence the 50-minute hour. The counselor who sets time aside at the end of the week to update clinical notes will find those notes to be less helpful in court than the ones written immediately or very shortly after a session (Greenlaw, 1982). Notes written at the end of the week appear to reflect a counselor's "interest in personal convenience instead of the client's best interest" (Snider, 1987, p. 139).

"OFFICIAL" vs. PRIVATE RECORDS

Some counselors keep a set of "official" records in their office file cabinet and "unofficial" clinical notes in their desks or some other secret place. When a counselor is subpoenaed to produce all records pertaining to a client, that may include "official" as well as "unofficial" notes.

A refusal to submit the "unofficial" notes may result either in a fine or imprisonment. The counselor who lies on the witness stand, saying there are no "unofficial" notes, when there are, may be found guilty of perjury, which is a criminal offense. Unofficial notes include anything written about a client, even one or two words in a date book (Remley, 1990; Beigel & Earle, 1990).

CLIENT ACCESS TO FILE

"If you can't confront the client with what you think about them, you certainly shouldn't be hiding it away in a record."

British Social Worker

General Trends

Clients expect to see their files upon request (VandeCreek et al., 1987) and, nationally, the trend is to honor such a request (Turkington, 1987; Fulero & Wilbert, 1988). Counselors are admonished to keep records with the assumption that clients may eventually see them (Soisson et al., 1987).

A survey of Arizona Counselors Association members (Christensen, 1991) found that 39.3% would disclose all of the client file to the client; 7.7% would disclose none of the file; and about 47% would disclose part of the file, depending on the circumstances.

Arizona Law

From a legal standpoint, clients generally have the right to view their own records (Remley, 1990; Bennett et al., 1990; Miller & Sales, 1986). Arizona law regulates the records of psychologists and psychiatrists (Miller & Sales, 1986). For example, the Arizona Administrative Code R4-26-150 states that psychologists are acting unprofessionally when:

Failing to make available to a client or to his designated representative, upon the client's written request, copies of records or documents which have been prepared for and paid for by the client. The psychologist may withhold such information from the client if in his professional judgement the release of such information clearly would adversely and substantially affect the client's mental health.

The new Arizona counselor credentialing law does not specifically address record keeping. Under this law, "unprofessional practices" (of counselors) include, "Any conduct or practice which is contrary to recognized standards of ethics. . ." (ARS §32-3251, 9).
Ethical Guidelines


The client has the right to obtain information about their [sic] case record and to have this information explained clearly and directly.

Under Principle 5.a. the Code states, "all materials in the official record shall be shared with the client." The Code does not clarify what an "official" record includes.

Pros and Cons

Mental health professionals have argued that records may contain interpretations, mannerisms, statements, overt actions, etc., which, if seen by the client, may adversely affect the client and the counseling relationship (Rinas & Clyne-Jackson, 1988). Others have not found any hard evidence for such a claim (Turkington, 1987). Generally, the therapeutic relationship as well as client progress seem to improve when clients have full access to their files. Some counselors use their clinical notes as therapeutic tools Doel & Lawson, 1986; Soisson et al., 1987).

How to Best Disclose File to Client

When clients make a "friendly" as opposed to "legal" request to see their file, and those files can stand scrutiny, you are advised to allow such access only in your presence, which assures that client questions are answered, clinical assessments interpreted and misinformation corrected.

SAFEKEEPING AND RETENTION OF RECORDS

Where is "Safe"?

All client records need to be filed in a secure place to protect clients' confidentiality. An absolute minimum security system is a locked file cabinet (Snider, 1987). The most secure system is a walk-in safe.

How Long Should Records be Kept?

AACD's ethical guidelines state that records be kept until they have outlived their usefulness. Many professionals follow the "Specialty Guidelines for the Delivery of Services" of the American Psychological Association (Bennett et al., 1990; Soisson et al., 1987) which recommend:

Retain records for a total of 15 years.

- full records for 3 years after termination
- full records or a summary for another 12 years

In the event a counselor dies or becomes permanently incapacitated, another counselor may be appointed by a professional standards review committee to review the records with the clients and to recommend a course of action.
WHO OWNS THE RECORD?

In Private Practice

The original record belongs to the writer with whom it should remain until it is destroyed. In the event a client request that the file be forwarded to another counselor, transmit only a copy or a summary of the file.

Files may never be sold to another therapist or counselor (Soisson et al., 1987; Bennett et al., 1990).

In an Agency or Institution

Ethical Standards of AACD state under Section B.5:

Records of the counseling relationship, including interview notes, test data, correspondence, taperecordings, electronic data storage, and other documents are to be considered professional information for use in counseling, and they should not be considered a part of the records of the institution or agency in which the counselor is employed unless specified by state statute or regulation.
CHAPTER 6

SEXUAL CONDUCT WITH CLIENTS

"It's Never OK"

REGULATION OF

Ethical Codes

AACD's Ethical Standards, Section B, 14, state:

The member will avoid any type of sexual intimacies with clients. Sexual relationships with clients are unethical.

The National Board for Certified Counselor's Code of Ethics (Herlihy & Golden, 1990), Section A, 10, states:

Certified counselors do not condone or engage in sexual harassment which is defined as deliberate or repeated comments, gestures, or physical contact of a sexual nature.

The Code of Ethics for Mental Health Counselors, 1987, regulates against sexual conduct under Principle 3, f:

Sexual conduct, not limited to sexual intercourse, between mental health counselors and clients is specifically in violation of this code of ethics. This does not however, prohibit the use of explicit instructional aids including films and videotapes. Such use is within accepted practices of trained and competent sex therapists.

Arizona Law

ARS §32-3302 states that "unprofessional practice" for behavioral health professionals includes, ". . . any conduct or practice which is contrary to recognized standards of ethics in the behavioral health profession."

Nationally

While sexual contact with clients is rare, it has been the number one complaint of clients since 1980 (Gabbard, 1989). Of those clients who reported counselor-client sexual relationships, only 4% filed formal complaints, and only half of those pursued the complaint to completion (Hotelling, 1988).

Some states control sexual misconduct by counselors in two ways: (1) educating consumers (Quinn, 1990; Public Education Work Group, 1990); (2) criminalizing such activity. For example, Michigan law considers sexual misconduct by therapists as rape (Hotelling, 1988).
MISCONCEPTIONS ABOUT SEX WITH CLIENTS

Some counselors believe that sexual contact is acceptable if:

1. It does not occur during the session;
2. It occurs after counseling has terminated;
3. It is initiated by the client;
4. One's colleague or supervisor was sexually involved with a student or client without being disciplined (Pope and Bouhoutsos, 1986).

Sex with Former Clients

While practitioners overwhelmingly agree that sexual contact with a current client is never ok, such contact with a former client is more controversial.

When does the therapeutic relationship end? The American Association for Marriage and Family Therapy (1988) recently included a new guideline which considers sexual contact with former clients to be unethical up to 2 years after the therapeutic relationship has ended. Some professionals believe it never ends.

Client Initiated Sexual Contact

Ethical committees and courts generally reject the defense that the client initiated and fully participated in the sexual contact (Corey et al., 1988; Hopkins & Anderson, 1990). The counselor is always responsible for preventing sexual contact with a client (Gabbard, 1989; Siegel, 1988).

Minnesota, which has criminalized sex with clients, informs consumers: "It makes no difference even if you agreed and actively participated in the sex. It is still a crime committed by the therapist" (Public Education Work Group, 1990).

Nonerotic Contact with Clients

Some counselors believe that non-erotic touching is "ok." Others in the profession say that any kind of physical contact between client and counselor should be avoided, because non-erotic touching can lead to erotic touching (Gabbard, 1989).

COUNSELING THE SEXUALLY EXPLOITED CLIENT

General Guidelines

Clients who have been sexually involved with a previous counselor or therapist may present a problem unrelated to the sexual contact. Clients are reluctant to reveal such contact, and need to develop a relationship of trust with the counselor first (Pope & Bouhoutsos, 1986).

Although any client may be sexually exploited, women are more often victims and male practitioners more often the perpetrators. Certain characteristics put clients at risk for sexual exploitation by the treating professional (Pope & Bouhoutsos, 1986, p. 47).
The low-risk group: Highly stressed patients who have no history of prior hospitalization, are normally high functioning, come from a stable family background, and who have had previous long-term fulfilling intimate emotional and sexual relationships.

The middle-risk group: Patients who give a history of prior relationship problems, appear to be somewhat dependent and needy, and may fall into the personality disorder category.

The high-risk group: Patients who have a history of previous hospitalization, suicide attempts, major psychiatric illnesses, and drug or alcohol addiction problems.

When the client tells you about sex with a former professional:

1. listen empathically and don't interject personal reactions;
2. be aware that such clients may have suicidal tendencies;
3. avoid acting as lawyer which could aggravate the client's condition;
4. respect the client's decisions and don't attempt to convince the client to file a complaint. (Cajoling the client to file a complaint may add to the client's sense of victimization);
5. become familiar with current theory, research, and treatment techniques in that area, or consider referring the client to a counselor who is experienced and adequately trained (Gabbard, 1989).

The Client Who Wants to File A Complaint

Three different avenues of filing complaints are open to the client: ethical, administrative, and legal (Hotelling, 1988).

1. Ethical:

   The first step is to determine of which professional associations, the practitioner is a member (some practitioners have no professional affiliations); next write and obtain the association's policies and procedures for filing complaints.

   The Arizona Counselors Association does not have its own policies and procedures for ethical complaints; members must contact AACD and request AACD's Policies and Procedures for Processing Complaints of Ethical Violations (Herlihy & Golden, 1990).

   A complaint to a professional organization could result in the practitioner's expulsion from that organization. This approach is limited in that the professional association cannot revoke a license, curtail or stop practice, or award monetary compensation to the victim. On the other hand, a loss of association membership may cause a loss of insurance coverage, public embarrassment, and may be used as evidence in a lawsuit.

   Some associations have no statutes of limitation in filing a complaint; in other words, it doesn't matter how long ago the incident occurred, a complaint can still be filed.
2. Administrative

To file an administrative complaint contact either the state licensing or certification board under which the practitioner is regulated; another avenue is to contact the agency or institution that may employ the practitioner. Not all professionals offering counseling services are licensed or certified.

A successful administrative complaint may cause the practitioner to lose state credentialing and a loss of a job, if employed by an agency or institution; some financial settlement may be possible.

3. Legal

Sexual misconduct may be tried as a civil and as a criminal action. Contact an attorney who is familiar with professional malpractice. Civil suits charge the professional with malpractice. This may be the avenue to take when the counselor is not licensed. Criminal suits are brought by the state for behavior "that the state has defined as illegal and thus punishable by law" (Hotelling, 1988, p. 235). Criminal suits have traditionally not included the award of damages to the victim.

The civil suit seeks compensation for the "cost of treatment, subsequent cost of healing, and/or 'pain and suffering'" (Hotelling, 1988, p. 235). Compensation depends on the practitioner’s insurance coverage. Some insurance policies, however, do not cover or limit payment for sexual misconduct. Insurance companies generally are reluctant to have such cases go to court and will try to settle.

Practitioners who want to avoid publicity will offer to settle in exchange for client’s written agreement not to file complaints with licensing boards and not to make any public statements.

A criminal suit may result in the professional being found guilty and punishable by law. An individual may be charged both civilly and criminally for the same wrongful act.

Some disadvantages of legal action are: the suit has to be filed within a specific time period determined by the statute of limitations of one’s state (the statute of limitations for minors does not begin until they reach the age of 18); juries are less sympathetic to clients who have had sexual contact with their counselors; the extensive time involvement; the expense and emotional drain; and the loss of confidentiality.

On the positive side, a successful legal suit may empower the client and have a healing effect. The errant professional may be put out of business.

THE UNETHICAL COLLEAGUE

A counselor may learn of a colleague’s potential sexual misconduct in one of three ways:

1. A client reveals the abuse;
2. Another colleague tells of the abuse;
3. The counselor learns first hand from the errant colleague or through observation (Levenson, 1986).

Professionals are often reluctant to report a colleague because they are not certain of the colleague’s guilt. Some professionals contend it is not the job of the professional to "be detective, judge, and jury" (Levenson, 1986, p. 317). AACD’s ethical guidelines, on the other hand, recommend that counselors first talk to the accused colleague before taking any further action.
AACD Policies and Procedures for Processing Complaints of Violations (Herlihy & Golden, 1990) include the following procedures for submitting complaints:

1. If feasible, the complainant should discuss with utmost confidentiality the nature of the complaint with a colleague to see if he/she views the situation as an ethical violation.

2. Whenever feasible, the complainant is to approach the accused directly to discuss and resolve the complaint.

3. In cases where a resolution is not forthcoming at the personal level, the complainant shall prepare a formal written statement of the complaint, stating the details of the alleged violation and shall submit it to the AACD Ethics Committee.

Mail all complaints, directed to the AACD Ethics Committee, to:

The Ethics Committee  
c/o The Executive Director  
American Association for Counseling and Development  
5999 Stevenson Avenue  
Alexandria, Virginia 22304

The envelope must be marked "CONFIDENTIAL" to ensure confidentiality both for the individual sending the complaint and the individual accused of the complaint.

The counselor who hears of misconduct and who reports a colleague, may not be the best professional to treat the client further (Levenson, 1986).
SECTION III:

COUNSELOR AND THE LAW
CHAPTER 7

THE COUNSELOR IN COURT

The licensed or certified professional counselor has a "high probability of going to court at least once during a lifetime of service" (Wills, 1987, p. 101). The counselor may be called as a friend of the court (amicus curiae), expert witness, witness of fact, defendant, or plaintiff (Krieshok, 1987). There are four different settings in which the counselor may be asked to appear: criminal court, juvenile court, civil court, and family court (Bennett et al., 1990).

WITNESS OF FACT

The counselor, as any other citizen, may be called to provide information that he or she knows from direct contact with the defendant or plaintiff (Krieshok, 1987). The information may be presented either through a taped interview, written report, deposition or direct court testimony (Bennett et al., 1990). The subpoena is a common form of summons for the counselor to appear in court.

Subpoena

A subpoena is "... a written order of the court compelling a witness to appear and give testimony" (Miller & Sales, 1986, p. 94). The subpoena, in itself, does not negate the certified counselor-client privileged communication, which stands until the client expressly waives it or until the court determines that it no longer exists.

A failure to appear in court at the specified time may result in contempt of court charges and a possible jail sentence until the counselor is willing to comply by the order.

Subpoena Duces Tecum

A counselor may also be served a subpoena duces tecum which requires that the witness bring specific physical evidence, such as client records, to court (Miller & Sales, 1986). When files are subpoenaed, everything in the file, unabridged, must be turned over (Whittington, 1988). The counselor may protest such orders to the judge, but may not refuse to comply (Hopkins & Anderson, 1990).

Protective Order

When a counselor is asked to testify about a client, the client's attorney should ask the judge for a protective order which limits the areas about which the counselor must testify (Krieshok, 1987).

EXPERT WITNESS

Definition

An expert witness is someone who knows more about trade, art or science or some other area than the average lay person and whose "expert opinion" comes from three spheres of knowledge: formal education and training, experience, and state of knowledge in a discipline.
Opinion is expected to be made with "reasonable certainty." "Reasonable" typically means "the average standard of the profession" (Kriesbrook, 1987, p. 95).

The main difference between an expert witness and any other witness is that the expert can base opinion on observation, tests, calculations, etc.; whereas, other witnesses can testify only to what they saw or heard (Maloney, 1986).

**Qualifications**

The expert witness does not need to have practiced for years and years; even relatively inexperienced experts may prove valuable to the court. They are expected to express opinions clearly and to present testimony that is "helpful" to the judge or jury, and do not need "special" or "complete" knowledge in their field of expertise (Maloney, 1986; Slovenko, 1987).

**Purpose**

The expert's opinion is given to assist in understanding the evidence before the judge or jury. Experts in some states cannot give an opinion about the ultimate issue before the court, i.e., the guilt or innocence of the defendant, or about the credibility of a witness; that is the decision of the judge or jury (Kriesbrook, 1987; Bulkley, 1988; Evans, 1983).

**Arizona Law**

Under Arizona law expert witnesses can be asked to state an opinion or inference about the guilt or innocence of a defendant (Arizona Rules of Evidence, Article VII).

**Suggestions for Appearing as Expert Witness**

Counselors are offered the following advice when appearing as an expert witness (Kriesbrook, 1987; Slovenko, 1987; Rinas & Clyne-Jackson, 1988; Wills, 1987):

**Before the Court Date:**

1. **Don't work for careless attorneys.** Those are the ones who won't allow you the information and access to their client which you need to feel comfortable about your opinion.

2. **Avoid attorneys who try to change your opinion.**

3. **Be aware that a good psychological assessment takes many hours; refuse to testify if you are given less time than you require; your credibility is on the line.**

4. **Know the legal issues covered by the case and the area to which your testimony will be addressed.**

5. **Get a release before talking to anyone or making an appearance.** Asking for a subpoena or judicial order may be an alternative.

6. **Give criminal defendants a Miranda warning before starting the examination.**
7. When assessing the defendant, do not ask questions about areas that are unrelated to the question under study. For example, if the question is: "Is the defendant competent to stand trial?" Do not ask: "What was the defendant's state of mind or behavior at the time of the crime?"

8. Avoid putting labels on the defendant; labels are notoriously unreliable and the public, i.e., a jury, may regard labels as absolutes. Instead use clear behavioral descriptions. Include no absolute statements about state of mind at a time other than the present.

9. Ask the referring attorney to make every effort to furnish all relevant material on which to base an opinion.

10. Do work very carefully: score tests twice; prepare a written report even if not required; let the attorney know what you will say.

11. Maintain a very accurate and detailed file on each case.

12. Critique and staff the case with a skilled forensic colleague in order to highlight areas where research and knowledge may be taken for granted.

13. Put yourself in the role of devil's advocate.

14. Insist on a conference with the attorney who requested your testimony to walk you through direct examination. This gives you an idea of what might be asked and where the weak spots in your testimony are.

15. Learn the rules of the court: where to stand, how to raise your hand for the oath, when to keep quiet, and so on.

16. Guard your credibility as expert witness; experts who testify frequently in front of the same judge may lose their credibility as certain judges get to know them.

In Court:

1. Dress and behave conservatively.

2. Arrive on time shortly before the scheduled appearance, sit quietly outside the courtroom, avoid conversation with the litigants and leave after making your appearance.

3. Be yourself. When some clinicians get into the witness box, former modest claims of professional objectives go out the window, and the expert makes outrageous claims of certainty.

4. Testify only within the area where expertise is clear. Be prepared to justify all conclusions and opinions.

5. Maintain the impartiality of a disinterested third party and avoid being lured into an advocate position.

6. Refrain from using pompous mental health jargon because it does not communicate.

7. Maintain an even temperament and professional style even when the challenge is ungracious.

8. Avoid over-elaboration as well as bombastic and flamboyant comments.
9. Comfortably concede the necessary issues in order to maintain an honest and creditable posture in spite of any damage to your testimony.

10. Do not make personal, social or moral statements in the guise of scientific judgments and opinions.

11. Leave immediately after making your appearance. Avoid further contact with the litigants.

After Your Appearance:

If you would like to evaluate and critique your testimony, you can buy a copy of your testimony from the court reporter.

The Cross Examination

During cross examination the expert witness may be challenged in three different areas:

1. Professional Training and Experience:

   Always be up front about your area of expertise and professional experience (Moloney, 1986; Glass, 1984).

2. The Work Product:

   You will be questioned about your methods, theories, principles, assessments, and reliability and validity of tests used (Glass, 1984).

   If using tests, be especially aware of their evaluation in Buros Mental Measurements Yearbook (Wills, 1987). Be aware that the DSM-III-R could be questioned as a reliable source for clinical diagnoses because the methods used, to include or exclude categories, are not always based on sound scientific data. For example, in 1973 the trustees of the American Psychiatric Association decided to remove the classification of homosexuality from the Manual based on a vote of the membership (Wills, 1987).

3. Professional Credentials:

   Never misrepresent your credentials; keep in mind that anything in your curriculum vitae (biographical resume of your career) is fair game for cross examination.

   Your professional credentials may be questioned if you were licensed or certified under a "grandfather" clause which did not require you to have passed an examination. Upon cross examination, the attorney is likely to ask if your credentialing included a test and demonstration of competency or just an application and payment of fees (Wills, 1987; Glass, 1987).
NEGLIGENCE

All adults are legally expected to behave the way any "ordinary and reasonable" person would act in the same or similar circumstances (Cohen, 1983; Everstine & Everstine, 1986). When a person's actions unintentionally fall below this standard, the behavior is described as negligent.

Negligence is:

conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm (Cohen, 1983, p. 10).

MALPRACTICE

Members of professions, like counseling, are held to a higher standard of conduct which is measured by the actions of ordinary and reasonable persons in their profession. If a professional falls below this higher standard the term "malpractice" applies (Cohen, 1983, p. 10).

Malpractice is:

The failure of one rendering professional services to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession with the result of injury, loss, or damage to the recipient of those services or to those entitled to rely upon them (Beis, 1984, p. 24).

That higher standard of care, however, does not imply perfection. Chief Justice Tindal in the 1832 case of Larmier v. Phinus stated that the professional "is not charged by law to be brilliant." Counselors, as well as other professionals, are not expected to be "guarantors of good results" (Cohen, 1983, p. 11).

PROFESSIONAL STANDARD OF CARE

How does the ordinary and prudent practitioner of the profession act under the same or similar circumstances? The standard is not clearly defined (Soisson et al., 1987). Generally, the professional is expected to perform "with the ordinary care and competence of a member in good standing of that profession" (Schopp & Wexler, 1989).

Who Is a "Professional"?

State law determines who can be called a "professional" (Bennett, 1990). For example, Arizona law regulates the title "certified professional counselor." A counselor, however, may not avoid malpractice by refusing to become state certified because unregulated practitioners are generally held to the
same higher standard of care as are professionals (Cohen & Mariano, 1982). Those who falsely represent themselves as professionals are also held to the higher standard of care (Cohen, 1983).

How Is the Standard Measured?

The standard of care is usually measured by other professionals who adhere to the same philosophical school and may be determined by a court of law through expert testimony, established by state law or professional ethical guidelines.

The form of treatment needs to be supported "by at least a 'respectable minority' of the members of the profession. If treatment is unorthodox, the practitioner may be required to justify its application (Cohen, 1983).

"Locality Rule"

The courts used to adhere to a "locality rule" to determine standard of care, which held that a professional's conduct was measured by the conduct of other similar professionals in one's "local" community. The community which defines the standard of care is now the entire state. However, standards in other states may also influence the standard in Arizona (Bennett et al., 1990; Soisson et al., 1987; Fulero & Wilbert, 1988).

What is a Reasonable Standard of Care?

The "reasonable" counselor (Sheldon-Wildgen, 1982):

1. Provides information to the client and obtains consent for treatment before counseling begins:
   a. description of services, goals, procedures,
   b. behavior required of client (i.e., active or passive),
   c. negatively and positively anticipated results,
   d. length and frequency of treatment,
   e. timetable for review of progress and client recourse if not satisfied,
   f. cost of services,
   g. statement about confidential and privileged information.

2. Provides appropriate treatment through:
   a. proper diagnosis of problem,
   b. use of instruments with proven validity and reliability,
   c. knowledge and reliance on current published literature for professional justification of treatment,
d. consultation with other professionals,
e. discussion of alternate treatments with client,
f. written record of agreed upon goals and treatment procedure.

3. Ensures professional behavior by:
   a. selecting a specialty,
   b. keeping abreast of research and developments in one's specialty,
   c. recognizing one's professional limitations,
   d. referring clients to qualified professional if no progress is evident.

4. Balances confidentiality and "Duty to Warn" by:
   a. informing client at the outset of therapy that all confidential information will be disclosed only with the client's permission,
   b. informing client in what situations confidentiality may need to be breached, according to law.

Standard of Care When Counseling Minority Group and Cross-cultural Clients

When counseling minority group and crosscultural clients, the basic standard of care, outlined above, applies. However, the basic standard of care is, by itself, not adequate and the counselor must gain additional skills through specialized training. The crosscultural counselor is expected to possess, at a minimum, the following abilities (Sue et al., 1981, p. 305):

1. Awareness and sensitivity about one's own cultural heritage, with an understanding and appreciation for other cultures;

2. Awareness of one's own values and biases and how they may affect counseling minority clients;

3. Comfort with differences between oneself and the client in terms of race and beliefs;

4. Sensitivity to personal biases, stage of ethnic identity, sociopolitical influences, etc., which may dictate referral of the minority client to a member of his/her own race/culture;

5. Understanding of the sociopolitical history of the United States with respect to its treatment of minorities and an understanding of institutional barriers which may prevent minority members from seeking counseling;

6. Knowledge and information about the particular client or group whom one is counseling;

7. Familiarity and working knowledge of a wide variety of verbal and nonverbal responses;

8. Ability to exercise institutional intervention skills on behalf of one's client when appropriate.
CHAPTER 9

LAWSUITS

LITIGAPHOBIA

The professional counseling literature admonishes practitioners to practice defensively lest they be involved in a lawsuit. Such advice and the general litigiousness of American society has instilled in some professionals a fear of lawsuits, or litigaphobia. However, the risk of a counselor being sued seems to be quite low. Individual psychologists, who are at higher risk because of the numerous tests they administer, have about a 0.5% chance of being sued (Wilbert & Fulero, 1988).

In 1987, mental health professionals were winning up to 70% of their cases. The price for winning may be quite expensive both in terms of the dollars spent and of the emotional toll on the professional.

PROOF OF HARM

Successful malpractice claims against mental health professionals are relatively low because harm is more difficult to prove. A successful suit needs to demonstrate the:

1. practitioner owed a duty to the plaintiff that was based on an established therapeutic relationship;
2. quality of care provided by the practitioner fell below the standard of care expected of the average practitioner;
3. [client] suffered or was caused harm or injury;
4. practitioner's dereliction of duty was the direct cause of the harm or injury (Soisson et al., 1987, p. 498; Bennett et al., 1990, p. 35).

All four elements need to be proved in order for the plaintiff to win. Most successful suits have involved practitioners whose clients inflicted real physical injury either to themselves or to others. However, courts are recognizing emotional distress as an injury more frequently (Cohen, 1983).

COMMON CAUSES OF LAWSUITS

Clients will sue their counselors when they believe they have been treated negligently. Certain counselor behavior and situations carry a higher lawsuit risk (Hendrickson, 1982; Cohen, 1983; Watkins & Watkins, 1983; Glass, 1984; Leesfield, 1987; Siegel, 1988; Bulkley, 1988; Wettington, 1988; Wilbert & Fulero, 1988; Bennett et al., 1990):

1. A dispute over fees. Collecting a huge unpaid bills may trigger a lawsuits; the bill will generally not be listed as the cause of the complaint.
2. Sexual misconduct is one of the most common causes of malpractice claims.
3. Any physical invasion, any physical contact including hugging, may be unsafe practice.
4. **Radical treatments** that produce unwanted effects.

5. **Breach of confidentiality:** failing to properly disguise a client's identity in published reports and in conversations with others; securing records improperly.

6. **Failure to breach confidentiality** in cases that warrant a duty to warn or duty to report.

7. **Interpretation of psychological tests:** the use of computer-generated assessment instruments which an untrained professional may perceive as "hard science"; the use of any tests without the skills to properly administer and evaluate.

8. **Poorly written records** which cannot substantiate clinical decisions. An absence of records, or inadequate records, may not trigger a lawsuit but may tip the scale against the professional who is involved in a lawsuit.

9. **Abandoning a client** by not properly terminating the relationship.

10. **Child custody evaluations.**

11. **Referring a client** to another professional who treats the client negligently.

12. **Disgruntled spouses and disgruntled parents.**

13. **A partner's negligent behavior.**

**HOW TO AVOID A LAWSUIT**

Practice prudently by avoiding the situations listed above and heed the following advice (Wright, 1981; Sheldon-Wildgen, 1982; Cohen, 1983; Wills, 1987; Bulkley, 1988; Gabbard, 1989; Hopkins & Anderson, 1990; Bennett et al., 1990; Beahrs, 1990):

1. Never allow a client to run up a high bill that you intend to collect.

2. Know the law—keep up with changes in both case law and state laws through professional literature, other counselors and your attorney.

3. As soon as one of your clients commits suicide or homicide contact your liability insurance broker who may be able to advise and assist you in obtaining help before any legal action has been taken.

4. Precede any "radical" treatment with the client's written consent: include the pros and cons of the treatment and give the client adequate time to consider the treatment. Remember a client cannot consent to improper or illegal treatment such as sexual misconduct.

5. Give written notice and provide information about alternate treatment possibilities when you terminate an uncooperative or abusive client.

6. Consult with a Peer Review or Human Rights Committee before you use a controversial or unorthodox treatment method.

7. **Know and follow the ethical guidelines of your professional organization.**

8. **Treat children and adolescents with special care.**

9. **NEVER ENGAGE IN SEX WITH YOUR CLIENTS.**
WHAT TO DO IF SUED

When the process server shows up on your door step and hands you a summons, you first response will probably be a high level of anxiety, followed by feelings of righteous indignation, anger, vindictiveness and lowered self-esteem (Wilbert & Fulero, 1988). The following are some basic guidelines for when you are sued:

1. "Do not panic" and under no circumstances call your client "to reconcile [sic], berate or apologize and beg for mercy" (Cohen, 1983, p. 19).

2. Do not write any letters to the client.

3. Promptly notify your malpractice insurance carrier. Failing to do so may negate the coverage. The carrier is responsible for your defense and will appoint an attorney. Some carriers will allow you to select your own attorney. If not, and you are not satisfied with the appointed attorney, you may want to retain your own attorney who will work in cooperation with the carrier's attorney.

Once retained, the insurance company appointed attorney may only represent your interests and not those of the insurance carrier (A. R. Christensen, attorney, personal communication, February, 1991).

4. Immediately stop treating a client who is suing you.

5. Only discuss the case with your attorney unless directed to do otherwise by the attorney. Do not discuss the case with your friends and family; only your spouse is immune from having to testify against you.

6. If you consult another mental health professional about the case, do so only with your attorney's knowledge and permission, and only discuss the case in hypothetical terms, because "professional case consultation is generally not considered privileged information" (Wright, 1981, p. 1541).

7. Collect all personal written documents that may pertain to the case. Do not make any additions or deletions to any files or notes, and do not destroy them. Consider that the plaintiff, your ex-client, could have the following corroborating evidence against you: journals, diaries, calendars, letters or notes from you, overheard phone calls by family members, confessions to friends, and knowledge of physical marks on intimate parts of your body.

8. The plaintiff, plaintiff's attorney and court may request documents; make them available only through your attorney and always keep the originals.

9. If you and your place of employment have been named in the suit, you may not want to agree to joint legal representation by one attorney; it is important to have your own attorney who will represent only your interests.

10. Your attorney should be a specialist in malpractice cases.

11. If your insurance carrier wants to settle and you want to "go the distance" you will need to do so at your own cost and expense.

12. Write summaries of all events pertinent to your case.

13. Anytime the plaintiff and plaintiff's attorney contact you, say nothing and immediately inform your own attorney. In our legal system, the plaintiff's attorney may not contact you directly (A.R. Christensen, personal communication, February, 1991).
14. Prepare yourself for a long involvement with the case, maybe years (Cohen, 1983; Wright, 1981; Bennett et al., 1990).

**How Do I Find My Own Attorney?**

In the event of a lawsuit, the insurance company will appoint an attorney (Wright, 1981). To consult with an attorney on mental health issues, the best way to find one may be by word of mouth.
CHAPTER 10

PROFESSIONAL LIABILITY INSURANCE

Insurance companies generally refer to malpractice insurance as "professional liability" insurance (PLI). All counselors are advised to carry PLI because they may be sued even if no wrongful deed was ever done.

PLI should cover two different types of liability: malpractice and injury to another. The first covers unprofessional conduct and the latter, any physical injury (Hopkins & Anderson, 1990).

TYPES OF POLICIES

Claims-made Policy

This type of policy covers only those acts that occur while you are insured under the plan and only if you have been continuously insured with the same company and the same plan up to the time the claim is filed.

In the event you opt to switch companies or plans, you can retain your coverage by purchasing a "tail," "rider," or "reporting endorsement." Individuals who are retired frequently avail themselves of that option because one could be sued years after ceasing practice (Bennett et al., 1990, p. 107).

Claims-made policies are usually less expensive than other types of policies.

Occurrence-based Policies

This type of policy cover any claims against acts that occurred during the policy period regardless of how long afterwards the claim is filed. This type of coverage is more expensive, but it, in effect, protects forever. An advantage under this type of plan is the freedom to switch insurance companies or policies when the need arises (Bennett et al., 1990).

COVERAGE

How Much Coverage is Enough?

The professional counseling literature suggests that coverage in the low hundred thousand dollar range may be sufficient protection even for a "catastrophic claim" (Bennett et al., 1990). Practicing counselors and attorneys recommend one million dollar coverage.

When Does the Coverage Start?

Some policies cover you only from the time a "formal legal complaint" is filed and not when the first warning signs of an impending suit may appear (Bennett et al., 1990, p. 110).
Who Selects the Attorney?

Insurance carriers generally select your attorney in the event of a lawsuit. Under some policies you may be able to select your own (Bennett et al., 1990; Hopkins & Anderson, 1990).

What Does the Policy Not Cover?

1. Criminal acts are never covered.

2. Sexual misconduct with a client is variously covered (Siegel, 1988). Some companies cover everything; others cover legal expenses only; others cover legal expenses with a lid on settlements or damages; and some cover nothing.

3. Fee disputes with client. If you sue your client over an outstanding bill and that client turns around and sues you for negligence you may not be covered.

4. Suing another insurance plan member is generally not covered.

5. Stepping outside your professional boundaries may not be covered. If part of your counseling strategy involves offering clients legal, financial, medical or other noncounseling advice, and you are sued for such advice, your PLI may not provide coverage. You need know how narrowly your insurance carrier defines the practice of counseling. Read your policy (Bennett et al., 1990).

6. "No PLI policy provides money to sue someone else" (Bennett et al., 1990, p. 114).

Am I Adequately Covered in My Place of Business?

If you have partners, are employed in an agency, or share an office with others who have no professional connection with you, you need to be sure you are covered as an individual in the event a claim is filed against one of the others; you most likely will also be named. Do not assume that you are immune from personal liability if you work for a large corporation (Bennett et al., 1990).

RATING YOUR INSURANCE CARRIER

Not all insurance companies are solvent when it comes time to pay a claim because the business of professional liability insurance tends to be volatile. All companies are regulated by state government through the state insurance commissioner. You can learn from the commissioner's office if your present or intended carrier protects its policyholders by a state-backed guarantee in the event of bankruptcy. A company's financial stability may also be determined by looking at the A. M. Best Company's rating guide, found in all public libraries. You want a company with either an A+ or A rating (Bennett et al., 1990).
SECTION IV:

ETHICS AND THE COUNSELOR
CHAPTER 11

WHEN ETHICAL ISSUES ARISE

"To Know Duty"

Ethics may be defined as "the science of moral obligation and duty." The Latin root of science, "scio", means to know. Ethics then is "to know duty" (Lindenberg, 1981, p. 255).

CODES OF ETHICS

Purpose of Codes

Ethical codes are one form of authority imposing rules on the counselor. Woody (1990, p. 137) wrote:

Professional codes of ethics appear to offer "absolute" rules and principles for proper conduct; but the terms used are, in fact, general and subject to definition and interpretation.

Counseling professionals disagree on the purpose of codes. Some suggest they represent the highest standard of conduct, others believe they describe a minimum standard, and still others suggest that codes are the profession's way of self regulation to avoid governmental regulation.

Most professionals would agree with the following description:

Although [a code's] primary function is to establish a framework for professional behavior and responsibility, the code also serves as a vehicle for professional identity and a mark of the maturity of the profession... The code is clearly a central part, but only a part, of the basis for the explication of professional responsibility (Mabe & Rollin, 1986, p. 294).

Limitations of Codes

Ethical codes seem to provide fairly general guidelines that are subject to interpretation. While a thorough knowledge and adherence to one's professional codes of ethics is apart of professional conduct, counselors must also recognize that codes have certain limitations.

1. Codes do not cover every issue.

2. Codes are generally not at the "cutting edge" of issues and are generally reactive to issues developed elsewhere.

3. Because codes are reactive, they may at times be in conflict with state and case law.

4. Counselors who are members of several professional organizations and who follow the codes of each organization may find some conflicting guidelines (Mabe & Rollin, 1986, p. 294).
Components of Ethical Behavior Inherent in All Codes

All ethical codes address the following four components of professional behavior: counselor responsibility, counselor competence, confidentiality, and client welfare (Gross & Robinson, 1987).

1. Responsibility

   Ethical codes give counselors responsibility for:

   a. the client,
   b. society,
   c. the community in which the counselor practices,
   d. the employing institution,
   e. the referral agency,
   f. minor clients’ parents or legal guardians,
   g. colleagues and professional associations,
   h. the state as required by state statutes,
   i. professional boards,
   j. oneself.

2. Competence

   Competence includes the following basic aspects:

   a. accurate representation of professional qualifications,
   b. professional growth through continuing education,
   c. provisions of only those services for which one is qualified,
   d. maintenance of accurate knowledge and expertise in specialized areas,
   e. assistance in solving personal issues which impede effectiveness.

3. Confidentiality

   a. Client has access to official record and decides who else may see the material;
   b. client’s anonymity is guaranteed and if required to be broken the client is informed;
   c. all information about the client in the record or that which is sent to a third party must be accurate, unbiased, and verifiable;
   d. client records require proper safe-keeping and disposition;
e. all testing and evaluation of the client is preceded by a thorough explanation of the purpose for and the ways in which the information will be used;

f. audio and video recording of the client is done so only with the permission of the client;

g. in group counseling, the counselor must set a norm of confidentiality regarding all group participants' disclosures.

4. Client Welfare

There are five practical suggestions for ensuring client welfare:

a. check that your clients are not currently involved in other counseling relationships;

b. develop clear written descriptions of what clients may expect in the way of tests, reports, billing, counseling regime and schedules;

c. know your own limitations and refer when appropriate;

d. be sure that your approaches and techniques are appropriate for the clients;

e. do not establish a counseling relationship with a supervisee, friend, relative, or employee unless all other referral possibilities have been exhausted.

Three other areas of ethical behavior are addressed by all codes:

5. Public Behavior

A counselor’s public behavior reflects on the profession. Counselors, therefore, are expected to act as role models for the rest of the community, revealing a 'healthy' approach to life and to other people (Rinas & Clyne-Jackson, 1988).


The ethical counselor respects clients by avoiding overbooking, by keeping the clients' waiting time to 15 minutes or less before a scheduled session, by charging reasonable fees, and by referring when appropriate (Rinas & Clyne-Jackson, 1988).

7. Protection

Protection of the adult client, society and children. One aspect of protection is professional monitoring.

ETHICAL DECISIONS

"Primum non nocere;" "first do no harm" (Wyatt, 1989, p. 33).

Basic Questions

Counselors, when faced with ethical issues, should ask themselves the following questions (Tennyson & Strom, 1986, p. 300):
- Why take this approach?
- What is it for?
- What difference will it make?
- How does it contribute to client growth?
- Who benefits from this service?
- What ends are being served?
- Whose interests are being served?
- How do my beliefs, values, and practices have a limiting or distorting effect on the possibilities open to clients?

When difficult ethical issues arise, contact the national ethics committee of your professional association, contact a competent legal advisor, and consult with experienced colleagues (Wright, 1981).

Arizona Counselors Association Members

A survey of Arizona Counselors Association members (Christensen, 1991) which asked how they handle ethical dilemmas shows that they follow their professional ethical guidelines most often, then consult colleagues, followed by trusting their own judgement; calling an attorney and reviewing the literature were last. Respondents make ethical decisions based primarily on their client's best interest and on their own values and personal ethics.

ETHICS AND THEORIES

Some mental health professionals regard counseling as an ethical balancing act with the ethics of the counselor and not the ethics of the counseling in question (Wylie, 1989). Blind adherence to a theoretical framework and disregard for what clients say they need and want becomes an "ethical failing." While theories influence the practitioner's ethical decision making, problems may arise when the theories are applied as though they embodied the "truth of the human condition" (Woody, 1990, p. 139). Counselors may be practicing unprofessionally if they adhere to only one or two traditional theories (Kelly, 1990).

What some consider ethical dilemmas, others consider treatment issues and differences of theoretical orientation (Green & Hansen, 1989).

One example, the use of paradoxical injunctions in marital and family therapy is quite controversial and raises questions about "honesty" in the counseling relationship (Ryder & Hepworth, 1990). Some professionals consider the use of this technique a questionable manipulation of the client (Paquin, 1988; Glick et al., 1987). A 1989 study of family therapists found that a great majority of the therapists are, however, "willing to manipulate the family for therapeutic benefit, even if this means being dishonest" (Green & Hansen, 1989, p. 157).

Another example involves Gestalt theory and the client's therapeutic release of anger. Certain Gestalt techniques which are used to facilitate such a release can result in "heightened verbal expression" (Daldrup, Beutler, Engle, & Greenberg, 1988, p. 132). Eager therapists who may believe that only vociferous catharsis of emotion is beneficial, may manipulate the client to express anger in that manner, By complying, clients risk losing their confidentiality especially if the work is completed in a crowded office which lacks soundproofed walls.
What is a Dual Relationship?

A dual, or dual-role, relationship exists when "one person simultaneously or sequentially plays two or more roles with another person" (Kitchener & Harding, 1990, p. 147).

The Code of Ethics for Mental Health Counselors, 1987, states under Principle 6.a. that dual relationships:

- include treating an employee or supervisor, treating a close friend or family relative, and sexual relationships with clients.

Other dual relationships include:

- Combining the roles of teacher and therapist,
- Trading therapy for goods or services,
- Bartering with needy clients,
- Providing therapy to a friend's relative,
- Socializing outside therapy sessions,
- Becoming emotionally or sexually involved with a client or former client (Corey et al., 1988, p. 214).

How Are Dual Relationships Problematical?

Dual relationships may be harmful to the client because of three factors (Kitchener & Harding, 1990, p. 147; Kitchener, 1988, p. 219):

1. The expectations for the two roles the counselor plays may not be compatible. An example is the individual who is both counselor and supervisor. As counselor, the individual is expected to act in the client's best interest and keep all of the client's communications confidential; as supervisor, the individual is expected to serve in the public's best interest and confidentiality is not a factor.

2. The obligations of the different roles may diverge. An example is the individual who acts as both counselor and as close friend. In the counseling relationship, the counselor's primary concern is the need of the client; in a personal relationship both individuals expect to have their needs met. Objectivity in the counseling relationship may be lost if the counselor attempts to meet both needs.

3. The potential power and prestige of the professional increases the risk of exploitation. Clients seek the help of a professional and may, as a result, find themselves in a dependent and less powerful position vis a vis the professional. The client who is in great emotional turmoil may be quite vulnerable to potential manipulation by the professional.

The Ethical Standards of AACC, Sec. B. 13, state:

Dual relationships with clients that might impair the member's objectivity and professional judgement (e.g., as with close friends or relatives) must be avoided and/or the counseling relationship terminated through referral to another competent professional.
Are They Always a Problem?

Dual relationships are not always considered unethical. The boundary between unethical and ethical dual relationships, however, is not easily defined (Beigel & Earle, 1990), with the exception of a client/counselor sexual relationship (Herlihy & Golden, 1990). In some cases, dual relationships may be difficult to avoid (Kitchener & Harding, 1990).

Dual Relationships and the Law

Two kinds of dual relationships may have legal ramifications: sexual relationships and bartering with clients (Sexual relationships are covered in Chapter 6.). Bartering can become a legal problem when bartered services or goods are not declared as income; failing to do so can result in charges of tax fraud (Beigel & Earle, 1990).

MINORITY GROUP AND MULTICULTURAL COUNSELING

The counseling profession took little interest in, or concern for, the status of racial, ethnic, or other minority groups until the mid-1960s (Atkinson et al., 1989). Twenty five years later the profession is still being criticized for its lack of sensitivity and skills in counseling such clients.

Likewise, professional ethical codes are criticized for their lack of relevancy to all clients (Ibrahim & Arredondo, 1990). Ibrahim and Arredondo have made specific recommendations for alternate and additional wording of AACD's Ethical Standards. They recommend that ethical codes incorporate the following issues:

1. Counselors need to "enhance their own multiculturalism" whether they consider themselves members of the mainstream culture or a minority group.

2. Competence in multicultural/minority counseling includes awareness, knowledge, and skills gained through appropriate education and training.

3. The belief of some counselors that "people are people" and that as a competent counselor I can work effectively with any population is not considered competent or ethical practice with minority and crosscultural clients.

4. The "language of communication," both written and spoken, is an important component of the counseling relationship.

5. Client "freedom of choice" may have different meanings in other cultures; i.e., the client who comes from a lineal-hierarchical social system may not have the same freedom of choice to refuse a specific treatment because the refusal may involve confronting an authority, the counselor.

6. Cultures have varying views and practices regarding self-disclosure.

7. "Counseling theories were developed in a specific context and may not apply to individuals who do not live within that context" (p. 141).

8. "People from diverse backgrounds may send and receive verbal and nonverbal messages differently" (p. 141).

9. Moral-ethical assumptions and beliefs vary across sociocultural groups.
10. Cultural differences are not equal to "personal limitations."

AACD's Ethical Standards address minority and multicultural clients under A.10, B.19, C.1 and C.12. The Code of Ethics for Mental Health Counselors addresses such populations under 1.a, 2.c, 2.h, and 8.c (See Appendix B and C of this handbook).

MULTIPLE CLIENT SYSTEMS

Introduction

Counselors who work with multiple client systems, such as families and couples (Gross & Robinson, 1987), face some of the same ethical issues as counselors who work with individuals, with added ethical issues unique to such systems (Glick et al., 1987). Many graduate programs which offer a degree in marriage and family therapy require a separate course in ethics and law pertaining to this specialty.

Marriage and family therapy is a recognized counseling specialty, and turf wars have erupted as to who should be allowed to conduct such therapy. While not all counselors choose to specialize in this area, it appears that almost all will eventually counsel couples and families in different settings. As with any other specialty, the general practice counselor needs to become aware of the standards of the profession and his or her own limitations.

Ethical Guidelines of AAMFT

The Ethical Principles of the American Association for Marriage and Family Therapy (AAMFT) provide guidelines for the counselor who works with multiple client groups. Like other ethical codes, the AAMFT Ethical Principles have been criticized for being incomplete and for dealing only superficially with multiple client systems (Green & Hansen, 1989; Gross & Robinson, 1987).

Green and Hansen (1989, p. 149) found nine commonly faced ethical dilemmas which are either not covered or only briefly covered in the Principles:

1. treating the entire family if one member does not want to participate;
2. the training and qualifications of family therapists;
3. seeing one family member without the others present;
4. informing clients of values implicit in the mode of therapy;
5. dealing with requests for information from family members;
6. sharing values with clients;
7. manipulating a family for therapeutic reasons;
8. obtaining the informed consent of children; and
9. preserving the family.
Who is the Client?

It is not always clear who the client in family counseling is. Some counseling approaches disregard the needs and problems of the individual, by ignoring the presenting problem and putting the focus on the family and not the "problem" member (Glick et al., 1987; Paquin, 1988; Wylie, 1989).

Marriage and family therapy, as espoused by AAMFT, is essentially a systems approach to treating the family (Everett, 1990). In a strict system's approach the family as a whole becomes more important than any of the individual family members (Wylie, 1989). The reverse can also happen: treating only one member of a family may have adverse effects on the rest of the family.
HANDBOOK APPENDIX A

ARIZONA STATUTES

PART I: Arizona Revised Statutes §32-3251, Behavioral Health Professionals

PART II: Arizona Revised Statutes §13-3620, Family Offenses (Duty to Report Child Abuse)
Appendix A: Part I

The following are excerpts from Arizona Revised Statutes §32-3251 to §32-3322.

CHAPTER 33. BEHAVIORAL HEALTH PROFESSIONALS

§32-3251. Definitions

In this chapter, unless the context otherwise requires:

1. "Board" means the board of behavioral health examiners.

2. "Counseling principles, methods, and procedures" includes counseling, appraisal, consulting, referral and research.

3. . . .

4. . . .

5. "Practice of counseling" means the professional application of counseling theories, methods and procedures in the diagnosis and treatment of mental and emotional conditions in individuals, families and groups, involves the presence of a diagnosed mental or physical disorder in at least one individual being treated and enhances personal, social, educational and vocational development and adjustment.

7. . . .

8. . . .

9. "Unprofessional practice" includes:

   (a) Conviction of a felony.

   (b) Use of fraud or deceit in connection with rendering services as a certified behavioral health professional or in establishing qualifications pursuant to this chapter.

   (c) Habitual intemperance in the use of narcotics, alcohol or drugs to the extent that performance of professional duties is impaired.

   (d) Obtaining a fee by fraud or misrepresentation.

   (e) Betraying a professional confidence.

   (f) Making use of statements of a character tending to deceive or mislead the public.

   (g) Aiding or abetting a person who is not certified as a behavioral health professional pursuant to this chapter in representing himself as a certified behavioral health professional in this state.
(h) Gross negligence in the practice of a behavioral health professional by a certified behavioral health professional.

(i) Any conduct or practice which is contrary to recognized standards of ethics in the behavioral health profession or which constitutes a danger to the health, welfare or safety of a client.

(j) Any conduct, practice or condition which impairs the ability of the certified behavioral health professional to safely and competently practice his profession.

(k) Engaging or offering to engage as a behavioral health professional in activities which are not congruent with the certified behavioral health professional's professional education, training or experience.

(l) Violating any provisions of this chapter or refusing or neglecting to comply with rules adopted pursuant to this chapter or any lawful order of the board or a credentialing committee.

§32-3283. Privileged communications

In any legal action a certified behavioral health professional shall not, without the consent of his client be examined as to any communication made by the client to him or as to any such knowledge obtained with respect to personnel dealing with the client. Unless the client has waived the behavioral health professional-client privilege in writing or in court testimony, a behavioral health professional shall not be required to divulge, nor shall he voluntarily divulge, information which he received by reason of the confidential nature of his practice as a behavioral health professional except that he shall divulge to the board any information it subpoenaes in connection with an investigation, public hearing or other proceeding. The behavioral health professional-client privilege shall not extend to cases in which the behavioral health professional has a duty to report nonaccidental injuries and physical neglect of minors as required by §13-3620.

Article 6. COUNSELING

§32-3301. Certified counselor

A person who desires to be certified by the board to provide counseling services as a certified counselor shall satisfy all of the following requirements:

1. Furnish evidence satisfactory to the counseling credentialing committee that the person has:

   (a) Earned a Master's degree in counseling, including a supervised practicum from a regionally accredited college or university.

   (b) At least two years of full-time or the equivalent part-time post-master's degree experience in counseling, including at least one year under the supervision of a certified counselor or a person who satisfies the education and experience requirements for certification as a certified counselor. An applicant may use a doctoral-clinical internship to satisfy the requirement for one year of experience under supervision.

2. Pass an examination approved by the counseling credentialing committee.

3. Pay the subscribed fee.
§32-3302. Unlawful acts

It is unlawful for a person to represent himself to the public by any title incorporating certified counselor or to describe his activities or services by such a title unless he is certified in that category pursuant to this article.

Added by laws 1988, Ch. 313, Sec. 2, eff. July 1, 1989.
Appendix A: Part II

Arizona Revised Statutes, Title 13. CRIMINAL CODE

CHAPTER 36. FAMILY OFFENSES

§13-3620. Duty and authority to report nonaccidental injuries, physical neglect and denial or deprivation of necessary medical or surgical care or nourishment of minors; duty to make medical records available; exception; violation; classification

A. Any physician, hospital intern or resident, surgeon, dentist, osteopath, chiropractor, podiatrist, county medical examiner, nurse, psychologist, school personnel, social worker, peace officer, parent or counselor or any other person having responsibility for the care or treatment of children whose observation or examination of any minor discloses reasonable grounds to believe that a minor is or has been the victim of injury, sexual abuse pursuant to §13-1404, sexual conduct with a minor pursuant to §13-1405, sexual assault pursuant to §13-1406, molestation of a child pursuant to §13-1410, commercial sexual exploitation of a minor pursuant to §13-3552, sexual exploitation of a minor pursuant to §13-3553, incest pursuant to §13-3608 or child prostitution pursuant to §13-3212, death, abuse or physical neglect which appears to have been inflicted upon such minor by other than accidental means or which is not explained by the available medical history as being accidental in nature or who has reasonable grounds to believe there has been a denial or deprivation of necessary medical treatment or surgical care or nourishment with the intent to cause or allow the death of an infant protected under §36-2281 shall immediately report or cause reports to be made of such information to a peace officer or to the child protective services of the department of economic security. Such reports shall be made forthwith by telephone or in person forthwith and shall be followed by a written report within seventy-two hours. Such reports shall contain:

1. The names and addresses of the minor and his parents or persons having custody of such minor, if known.

2. The minor's age and the nature and extent of his injuries or physical neglect, including any evidence of previous injuries or physical neglect.

3. Any other information that such person believes might be helpful in establishing the cause of the injury or physical neglect.

B. Any person other than one required to report or cause reports to be made in subsection A of this section who has reasonable grounds to believe that a minor is or has been a victim of abuse or neglect may report the information to a peace officer or to the child protection services of the department of economic security.

C. A person having custody or control of medical records of a minor for whom a report is required or authority under this section shall make such records, or a copy of such records, available to a peace officer or child protective services worker investigating the minor's neglect or abuse on written request for the records signed by the peace officer or child protective services worker. Records disclosed pursuant to this subsection are confidential and may be used only in a judicial or administrative proceeding or investigation resulting from a report required or authorized under this section.

D. When such telephone or in-person reports are received by the peace officer, they shall immediately notify the child protective services of the department of economic security, when the child protective services receives these reports by telephone or in person, it shall immediately notify a peace officer in the appropriate jurisdiction.
E. Any person required to receive reports pursuant to subsection A of this section may take or cause to be taken photographs of the child and the vicinity involved. Medical examinations including, but not limited to radiological examinations of the involved child may be performed.

F. A person furnishing a report, information or records required or authorized under this section, or a person participating in a judicial or administrative proceeding or investigation resulting from a report, information or records required or authorized under this section, shall be immune from any civil or criminal liability by reason of such action unless such person acted with malice or unless such person has been charged with or is suspected of abusing or neglecting the child or children in question. Except as provided in subsection G of this section, the physician-patient privilege, the husband-wife privilege or any privilege except the attorney-client privilege, provided for by professions such as the practice of social work or nursing covered by law or a code of ethics regarding practitioner-client confidences, both as they relate to the competency of the witness and to the exclusion of confidential communications, shall not pertain in any civil or criminal litigation or administrative proceeding in which a child's neglect, dependency, abuse or abandonment is an issue nor in any judicial or administrative proceeding resulting from a report, information or records submitted pursuant to this section nor in any investigation of a child's neglect or abuse conducted by a peace officer or the child protective services of the department of economic security.

G. In any civil or criminal litigation in which a child's neglect, dependency, abuse or abandonment is an issue, a clergyman or priest shall not, without his consent, be examined as a witness concerning any confession made to him in his role as a clergyman or a priest in the course of the discipline enjoined by the church to which he belongs. Nothing in this subsection discharges a clergyman or priest from the duty to report pursuant to subsection A of this section.

H. If psychiatric records are requested pursuant to subsection C of this section, the custodian of the records shall notify the attending psychiatrist, who may excise from the records, before they are made available:

1. Personal information about individuals other than the patient.

2. Information regarding specific diagnosis or treatment of a psychiatric condition, if the attending psychiatrist certifies in writing that release of the information would be detrimental to the patient's health or treatment.

I. If any portion of a psychiatric record is excised pursuant to subsection H of this section, a court, upon application of a peace officer or child protective services worker, may order that the entire record or any portion of such record containing information relevant to the reported abuse or neglect be made available to the peace officer or child protective services worker investigating the abuse or neglect.

J. A person who violates any provision of this section is guilty of a class 1 misdemeanor.

§13-3623. Child abuse; definitions

A. In this section, unless the context otherwise requires:

1. "Child, youth or juvenile" means an individual who is under the age of eighteen years of age.

2. "Physical injury" means the impairment of physical condition and includes but shall not be limited to any skin bruising, bleeding, failure to thrive, malnutrition, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ or any physical condition which imperils a child's health or welfare.
3. "Serious physical injury" means physical injury which creates a reasonable risk of death, or which causes serious or permanent disfigurement, or serious impairment of health or loss or protracted impairment of the function of any bodily organ or limb.

Effective 5-9-86
HANDBOOK APPENDIX B

ETHICAL STANDARDS

of the

American Association for Counseling and Development
(as revised by AACD Governing Council, March 1988)
ETHICAL STANDARDS
of the
American Association for Counseling and Development
(as revised by AACD Governing Council, March 1988)

PREAMBLE

The Association is an educational, scientific, and professional organization whose members are dedicated to the enhancement of the worth, dignity, potential, and uniqueness of each individual and thus to the service of society.

The Association recognizes that the role definitions and work settings of its members include a wide variety of academic disciplines, levels of academic preparation, and agency services. This diversity reflects the breadth of the Association's interest and influence. It also poses challenging complexities in efforts to set standards for the performance of members, desired requisite preparation or practice, and supporting social, legal, and ethical controls.

The existence of such standards serves to stimulate greater concern by members for their own professional functioning and for the conduct of fellow professionals such as counselors, guidance and student personnel workers, and others in the helping professions. As the ethical code of the Association, this document establishes principles that define the ethical behavior of Association members. Additional ethical guidelines developed by the Association's Divisions for their specialty areas may further define member's ethical behavior.

Section A:
General

1. The member influences the development of the profession by continuous efforts to improve professional practices, teaching, services, and research. Professional growth is continuous throughout the member's career and is exemplified by the development of a philosophy that explains why and how a member functions in the helping relationship. Members must gather data on their effectiveness and be guided by the findings. Members recognize the need for continuing education to ensure competent service.

2. The member has a responsibility both to the individual who is served and to the institution within which the service is performed to maintain high standards of professional conduct. The member strives to maintain the highest level of professional services offered to the individuals to be served. The member also strives to assist the agency, organization, or institution in providing the highest caliber of professional services. The acceptance of employment in an institution implies that the member is in agreement with the general policies and principles of the institution. Therefore the professional activities of the member are also in accord with the objectives of the institution. If, despite concerted efforts, the member cannot reach agreement with the employer as to acceptable standards of conduct that allow for changes in institutional policy conducive to the positive growth and development of clients, then terminating the affiliation should be seriously considered.

3. Ethical behavior among professional associates, both members and nonmembers, must be expected at all times. When information is possessed that raises doubt as to the ethical behavior of professional colleagues, whether Association members or not, the member must take action to attempt to rectify such a condition. Such action shall use the institution's channels first and then use procedures established by the Association.
4. The member neither claims nor implies professional qualifications exceeding those possessed and is responsible for correcting any misrepresentations of these qualifications by others.

5. In establishing fees for professional counseling services, members must consider the financial status of clients and locality. In the event that the established fee structure is inappropriate for the client, assistance must be provided in finding comparable services of acceptable cost.

6. When members provide information to the public or to subordinates, peers, or supervisors, they have a responsibility to ensure that the content is general, unidentified client information that is accurate, unbiased, and consists of objective, factual data.

7. Members recognize their boundaries of competence and provide only those services and only those techniques for which they are qualified by training or experience. Members should only accept those positions for which they are professionally qualified.

8. In the counseling relationship, the counselor is aware of the intimacy of the relationship and maintains respect for the client and avoids engaging in activities that seek to meet the counselor's needs at the expense of that client.

9. Members do not condone or engage in sexual harassment which is defined as deliberate or repeated comments, gestures, or physical contacts of a sexual nature.

10. The member avoids bringing personal issues into the counseling relationship, especially if the potential for harm is present. Through awareness of the negative impact of both racial and sexual stereotyping and discrimination, the counselor guards the individual rights and personal dignity of the client in the counseling relationship.

11. Products or services provided by the member by means of classroom instruction, public lectures, demonstrations, written articles, radio or television programs, or other types of media must meet criteria cited in these standards.

Section B
Counseling Relationship

This section refers to practices and procedures of individual and/or group counseling relationships.

The member must recognize the need for client freedom of choice. Under those circumstances where this is not possible, the member must apprise clients of restrictions that may limit their freedom of choice.

1. The member's primary obligation is to respect the integrity and promote the welfare of the client(s), whether the client(s) is (are) assisted individually or in a group relationship. In a group setting, the member is also responsible for taking reasonable precautions to protect individuals from physical and/or psychological trauma resulting from interaction within the group.

2. Members make provisions for maintaining confidentiality in the storage and disposal of records and follow an established record retention and disposition policy. The counseling relationship and information resulting therefrom must be kept confidential, consistent with the obligations of the member as a professional person. In a group counseling setting, the counselor must set a norm of confidentiality regarding all group participants' disclosures.

3. If an individual is already in a counseling relationship with another professional person, the member does not enter into a counseling relationship without first contacting and receiving approval of that other professional. If the member discovers that the client is in another counseling relationship after the
counseling relationship begins, the member must gain consent of the other professional or terminate the relationship, unless the client elects to terminate the other relationship.

4. When the client's condition indicates that there is clear and imminent danger to the client or others, the member must take reasonable personal action or inform responsible authorities. Consultation with other professionals must be used where possible. The assumption of responsibility for the client's (s') behavior must be taken only after careful deliberation. The client must be involved in the resumption of responsibility as quickly as possible.

5. Records of the counseling relationship, including interview notes, test data, correspondence, tape recordings, electronic data storage, and other documents are to be considered professional information for use in counseling, and they should not be considered a part of the records of the institution or agency in which the counselor is employed unless specified by state statute or regulation. Revelation to others of counseling material must occur only upon the expressed consent of the client.

6. In view of the extensive storage and processing capacities of the computer, the member must ensure that data maintained on a computer is: (a) limited to information that is appropriate and necessary for the services being provided; (b) destroyed after it is determined that the information is no longer of any value in providing services; and (c) restricted in terms of access to appropriate staff members involved in the provision of services by using the best computer security methods available.

7. Use of data derived from a counseling relationship for purposes of counselor training or research shall be confined to content that can be disguised to ensure full protection of the identity of the subject client.

8. The member must inform the client of the purposes, goals, techniques, rules of procedure, and limitations that may affect the relationship at or before the time that the counseling relationship is entered. When working with minors or persons who are unable to give consent, the member protects these clients' best interest.

9. In view of common misconceptions related to the perceived inherent validity of computer-generated data and narrative reports, the member must ensure that the client is provided with information as part of the counseling relationship that adequately explains the limitations of computer technology.

10. The member must screen prospective group participants, especially when the emphasis is on self-understanding and growth through self-disclosure. The member must maintain an awareness of the group participants' compatibility throughout the life of the group.

11. The member may choose to consult with any other professionally competent person about a client. In choosing a consultant, the member must avoid placing the consultant in a conflict of interest situation that would preclude the consultant's being a proper party to the member's efforts to help the client.

12. If the member determines an inability to be of professional assistance to the client, the member must either avoid initiating the counseling relationship or immediately terminate that relationship. In either event, the member must suggest appropriate alternatives. (The member must be knowledgeable about referral sources so that a satisfactory referral can be initiated.) In the event the client declines the suggested referral, the member is not obligated to continue the relationship.

13. When the member has other relationships, particularly of an administrative, supervisory, and/or evaluative nature with an individual seeking counseling services, the member must not serve as the counselor but should refer the individual to another professional. Only in instances where such an alternative is unavoidable and where the individual's situation warrants counseling intervention should the member enter into and/or maintain a counseling relationship. Dual relationships with clients that might impair the member's
objectivity and professional judgement (e.g., as with close friends or relatives) must be avoided and/or the counseling relationship terminated through referral to another competent professional.

14. The member will avoid any type of sexual intimacies with clients. Sexual relationships with clients are unethical.

15. All experimental methods of treatment must be clearly indicated to prospective recipients, and safety precautions are to be adhered to by the member.

16. When computer applications are used as a component of counseling services, the member must ensure that: (a) the client is intellectually, emotionally, and physically capable of using the computer application; (b) the computer application is appropriate for the needs of the client; (c) the client understands the purpose and operation of the computer application; and (d) a follow-up of client use of a computer application is provided to both correct possible problems (misconceptions or inappropriate use) and assess subsequent needs.

17. When the member is engaged in short-term group treatment/training programs (e.g., marathons and other encounter-type growth groups), the member ensures that there is professional assistance available during and following the group experience.

18. Should the member be engaged in a work setting that calls for any variation from the above statements, the member is obligated to consult with other professionals whenever possible to consider justifiable alternatives.

19. The member must ensure that members of various ethnic, racial, religious, disability, and socioeconomic groups have equal access to computer applications used to support counseling services and that the content of available computer applications does not discriminate against the groups described above.

20. When computer applications are developed by the member for use by the general public as self-help/stand-alone computer software, the member must ensure that: (a) self-help computer applications are designed from the beginning to function in a stand-alone manner, as opposed to modifying software that was originally designed to require support from a counselor; (b) self-help computer applications will include within the program statements regarding intended user outcomes, suggestions for using the software, a description of the conditions under which self-help computer applications might not be appropriate, and a description of when and how counseling services might be beneficial; and (c) the manual for such applications will include the qualifications of the developer, the development process, validation data, and operating procedures.

Section C: Measurement and Evaluation

The primary purpose of educational and psychological testing is to provide descriptive measures that are objective and interpretable in either comparative or absolute terms. The member must recognize the need to interpret the statements that follow as applying to the whole range of appraisal techniques including test and nontest data. Test results constitute only one of a variety of pertinent sources of information for personnel, guidance, and counseling decisions.

1. The member must provide specific orientation or information to the examinee(s) prior to and following the test administration so that the results of testing may be placed in proper perspective with other relevant factors. In so doing, the member must recognize the effects of socioeconomic, ethnic, and cultural factors on test scores. It is the member's professional responsibility to use additional unvalidated information carefully in modifying interpretation of the test results.
2. In selecting tests for use in a given situation or with a particular client, the member must consider carefully the specific validity, reliability, and appropriateness of the test(s). General validity, reliability, and related issues may be questioned legally as well as ethically when tests are used for vocational and educational selection, placement, or counseling.

3. When making any statements to the public about tests and testing, the member must give accurate information and avoid false claims or misconceptions. Special efforts are often required to avoid unwarranted connotations of such terms as IQ and grade equivalent scores.

4. Different tests demand different levels of competence for administration, scoring, and interpretation. Members must recognize the limits of their competence and perform only those functions for which they are prepared. In particular, members using computer-based test interpretations must be trained in the construct being used prior to using this type of computer application.

5. In situations where a computer is used for test administration and scoring, the member is responsible for ensuring that administration and scoring programs function properly to provide clients with accurate test results.

6. Tests must be administered under the same conditions that were established in their standardization. When tests are not administered under standard conditions or when unusual behavior or irregularities occur during the testing session, those conditions must be noted and the results designated as invalid or of questionable validity. Unsupervised or inadequately supervised test-taking, such as the use of tests through the mails, is considered unethical. On the other hand, the use of instruments to be self-administered and self-scored, such as interest inventories, is to be encouraged.

7. The meaningfulness of test results used in personnel, guidance, and counseling functions generally depends on the examinee's unfamiliarity with the specific items on the test. Any prior coaching or dissemination of the test materials can invalidate test results. Therefore, test security is one of the professional obligations of the member. Conditions that produce most favorable test results must be made known to the examinee.

8. The purpose of testing and the explicit use of the results must be made known to the examinee prior to testing. The counselor must ensure that instrument limitations are not exceeded and that periodic review and/or retesting are made to prevent client stereotyping.

9. The examinee's welfare and explicit prior understanding must be the criteria for determining the recipients of the test results. The member must see that specific interpretation accompanies any release of individual or group test data. The interpretation of test data must be related to the examinee's particular concerns.

10. Members responsible for making decisions based on test results have an understanding of educational and psychological measurement, validation criteria, and test research.

11. The member must be cautious when interpreting the results of research instruments possessing insufficient technical data. The specific purposes for the use of such instruments must be stated explicitly to examinees.

12. The member must proceed with caution when attempting to evaluate and interpret the performance of minority group members or other persons who are not represented in the norm group on which the instrument was standardized.

13. When computer-based interpretations are developed by the member to support the assessment process, the member must ensure that the validity of such interpretations is established prior to the commercial distribution of such computer application.
14. The member recognizes that test results may become obsolete. The member will avoid and prevent misuse of obsolete test results.

15. The member must guard against the appropriation, reproduction, or modification of published tests or parts thereof without acknowledgment and permission from the previous publisher.

16. Regarding the preparation, publication, and distribution of tests, reference should be made to:


Section D:
Research and Publication

1. Guidelines on research with human subjects shall be adhered to, such as:


   b. Code of Federal Regulation, Title 45, Subtitle A, Part 46, as currently issued.

   c. Ethical Principles of Psychologists, American Psychological Association, Principle #9: Research with Human Participants.

   d. Family Educational Rights and Privacy Act (the Buckley Amendment).

   e. Current federal regulations and various state rights privacy acts.

2. In planning any research activity dealing with human subjects, the member must be aware of and responsive to all pertinent ethical principles and ensure that the research problem, design, and execution are in full compliance with them.

3. Responsibility for ethical research practice lies with the principal researcher, while others involved in the research activities share ethical obligation and full responsibility for their own actions.

4. In research with human subjects, researchers are responsible for the subjects' welfare throughout the experiment, and they must take all reasonable precautions to avoid causing injurious psychological, physical, or social effects on their subjects.

5. All research subjects must be informed of the purpose of the study except when withholding information or providing misinformation to them is essential to the investigation. In such research the member must be responsible for corrective action as soon as possible following completion of the research.
6. Participation in research must be voluntary. Involuntary participation is appropriate only when it can be demonstrated that participation will have no harmful effects on subjects and is essential to the investigation.

7. When reporting research results, explicit mention must be made of all variables and conditions known to the investigator that might affect the outcome of the investigation or the interpretation of the data.

8. The member must be responsible for conducting and reporting investigations in a manner that minimizes the possibility that results will be misleading.

9. The member has an obligation to make available sufficient original research data to qualified others who may wish to replicate the study.

10. When supplying data, aiding in the research of another person, reporting research results, or making original data available, due care must be taken to disguise the identity of the subjects in the absence of specific authorization from such subjects to do otherwise.

11. When conducting and reporting research, the member must be familiar with and give recognition to previous work on the topic, as well as to observe all copyright laws and follow the principles of giving full credit to all to whom credit is due.

12. The member must give due credit through joint authorship, acknowledgment, footnote statements, or other appropriate means to those who have contributed significantly to the research and/or publication, in accordance with such contributions.

13. The member must communicate to other members the results of any research judged to be of professional or scientific value. Results reflecting unfavorably on institutions, programs, services, or vested interests must not be withheld for such reasons.

14. If members agree to cooperate with another individual in research and/or publication, they incur an obligation to cooperate as promised in terms of punctuality of performance and will [Sic. "with"] full regard to the completeness and accuracy of the information required.

15. Ethical practice requires that authors not submit the same manuscript or one essentially similar in content for simultaneous publication consideration by two or more journals. In addition, manuscripts published in whole or in substantial part in another journal or published work should not be submitted for publication without acknowledgment and permission from the previous publication.

Section E: Consulting

Consultation refers to a voluntary relationship between a professional helper and help-needing individual, group, or social unit in which the consultant is providing help to the client(s) in defining and solving a work-related problem or potential problem with a client or client system.

1. The member acting as consultant must have a high degree of self-awareness of his/her own values, knowledge, skills, limitations, and needs in entering a helping relationship that involves human and/or organizational change and that the focus of the relationship be on the issues to be resolved and not on the person(s) presenting the problem.

2. There must be understanding and agreement between member and client for the problem definition, change of goals, and prediction of consequences of interventions selected.
3. The member must be reasonably certain that she/he or the organization represented has the necessary competencies and resources for giving the kind of help that is needed now or may be needed later and that appropriate referral resources are available to the consultant.

4. The consulting relationship must be one in which client adaptability and growth toward self-direction are encouraged and cultivated. The member must maintain this role consistently and not become a decision maker for the client or create a future dependency on the consultant.

5. When announcing consultant availability for services, the member conscientiously adheres to the Association’s Ethical Standards.

6. The member must refuse a private fee or other remuneration for consultation with persons who are entitled to these services through the member’s employing institution or agency. The policies of a particular agency may make explicit provisions for private practice with agency clients by members of its staff. In such instances, the clients must be apprised of other options open to them should they seek private counseling services.

Section F:
Private Practice

1. The member should assist the profession by facilitating the availability of counseling services in private as well as public settings.

2. In advertising services as a private practitioner, the member must advertise the services in a manner that accurately informs the public of professional services, expertise, and techniques of counseling available. A member who assumes an executive leadership role in the organization shall not permit his/her name to be used in professional notices during periods when he/she is not actively engaged in the private practice of counseling.

3. The member may list the following: Highest relevant degree, type and level of certification and/or license, address, telephone number, office hours, type and/or description of services, and other relevant information. Such information must not contain false, inaccurate, misleading, partial, out-of-context, or deceptive material or statements.

4. Members do not present their affiliation with any organization in such a way that would imply inaccurate sponsorship or certification by that organization.

5. Members may join in partnership/corporation with other members and/or other professionals provided that each member of the partnership or corporation makes clear the separate specialties by name in compliance with the regulations of the locality.

6. A member has an obligation to withdraw from a counseling relationship it is believed that employment will result in violation of the Ethical Standards. If the mental or physical condition of the member renders it difficult to carry out an effective professional relationship or if the member is discharged by the client because the counseling relationship is no longer productive for the client, then the member is obligated to terminate the counseling relationship.

7. A member must adhere to the regulations for private practice of the locality where the services are offered.

8. It is unethical to use one’s institutional affiliation to recruit clients for one’s private practice.
Section G: Personnel Administration

It is recognized that most members are employed in public or quasi-public institutions. The functioning of a member within an institution must contribute to the goals of the institution and vice versa if either is to accomplish their respective goals or objectives. It is therefore essential that the member and the institution function in ways to: (a) make the institutional goals specific and public; (b) make the member’s contribution to institutional goals specific; and (c) foster mutual accountability for goal achievement.

To accomplish these objectives, it is recognized that the member and the employer must share responsibilities in the formulation and implementation of personnel policies.

1. Members must define and describe the parameters and levels of their professional competency.

2. Members must establish interpersonal relations and working agreements with supervisors and subordinates regarding counseling or clinical relationships, confidentiality, distinction between public and private material, maintenance and dissemination of recorded information, work load, and accountability. Working agreements in each instance must be specified and made known to those concerned.

3. Members must alert their employers to conditions that may be potentially disruptive or damaging.

4. Members must inform employers of conditions that may limit their effectiveness.

5. Members must submit regularly to professional review and evaluation.

6. Members must be responsible for in-service development of self and/or staff.

7. Members must inform their staff of goals and programs.

8. Members must provide personnel practices that guarantee and enhance the rights and welfare of each recipient of their service.

9. Members must select competent persons and assign responsibilities compatible with their skills and experience.

10. The member, at the onset of a counseling relationship, will inform the client of the member’s intended use of supervisors regarding the disclosure of information concerning this case. The member will clearly inform the client of the limits of confidentiality in the relationship.

11. Members, as either employers or employees, do not engage in or condone practices that are inhumane, illegal, or unjustifiable (such as considerations based on sex, handicap, age, race) in hiring, promotion, or training.

Section H: Preparation Standards

Members who are responsible for training others must be guided by the preparation standards of the Association and relevant Division(s). The member who functions in the capacity of trainer assumes unique ethical responsibilities that frequently go beyond that of the member who does not function in a training capacity. These ethical responsibilities are outlined as follows:
1. Members must orient students to program expectations, basic skills development, and employment prospects prior to admission to the program.

2. Members in charge of learning experiences must establish programs that integrate academic study and supervised practice.

3. Members must establish a program directed toward developing students' skills, knowledge, and self-understanding, stated whenever possible in competency or performance terms.

4. Members must identify the levels of competencies of their students in compliance with relevant Division standards. These competencies must accommodate the paraprofessional as well as the professional.

5. Members, through continual student evaluation and appraisal, must be aware of the personal limitations of the learner that might impede future performance. The instructor must not only assist the learner in securing remedial assistance but also screen from the program those individuals who are unable to provide competent services.

6. Members must provide a program that includes training in research commensurate with levels of role functioning. Paraprofessional and technical-level personnel must be trained as consumers of research. In addition, personnel must learn how to evaluate their own and their program's effectiveness. Graduate training, especially at the doctoral level, would include preparation for original research by the member.

7. Members must make students aware of the ethical responsibilities and standards of the profession.

8. Preparatory programs must encourage students to value the ideals of service to individuals and to society. In this regard, direct financial remuneration or lack thereof must not be allowed to overshadow professional and humanitarian needs.

9. Members responsible for educational programs must be skilled as teachers and practitioners.

10. Members must present thoroughly varied theoretical positions so that students may make comparisons and have the opportunity to select a position.

11. Members must develop clear policies within their educational institutions regarding field placement and the roles of the student and the instructor in such placement.

12. Members must ensure that forms of learning focusing on self-understanding or growth are voluntary, or if required as part of the educational program, are made known to prospective students prior to entering the program. When the educational program offers a growth experience with an emphasis on self-disclosure or other relatively intimate or personal involvement, the member must have no administrative, supervisory, or evaluating authority regarding the participant.

13. The member will at all times provide students with clear and equally acceptable alternatives for self-understanding or growth experiences. The member will assure students that they have a right to accept these alternatives without prejudice or penalty.

14. Members must conduct an educational program in keeping with the current relevant guidelines of the Association.
HANDBOOK APPENDIX C

CODE OF ETHICS FOR MENTAL HEALTH COUNSELORS

AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION
CODE OF ETHICS FOR MENTAL HEALTH COUNSELORS, 1987

PREAMBLE

Mental Health Counselors believe in the dignity of the individual. They are committed to increasing knowledge of human behavior and understanding of themselves and others. While pursuing these endeavors, they make every reasonable effort to protect the welfare of those who seek their services or of any subject that may be the object of study. They use their skills only for purposes consistent with these values and do not knowingly permit their misuse by others. While demanding for themselves freedom of inquiry and community, mental health counselors accept responsibility this freedom confers: competence, objectivity in the application of skills and concern for the best interests of clients, colleagues, and society in general. In the pursuits of these ideals, mental health counselors subscribe to the following principles:

PRINCIPLE 1. RESPONSIBILITY

In their commitment to the understanding of human behavior, mental health counselors value objectivity and integrity, and in providing services they maintain the highest standards. They accept responsibility for the consequences of their work and make every effort to insure that their services are used appropriately.

a. Mental health counselors accept ultimate responsibility for selecting appropriate areas of investigation and the methods relevant to minimize the possibility that their finding will be misleading. They provide thorough discussion of the limitations of their data and alternative hypotheses, especially where their work touches on social policy or might be misconstrued to the detriment of specific age, sex, ethnic, socioeconomic, or other social categories. In publishing reports of their work, they never discard observations that may modify the interpretation of results. Mental health counselors take credit only for the work they have actually done. In pursuing research, mental health counselors ascertain that their efforts will not lead to changes in individuals or organizations unless such changes are part of the agreement at the time of obtaining informal consent. Mental health counselors clarify in advance the expectations for sharing and utilizing research data. They avoid dual relationships which may limit objectivity, whether theoretical, political, or monetary, so that interference with data, subjects, and milieu is kept to a minimum.

b. As employees of an institution or agency, mental health counselors have the responsibility of remaining alert to institutional pressures which may distort reports of counseling findings or use them in ways counter to the promotion of human welfare.

c. When serving as members of governmental or other organizational bodies, mental health counselors remain accountable as individuals to the Code of Ethics of the American Mental Health Counselors Association (AMHCA).

d. As teachers, mental health counselors recognize their primary obligation to help others acquire knowledge and skill. They maintain high standards of scholarship and objectivity by presenting counseling information fully and accurately, and by giving appropriate recognition to alternative viewpoints.

e. As practitioners, mental health counselors know that they bear a heavy social responsibility because their recommendations and professional actions may alter the lives of others. They, therefore, remain fully cognizant of their impact and alert to personal, social, organizational, financial or political situations or pressures which might lead to misuse of their influence.

f. Mental health counselors provide reasonable and timely feedback to employees, trainees, supervisors, students, clients, and others whose work they may evaluate.
PRINCIPLE 2. COMPETENCE

The maintenance of high standards of professional competence is a responsibility shared by all mental health counselors in the interest of the public and the profession as a whole. Mental health counselors recognize the boundaries of their competence and the limitations of their techniques and only provide services, use techniques, or offer opinions as professionals that meet recognized standards. Throughout their careers, mental health counselors maintain knowledge of professional information related to the services they render.

a. Mental health counselors accurately represent their competence, education, training and experience.

b. As teachers, mental health counselors perform their duties based on careful preparation so that their instruction is accurate, up-to-date and scholarly.

c. Mental health counselors recognize the need for continuing training to prepare themselves to serve persons of all ages and cultural backgrounds. They are open to new procedures and sensitive to differences between groups of people and changes in expectations and values over time.

d. Mental health counselors with the responsibility for decisions involving individuals or policies based on test results should know and understand literature relevant to the tests used and testing problems with which they deal.

e. Mental health counselors and practitioners recognize that their effectiveness depends in part upon their ability to maintain sound interpersonal relations, that temporary or more enduring aberrations on their part may interfere with their abilities or distort their appraisals of others. Therefore, they refrain from undertaking any activity in which their personal problems are likely to lead to inadequate professional services or harm to a client, or, if they are already engaged in such activity when they become aware of their personal problems, they would seek competent professional assistance to determine whether they should suspend or terminate services to one or all of their clients.

f. The mental health counselor has a responsibility both to the individual who is served and to the institution with which the service is performed to maintain high standards of professional conduct. The mental health counselor strives to maintain the highest levels of professional services offered to the individuals to be served. The mental health counselor also strives to assist the agency, organization or institution in providing the highest caliber of professional services. The acceptance of employment in an institution implies that the mental health counselor is in substantial agreement with the general policies and principles of the institution. If, despite concerted efforts, the member cannot reach agreement with the employer as to acceptable standards of conduct that allow for changes in institutional policy conducive to the positive growth and development of counseling, then terminating the affiliation should be seriously considered.

g. Ethical behavior among professional associates, mental health counselors, is expected at all times. When information is possessed which raises serious doubt as to the ethical behavior of professional colleagues, whether Association members or not, the mental health counselor is obligated to take action to attempt to rectify such a condition. Such action shall utilize the institution's channels first and then utilize procedures established by the state, division, or Association.

h. The mental health counselor is aware of the intimacy of the counseling relationship and maintains a healthy respect for the personhood of the client and avoids engaging in activities that seek to meet the mental health counselor's personal needs at the expense of the client. Through awareness of the negative impact of both racial and sexual stereotyping and discrimination, the member strives to ensure the individual right and personal dignity of the client in the counseling relationship.
PRINCIPLE 3. MORAL AND LEGAL STANDARDS

Mental health counselors moral, ethical and legal standards of behavior are a personal matter to the same degree as they are for any other citizen, except as these may compromise the fulfillment of their professional responsibilities, or reduce the trust in counseling or counselors held by the general public. Regarding their own behavior, mental health counselors should be aware of the prevailing community standards and of the possible impact upon their conformance to or deviation from these standards. Mental health counselors should also be aware of the possible impact of their public behavior upon the ability of colleagues to perform their professional duties.

a. To protect public confidence in the profession of counseling, mental health counselors will avoid public behavior that is clearly in violation of accepted moral and legal standards.

b. To protect students, mental health counselors/teachers will be aware of the diverse backgrounds of students and, when dealing with topics that may give offense, will see that the material is treated objectively, that it is clearly relevant to the course, and that it is treated in a manner for which the student is prepared.

c. Providers of counseling services conform to the statutes relating to such services as established by their state and its regulating professional board(s).

d. As employees, mental health counselors refuse to participate in employer's practices which are inconsistent with the moral and legal standards established by federal or state legislation regarding the treatment of employees or of the public. In particular and for example, mental health counselors will not condone practices which result in illegal or otherwise unjustifiable discrimination on the basis of race, sex, religion or national origin in hiring, promotion or training.

e. In providing counseling services to clients mental health counselors avoid any action that will violate or diminish the legal and civil rights of clients or of others who may be affected by the action.

f. Sexual conduct, not limited to sexual intercourse, between mental health counselors and clients is specifically in violation of this code of ethics. This does not, however, prohibit the use of explicit instructional aids including films and video tapes. Such use is within accepted practices of trained and competent sex therapists.

PRINCIPLE 4. PUBLIC STATEMENTS

Mental health counselors in their professional roles may be expected or required to make public statements providing counseling information, professional opinions, or supply information about the availability of counseling products and services. In making such statements, mental health counselors take full account of the limits and uncertainties of present counseling knowledge and techniques. They represent, as objectively as possible, their professional qualifications, affiliations, and functions, as well as those of the institutions and organizations with which the statements may be associated. All public statements, announcements of services, and promotional activities should serve the purpose of providing sufficient information to aid the consumer public in making informed judgments and choices on matters that concern it.

a. When announcing professional counseling services, mental health counselors limit the information to: name, highest relevant degree conferred, certification or licensure, address, telephone number, office hours, cost of services, and a brief explanation of the other types of services offered but not evaluative as to their quality or uniqueness. They will not contain testimonials by implication. They will not claim uniqueness of skill or methods beyond those acceptable and public scientific evidence.

b. In announcing the availability of counseling services or products, mental health counselors will not display their affiliations with organizations or agencies in a manner that implies the sponsorship or
certification of the organization or agency. They will not name their employer or professional associations unless the services are in fact to be provided by or under the responsible, direct supervision and continuing control of such organizations or agencies.

c. Mental health counselors associated with the development of promotion of counseling device, books, or other products offered for commercial sale will make every effort to insure that announcements and advertisements are presented in a professional and factually informative manner without unsupported claims of superiority and must be supported by scientifically acceptable evidence or by willingness to aid and encourage independent professional scrutiny or scientific test.

d. Mental health counselors engaged in radio, television or other public media activities will not participate in commercial announcements recommending to the general public the purchase or use of any proprietary or single-source product or service.

e. Mental health counselors who describe counseling or the services of professional counselors to the general public accept obligation to present the material fairly and accurately, avoiding misrepresentation through sensationalism, exaggeration or superficiality. Mental health counselors will be guided by the primary obligation to aid the public in forming their own informed judgments, opinions and choices.

f. As teachers, mental health counselors ensure their statements in catalogs and course outlines are accurate, particularly in terms of subject matter to be covered, bases for grading, and nature of classroom experience.

g. Mental health counselors accept the obligation to correct others who may represent their professional qualifications or associations with products or services in a manner incompatible with these guidelines.

h. Mental health counselors providing consultation, workshops, training, and other technical services may refer to previous satisfied clients in their advertising, provided there is no implication that such advertising refers to counseling services.

**PRINCIPLE 5. CONFIDENTIALITY**

Mental health counselors have a primary obligation to safeguard information about individuals obtained in the course of teaching, practice, or research. Personal information if communicated to others only with the person's written consent or in those circumstances where there is clear and imminent danger to the client, to others or to society. Disclosures of counseling information are restricted to what is necessary, relevant, and verifiable.

a. All materials in the official record shall be shared with the client who shall have the right to decide what information may be shared with anyone beyond the immediate provider of service and to be informed of the implications of the materials to be shared.

b. The anonymity of clients served in public and other agencies is preserved, if at all possible, by withholding names and personal identifying data. If external conditions require reporting such information, the client shall be so informed.

c. Information received in confidence by one agency or person shall not be forwarded to another person or agency without the client's written permission.

d. Service providers have a responsibility to insure the accuracy and to indicate the validity of data shared with their parties.
e. Case reports presented in classes, professional meetings, or in publications shall be so disguised that no identification is possible unless the client or responsible authority has read the report and agreed in writing to its presentation or publication.

f. Counseling reports and records are maintained under conditions of security and provisions are made for their destruction when they have outlived their usefulness. Mental health counselors insure that privacy and confidentiality are maintained by all persons in the employ or volunteers, and community aides.

g. Mental health counselors who ask that an individual reveal personal information in the course of interviewing, testing or evaluation, or who allow such information to be divulged, do so only after making certain that the person or authorized representative is fully aware of the purposes of the interview, testing or evaluation and of the ways in which the information will be used.

h. Sessions with clients are taped or otherwise recorded only with their written permission or the written permission of a responsible guardian. Even with guardian written consent one should not record a session against the expressed wishes of a client.

i. Where a child or adolescent is the primary client, the interests of the minor shall be paramount.

j. In working with families, the rights of each family member should be safeguarded. The provider of service also has the responsibility to discuss the contents of the record with the parent and/or child, as appropriate, and to keep separate those parts which should remain the property of each family member.

**PRINCIPLE 6. WELFARE OF THE CONSUMER**

Mental health counselors respect the integrity and protect the welfare of the people and groups with whom they work. When there is a conflict of interest between the client and the mental health counselor employing institution, the mental health counselors clarify the nature and direction of their loyalties and responsibilities and keep all parties informed of their commitments. Mental health counselors fully inform consumers as to the purpose and nature of any evaluative, treatment, educational or training procedure, and they freely acknowledge that clients, students, or subjects have freedom of choice with regard to participation.

a. Mental health counselors are continually cognizant both of their own needs and of their inherently powerful position "vis-a-vis" clients, in order to avoid exploiting the client's trust and dependency. Mental health counselors make every effort to avoid dual relationships with clients and/or relationships which might impair their professional judgement or increase the risk of client exploitation. Examples of such dual relationships include treating an employee or supervisor, treating a close friend or family relative and sexual relationships with clients.

b. Where mental health counselors work with members of an organization goes beyond reasonable conditions of employment, mental health counselors recognize possible conflicts of interest that may arise. When such conflicts occur, mental health counselors clarify the nature of the conflict and inform all parties of the nature and directions of the loyalties and responsibilities involved.

c. When acting as supervisors, trainers, or employers, mental health counselors accord recipients informed choice, confidentiality, and protection from physical and mental harm.

d. Financial arrangements in professional practice are in accord with professional standards that safeguard the best interests of the client and that are clearly understood by the client in advance of billing.
This may best be done by the use of a contract. Mental health counselors are responsible for assisting clients in finding needed services in those instances where payment of the usual fee would be a hardship. No commission or rebate or other form of remuneration may be given or received for referral of clients for professional services, whether by an individual or by an agency.

e. Mental health counselors are responsible for making their services readily accessible to clients in a manner that facilitates the client's ability to make an informed choice when selecting a service provider. This responsibility includes a clear description of what the client may expect in the way of tests, reports, billing, therapeutic regime and schedules and the use of the mental health counselor's Statement of Professional Disclosure.

f. Mental health counselors who find that their services are not beneficial to the client have the responsibility to make this known to the responsible persons.

g. Mental health counselors are accountable to the parties who refer and support counseling services and to the general public and are cognizant of the indirect or long-range effects of their intervention.

h. The mental health counselor attempts to terminate a private service or consulting relationship when it is reasonably clear to the mental health counselor that the consumer is not benefitting from it. If a consumer is receiving services from another mental health professional, mental health counselors do not offer their services directly to the consumer without informing the professional persons already involved in order to avoid confusion and conflict for the consumer.

i. The mental health counselor has the responsibility to screen prospective group participants, especially when the emphasis is on self-understanding and growth through self-disclosure. The member should maintain an awareness of the group participants' compatibility throughout the life of the group.

j. The mental health counselor may choose to consult with any other professionally competent person about a client. In choosing a consultant, the mental health counselor should avoid placing the consultant in a conflict of interest situation that would preclude the consultant's being a proper party to the mental health counselors' efforts to help the clients.

k. If the mental health counselor is unable to be of professional assistance to the client, the mental health counselor should avoid initiating the counseling relationship or the mental health counselor terminates the relationship. In either event, the member is obligated to suggest appropriate alternatives. (It is incumbent upon the mental health counselors to be knowledgeable about referral resources so that a satisfactory referral can be initiated.) In the event the client declines the suggested referral, the mental health counselor is not obligated to continue the relationship.

l. When the mental health counselor has other relationships, particularly of an administrative, supervisory, and/or evaluative nature, with an individual seeking counseling services, the mental health counselor should not serve as the counselor but should refer the individual to another professional. Only in instances where such an alternative is unavailable and where the individual's situation definitely warrants counseling intervention should the mental health counselor enter into and/or maintain a counseling relationship. Dual relationships with clients might impair the member's objectivity and professional judgement (such as with close friends or relatives, sexual intimacies with any client, etc.) must be avoided and/or the counseling relationship terminated through referral to another competent professional.

m. All experimental methods of treatment must be clearly indicated to prospective recipients, and safety precautions are to be adhered to by the mental health counselor instituting treatment.

n. When the member is engaged in short-term group treatment/training programs e.g., marathons and other encounter-type growth groups, the member ensures that there is professional assistance available during and following the group experience.
PRINCIPLE 7. PROFESSIONAL RELATIONSHIP

Mental health counselors act with due regard to the needs and feelings of their colleagues in counseling and other professions. Mental health counselors respect the prerogatives and obligations of the institutions or organizations with which they are associated.

a. Mental health counselors understand the areas of competence of related professions and make full use of other professional, technical, and administrative resources which best serve the interests of consumers. The absence of formal relationships with other professional workers does not relieve mental health counselors from the responsibility of securing for their clients the best possible professional service; indeed, this circumstance presents a challenge to the professional competence of mental health counselors, requiring special sensitivity to problems outside their areas of training, and foresight, diligence, and tact in obtaining the professional assistance needed by clients.

b. Mental health counselors know and take into account the traditions and practices of other professional groups with which they work and cooperate fully with members of such groups when research, services, and other functions are shared or in working for the benefit of public welfare.

c. Mental health counselors strive to provide positive conditions for those they employ and they spell out clearly the conditions of such employment. They encourage their employees to engage in activities that facilitate their further professional development.

d. Mental health counselors respect the viability, reputation, and the proprietary right of organizations which they serve. Mental health counselors show due regard for the interest of their present or prospective employers. In those instances where they are critical of policies, they attempt to effect change by constructive action within the organization.

e. In the pursuit of research, mental health counselors give sponsoring agencies, host institutions, and publication channels the same respect and opportunity for giving informed consent that they accord to individual research participants. They are aware of their obligation to future research workers and insure that host institutions are given feedback information and proper acknowledgment.

f. Credit is assigned to those who have contributed to a publication, in proportion to their contribution.

g. When a mental health counselor violates ethical standards, mental health counselors who know first-hand of such activities should, if possible, attempt to rectify the situation. Failing an informal solution, mental health counselors should bring such unethical activities to the attention of the appropriate state, and/or national committee on ethics and professional conduct. Only after all professional alternatives have been utilized will a mental health counselor begin legal action for resolution.

PRINCIPLE 8. UTILIZATION OF ASSESSMENT TECHNIQUES

In the development, publication, and utilization of counseling assessment techniques, mental health counselors follow relevant standards. Individuals examined, or their legal guardians, have the right to know the results, the interpretations made, and where appropriate, the particulars on which final judgment was based. Test users should take precautions to protect test security but not at the expense of an individual's right to understand the basis for decisions that adversely affect that individual or that individual's dependents.

a. The client has the right to have and the provider has the responsibility to give explanations of test results in language the client can understand.
b. When a test is published or otherwise made available for operational use, it should be accompanied by a manual (or other published or readily available information) that makes every reasonable effort to describe fully the development of the test, the rationale, specifications followed in writing items analysis or other research. The test, the manual, the record forms and other accompanying material should help users make correct interpretations of the test results and should warn against common misuses. The test manual should state explicitly the purposes and applications for which the test is recommended and identify any special qualifications required to administer the test and to interpret it properly. Evidence of validity and reliability, along with other relevant research data, should be presented in support of any claims made.

c. Norms presented in test manuals should refer to defined and clearly described populations. These populations should be the groups with whom users of the test will ordinarily wish to compare the persons tested. Test users should consider the possibility of bias in tests or in test items. When indicated, there should be an investigation of possible differences in validity for ethnic, sex, or other subsamples that can be identified when the test is given.

d. Mental health counselors who have the responsibility for decisions about individuals or policies that are based on test results should have a thorough understanding of counseling or educational measurement and of validation and other test research.

e. Mental health counselors should develop procedures for systematically eliminating from data files test score information that has, because of the lapse of time, become obsolete.

f. Any individual or organization offering test scoring and interpretation services must be able to demonstrate that their programs are based on appropriate research to establish the validity of the programs and procedures used in arriving at interpretations. The public offering of an automated test interpretation service will be considered as a professional-to-professional consultation. In this the formal responsibility of the consultant is to the consultee but his/her ultimate and overriding responsibility is to the client.

g. Counseling services for the purpose of diagnosis, treatment, or personalized advice are provided only in the context of a professional relationship, and are not given by means of public lectures or demonstrations, newspapers or magazine articles, radio or television programs, mail, or similar media. The preparation of personnel reports and recommendations based on test data secured solely by mail is unethical unless such appraisals are an integral part of a continuing client relationship with a company, as a result of which the consulting clinical mental health counselor has intimate knowledge of the client's personal situation and can be assured thereby that his written appraisals will be adequate to the purpose and will be properly interpreted by the client. These reports must not be embellished with such detailed analyses of the subject's personality traits as would be appropriate only for intensive interviews with the subjects.

**PRINCIPLE 9. PURSUIT OF RESEARCH ACTIVITIES**

The decision to undertake research should rest upon a considered judgment by the individual mental health counselor about how best to contribute to counseling and to human welfare. Mental health counselors carry out their investigations with concern for their dignity and welfare.

a. In planning a study the investigator has the personal responsibility to make a careful evaluation of its ethical acceptability, taking into account the following principles for research with human beings. To the extent that this appraisal, weighing scientific and humane values, suggests a deviation from any principle, the investigator incurs an increasingly serious obligation to seek ethical advice and to observe more stringent safeguards to protect the rights of the human research participants.
b. Mental health counselors know and take into account the traditions and practices of other professional groups with members of such groups when research, services, and other functions are shared or in working for the benefit of public welfare.

c. Ethical practice requires the investigator to inform the participant of all features of the research that reasonable [Sic. "reasonably"?] might be expected to influence willingness to participate, and to explain all other aspects of the research about which the participant inquires. Failure to make full disclosure gives added emphasis to the investigators abiding responsibility to protect the welfare and dignity of the research participant.

d. Openness and honesty are essential characteristics of the relationship between investigator and research participant. When the methodological requirements of a study necessitate concealment or deception, the investigator is required to insure as soon as possible the participant's understanding of the reasons for this action and to restore the quality of the relationship with the investigator.

e. In the pursuit of research, mental health counselors give sponsoring agencies, host institutions, and publication channels the same respect and opportunity for giving informed consent that they accord individual research participants. They are aware of their obligation to future research workers and insure that host institutions are given feedback information and proper acknowledgment.

f. Credit is assigned to those who have contributed to a publication, in proportion to their contribution.

g. The ethical investigator protects participants from physical and mental discomfort, harm and danger. If the risk of such consequences exists, the investigator is required to inform the participant of that fact, secure consent before proceeding, and take all possible measures to minimize distress. A research procedure may not be used if it is likely to cause serious and lasting harm to participants.

h. After the data are collected, ethical practice requires the investigator to provide the participant with a full clarification of the nature of the study and to remove any misconceptions that may have arisen. Where scientific or humane values justify delaying or withholding information the investigator acquires a special responsibility to assure that there are no damaging consequences for the participants.

i. Where research procedure may result in undesirable consequences for the participant, the investigator has the responsibility to detect and remove or correct these consequences, including, where relevant, long-term after effects.

j. Information obtained about the 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 the participants as a part of the procedure for obtaining informed consent.

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PRINCIPLE 10. PRIVATE PRACTICE

a. A mental health counselor should assist where permitted by legislation or judicial decision the profession in fulfilling its duty to make counseling services available in private settings.

b. In advertising services as a private practitioner the mental health counselor should advertise the services in such a manner so as to accurately inform the public as to services, expertise, profession, techniques of counseling in a professional manner. A mental health counselor who assumes an executive leadership role in the organization shall not permit his/her name to be used in professional notices during periods when not actively engaged in the private practice of counseling.
The mental health counselor may list the following: Highest relevant degree, type and level of certification or license, type and/or description of services and other relevant information. Such information should not contain false, inaccurate, misleading, partial, out-of-context or deceptive material or statements.

c. The mental health counselors may join in partnership/corporation with other mental health counselors and/or other professionals provided that each mental health counselor of the partnership or corporation makes clear the separate specialties by name in compliance with the regulations of the locality.

d. A mental health counselor has an obligation to withdraw from a counseling relationship if it is believed that employment will result in violation of the code of ethics, if their mental capacity or physical condition renders it difficult to carry out an effective professional relationship, or if the mental health counselor is discharged by the client because the counseling relationship is no longer productive for the client.

e. A mental health counselor should adhere to and support the regulations for private practice of the locality where the services are offered.

f. Mental health counselors are discouraged from deliberate attempts to utilize one's institutional affiliation to recruit clients for one's private practice. Mental health counselors are to refrain from offering their services in the private sector, when they are employed by an institution in which this is prohibited by stated policies reflecting conditions for employment.

g. In establishing fees for professional counseling services, mental health counselors should consider the financial status of clients and locality. In the event that the established fee structure is inappropriate for a client, assistance should be provided in finding services of acceptable cost.

PRINCIPLE 11. CONSULTING

a. The mental health counselor acting as consultant must have a high degree of self-awareness of his/her own values, knowledge, skills and needs in entering a helping relationship which involves human and/or organizational change and that the focus of the relationship be on issues to be resolved and not on the person(s) presenting the problem.

b. There should be understanding and agreement between the mental health counselor and client for the problem definition, change goals and predicted consequences of interventions selected.

c. The mental health counselor must be reasonable certain that she/he or the organization represented have the necessary competencies and resources for giving the kinds of help which is needed now or may develop later and that appropriate referral resources are available to the consultant, if needed later.

d. The mental health counselor relationship must be one in which client adaptability and growth toward self-direction are encouraged and cultivated. The mental health counselor must maintain this role consistently and not become a decision maker or substitute for the client.

e. When announcing consultant availability for services, the mental health counselor conscientiously adheres to professional standards.

f. The mental health counselor is expected to refuse a private fee or other remuneration for consultation with persons who are entitled to these services through the members' employing institution or agency. The policies of a particular agency may make explicit provisions for private practice with agency counselees by members of its staff. In such instances, the counselees must be apprised of other options open to them should they seek private counseling services.
PRINCIPLE 12. CLIENT RIGHTS

The following apply to all consumers of mental health services, including both in- and out-patients in all state, county, local, and private care mental health facilities, as well as patients/clients of mental health practitioners in private practice.

The client has the right:

a. to be treated with consideration and respect;

b. to expect quality service provided by concerned, competent staff;

c. to a clear statement of the purposes, goals, techniques, rules of procedure, and limitations as well as potential dangers of the services to be performed and all other information related to or likely to affect the on-going counseling relationship;

d. to obtain information about their case record and to have this information explained clearly and directly;

e. to full, knowledgeable, and responsible participation in the on-going treatment plan, to the maximum feasible extent;

f. to expect complete confidentiality and that no information will be released without written consent;

g. to see and discuss their charges and payment records;

h. to refuse any recommended services and be advised of the consequences of this action.
HANDBOOK APPENDIX D

SAMPLE COUNSELING FORMS

PART I: Sample Client Information Forms
PART II: Sample Professional Disclosure Statement
PART III: SOAP Format
PART I: Sample I

Sessions last fifty minutes. All information shared during sessions will be confidential except in cases where Arizona law overrides confidentiality explicitly: when there is a danger of imminent suicide, a serious threat or aggression which may endanger another life, or ongoing physical or sexual abuse. If I must break confidentiality, I will make every effort to inform you prior to doing so.

If I have need to exchange information with another professional, I will ask for your written consent.

If you are unable to attend a scheduled session, please let me know in advance. Without 24-hour notice, I will charge one-half the usual fee for a missed session.

______________________________  _________________________
Client                                  Date
PART I: Sample 2

COUNSELING GUIDELINES

Welcome. If this is your first time, please feel free to ask questions. Each counseling session is 50 minutes in length and is typically scheduled weekly. The length of time you will spend in counseling will be determined by the goals you have set for yourself. When you are ready to consider ending your counseling experience, it can be beneficial to have a last session to assess your progress, or to come on a less frequent basis before stopping.

Fees for professional services are expected to be paid as services are rendered. We can assist you in a claim with your insurance company, but the responsibility for payment remains with you. A prorated fee may be charged for telephone consultations in excess of ten minutes.

Since an appointment represents a mutual commitment to a designated time, appointments not cancelled 24 HOURS IN ADVANCE will be billed in full. Circumstances that are unavoidable will be taken into account. If you find you must cancel, you must confirm your next appointment.

You may be assured that any information regarding your counseling will not be revealed without your permission, except in the following circumstances:

1. You threaten to harm yourself or another person.
2. If child abuse or neglect is suspected.
3. If the counselor and/or case records are subpoenaed by the court.
4. If an insurance claim is filed, your case may be staffed with ________________, consulting psychiatrist/clinical psychologist.

Your signature on this document signifies your agreement to be financially responsible for all incurred costs and that you have read the informed consent guidelines. Thank you.

_________________________________________  ____________________________
Signature                                                  Date
PART I: Sample 3

Thank you for placing your confidence in this practice. Be assured that we will do our best to provide you the best possible services. Please read the information supplied on this form and sign below; you will be provided with a copy of this form upon request.

CONFIDENTIALITY:

Information divulged to your therapist during treatment remains confidential. This means that your therapist is not at liberty to discuss your case with anyone else but you without your written permission. Certain limitations apply to the confidentiality rule, however, and are listed below:

1. Parents of minors (individuals under the age of 18) have the legal right to know what information is discussed in therapy sessions. Since this is often counterproductive to the therapeutic process, parents are asked to sign a form allowing this office to protect the confidentiality of the therapy session;

2. In cases where the safety and well-being of the client or of another person may be in jeopardy, this office is ethically obligated to notify the appropriate authorities, or to contact the person whose safety is endangered;

3. In cases where child abuse may be a concern, the therapist is legally bound to notify the Child Protective Services office;

4. In a court of law, the therapist may be court ordered to testify regarding information discussed in therapy.

FEES:

Payment is due at the time services are rendered. If you prefer paying your balance on a monthly basis, please talk with the Office Manager during your initial visit. Please note accounts are due and payable monthly as work progresses, regardless of insurance coverage. A charge will be made for appointments cancelled with less than 24-hours notice.

<table>
<thead>
<tr>
<th>Type of Visit</th>
<th>Time</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Consultation</td>
<td>60 minutes</td>
<td>(Rates are subject to change)</td>
</tr>
<tr>
<td>Individual/Family Therapy</td>
<td>60 minutes</td>
<td></td>
</tr>
<tr>
<td>Group Psychotherapy</td>
<td>90 minutes</td>
<td></td>
</tr>
</tbody>
</table>

Evaluations—Times and Fees vary according to the type of services needed. Exact costs will be determined before the evaluation is begun.

Name (Print) _______________________________ Signature _______________ Date _______________
PART II: Professional Disclosure Statement

OUR AGREEMENT TO WORK TOGETHER

My job as your counselor is to provide you with quality service. I am a member of the ______ Association, and the responsibilities I have to you are outlined in their ethical code. Even if you believe that the situations described here do not apply to you and me, please read them carefully before signing this agreement. Ask me questions about anything in this agreement.

Confidentiality

One of the primary reasons you come to see me is to have a private place to talk about a problem. I understand that you may talk to me about experiences that you have never shared with anyone else and may express feelings and thoughts you have never shared with anyone else. I want to give you a safe place to talk and feel and make decisions.

I agree to obtain your written or, in the case of a life-threatening emergency, your oral permission before talking to anyone about what you tell me. That permission applies to family, friends, and other professionals.

Limitations to Confidentiality

In certain situations I will not be able to keep the above agreement to obtain your permission before talking to someone else about what you tell me.

The first limitation is my responsibility to preserve life whenever possible. If you tell me about a homicide threat (to you or someone else), plans to commit suicide (either your or someone else’s) or an incident of child abuse (either to you or someone else), I will call the police if the threat is immediate. I am also required by state law to call Child Protective Services to report any incident of child abuse. I will ask you to make the call, or to use a lawyer to make the report, but if you are unwilling to prevent the violence, I will take action myself. I will notify any potential victim of violence, as well as close family members if the individual is a minor.

The second limitation to confidentiality is based on my need to consult with other professional in order to provide you with quality care. I receive supervision from ________________ regularly in order to improve my work with clients. I do not reveal the names of my clients during this supervision. If there is a reason you do not want me to talk to these people, we will need to arrange for me to consult with another professional of your choice.

The third limitation is that I take brief notes of our sessions together, including information about homework assignments, threats to life and conflicts between us that may arise as we work together. These notes may be subpoenaed by a lawyer if you are involved in a court case. Also if you submit a claim to an insurance company to cover my fee, the company will likely ask me for a psychological diagnosis, which will mean that information about you will be stored in the company computer.
Limits of Our Relationship

Our professional relationship is different than a relationship you may have with a family member or a friend. I am willing to listen and to help you to solve problems, but we will not have a relationship after we stop working together. We make a trade: I give you a safe place to talk without being judged, and you agree at some point to say good-bye to me.

If we meet at a social gathering or in a public place, I will say "hello" but not encourage conversation with you, unless you initiate such conversation. Remember that I am not judging you or thinking about what you have told me in my office in these situations. We can talk about these social contacts during our appointment time if you need to.

I will not agree to meet with you outside my office, unless we agree that working in a setting other than my office is necessary to meet a specific counseling goal. I might, for example, meet you in a shopping mall to help you overcome a fear of being in a public place. Under no circumstances is it appropriate for us to have sexual contact. Under no circumstances is it appropriate for us to barter or develop a business relationship.

My Availability in Addition to Our Counseling Appointments

When I am not working with you, I am working with another client, completing business tasks or taking time to rest and rejuvenate. I will set boundaries with you about contact between sessions. These boundaries may vary, depending on your situation and mine.

You may call and leave messages on my answering machine at any time. You may need to call for these reasons:

1. Make appointments or change appointment times.
2. Report the results of an agreement we made during sessions about something you would do after session. For example, we practice a conversation you are to have with a friend and later you call me to report how the conversation actually turned out.
3. Report emotional reactions or experiences that may happen between sessions that you want to tell me about but that do not require any action on my part except to listen.
4. Report progress you make or frustrations you may feel with the goals we have agreed on in session.

If you ask me to call you back, I will do so when I can. I return calls between 8:00 A.M. and 8:00 P.M., Monday through Thursday, during my office hours. Friday, Saturday, and Sunday are my days to rest and I will return calls when I am able to. If you require me to call you back more than three times while we work together, we will need to establish an individual agreement about how you can get support from other people in your life or make a different agreement about how we work together. For example, we may need to meet more frequently, or you may need to call me regularly the day after our session. If I am not able to provide sufficient care to meet your needs, I will help you find another counselor who can be more available to you between sessions.

There will be times when I will be on vacation or unavailable because of a family emergency. I will help you to identify someone to stand in for me when I have time to prepare for the absence. In the case of an emergency, a counselor will be available. You can find out who is standing in for me by calling and listening to the message on my answering machine. I will prepare the counselor who stands in for me if possible and will review with him or her what has happened during my absence when I return.
Payment for Services

My fee is ______ per session, and I ask that you pay each time we meet. I do not work on a sliding scale. I do not charge for missed appointments, but I will discuss with you whether or not we can continue to work together if you miss on a regular basis. If you have insurance coverage for mental health services, I will give you a bill when you pay me each time, and you can submit that bill with your insurance form to be reimbursed. You need to check with your insurance company to find out whether or not the coverage includes a certified _____________ in private practice.

Evaluation of Counseling Services

Even though you and I work together in good faith, there is no guarantee that you will make all the changes we identify that you want or need to make. My job is to help you identify goals and develop plans to reach them. Your job is to decide what plans will be useful to you and to carry out these plans, as you decide is best for you. You have the right to stop working with me or to ask to renegotiate our agreement at any time.

When we agree to end our work together, we will discuss what has been helpful and what has not, what further support you will need to continue to work on your goals, and how you might decide to resume working with me or another therapist.

During the time we meet together and after we complete our work together, I will ask you to complete evaluations of my work. These evaluations will help me to do a better job with you and with the other people I work with.

If at any time you have questions about what I am saying or asking you to do, please talk to me. if you do not feel safe talking to me, talk to another counselor or a friend.

If there is a conflict between us that we cannot resolve, I will ask you to meet with me and another counselor you feel safe with so that we can get help in deciding how to work together.

SIGNATURES

I understand the agreements in this document and agree to work with

______________________________ to meet these responsibilities.

Signed ______________________ Date: ______________________ Client

I understand the agreements stated in this document and agree to work with

______________________________ to meet these responsibilities.

Signed ______________________ Date: ______________________ Counselor
PART III: SOAP Progress Notes Form

PROGRESS NOTES

Client: ___________________________
Date: __________ Session No: ______

SUBJECTIVE REPORTING:  OBJECTIVE OBSERVATION:

ASSESSMENT/IMPRESSION  PLAN (Intervention)

TREATMENT
SELECTED BIBLIOGRAPHY


Hamman v. County of Maricopa, 161 Ariz. 53 (App., 1987).


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APPENDIX B

COVER LETTER TO PROFESSIONALS
11-01-90

Dear

I am preparing a handbook on ethics and Arizona State law for private mental health counselors. To help with this thesis project I am forming a fifteen-member advisory panel. Because of your experience as a professional counselor, I would like you to be one of the members of that group.

If you agree to be a member, I will contact you for advice on two occasions. Both contacts will be by mail. Of course, if you wish to advise me further I would welcome that advice.

My first contact with panel members will be in mid-to late November, 1990, and will require less than one-half hour of each member's time. This contact will involve reviewing and commenting upon a proposed one-page Table of Contents and one-page questionnaire. The second contact will be in February, 1991, and will involve reviewing and commenting on the second draft of the handbook.

Included with this letter is a copy of the project proposal for your information. In a few days I will telephone you to discuss your possible involvement in this project.

I look forward to your advice and I hope you have the time to participate in this project.

Sincerely,

Liz Christensen
Counseling and Guidance Masters Candidate
577-6128

Philip Lauver, Ph.D.
Thesis Committee Chair
APPENDIX C

COVER LETTER TO ADVISORY PANEL MEMBERS:
FIRST EVALUATION
Dear

Thank you for agreeing to be a member on the advisory panel. This is the first mailing which I would like you to read and critique. Please send your comments back to me at the above address.

Both the Questionnaire and the proposed Table of Contents will be sent to counselors in Tucson, some in Phoenix, and some in Flagstaff. I would like you to read both and make additions, deletions, and/or suggestions for alternate wording. All of your comments are welcome.

Before you critique the Questionnaire and Table of Contents, you may find it useful to know my purpose for surveying counselors throughout the State. First, I want some indication of the possible usefulness of such a handbook. Second, am I covering the areas counselors would like to know more about? Third, what are some of the standards by which "local" counselors practice?

Please call me if you have any questions or would like to meet with me in person. One of the advisory panel members expressed an interest in a group meetings of the members; please indicate if you would also like such a meeting.

Thank you for your help. Please return your comments by December 5, 1990.

Sincerely,

Liz Christensen
577-6128
APPENDIX D

QUESTIONNAIRE COVER LETTER
Dear

I am preparing a handbook on ethics and Arizona law for private mental health counselors. I perceive an information gap in these areas. This handbook is intended to bridge that gap. To help determine the scope of this handbook, I am asking for your advice. Your responses will be used in the handbook as illustrations to other counselors what professional practices are customary and usual in different communities throughout the state.

Included in this mailing is a proposed Table of Contents for the handbook and a questionnaire. The questionnaire is designed to be completed in less than ten minutes. Please read the Table of Contents, answer the questionnaire, and return it to me. For your convenience I have included a return envelope.

The questionnaire is anonymous; please do not put your name on it. If you wish to make any additional comments about the proposed handbook please do so on the back of the questionnaire. Of course, if you wish to contact me directly, I would welcome such contact.

I greatly appreciate your help on this project. If at any time in the future you would like any further information about this project, please don't hesitate to contact me.

Sincerely,

Elizabeth Christensen
Counseling and Guidance Masters Candidate
577-6128

Philip Lauver, Ph.D.
Thesis Committee Chair
APPENDIX E

QUESTIONNAIRE
1. In the past twelve months, have you had legal questions arise in your practice? yes no

2. If yes, did you seek an answer?  
   always  sometimes  never

3. If always or sometimes, are satisfactory answers relatively easy to find?  
   always  sometimes  never

4. How do you commonly find answers to legal issues that pertain to your practice?  
   (Please check all that apply)
   _____ Other counselors  _____ Libraries
   _____ Professional literature  _____ State Attorney General's office
   _____ Statutes and regulations  _____ Attorneys
   _____ Mailings from professional organizations
   _____ Other, please specify

5. How do you commonly handle ethical dilemmas? (Please check all that apply)
   _____ Follow ethical guidelines, which ones
   _____ Consult other counselors
   _____ Trust my own judgement
   _____ Review literature
   _____ Call an Attorney
   _____ Other, please specify

6. How important are the following when you make an ethical and/or legal decision in your practice? (Please rank in order of importance)
   _____ Client's best interest
   _____ Possibility of lawsuit
   _____ Possibility of complaint to professional organization
   _____ Personal ethics and values
   _____ Philosophy and/or standards in my workplace

7. What book(s) do you use most often in making legal and/or ethical decisions?  
   (Title/Author)

8. What kind of official notes do you keep on client's sessions? (Please check all those that apply)
   _____ None. Why not?
   _____ Specific Method (S.O.A.P., etc.), please specify
   _____ Brief, please describe
   _____ Detailed, please describe or send a sample
   _____ Clinical Notes not kept in official client file; where kept
9. Where did you learn your record-keeping system?

_____ Made up my own system       _____ Other professionals
_____ Graduate school            _____ Agencies
_____ Professional literature    
_____ Other, please specify ____________________________

10. Would you show a client her/his file upon request?

_____ None of it      _____ Part of it      _____ All of it
_____ Other, please specify ____________________________

11. Do you give your clients any of the following when they first come in? * (Please check all that apply)

_____ Disclosure statement
_____ Clients' rights pamphlet/handout
_____ Consent to treatment form
_____ Statement on confidentiality and its exclusions
_____ Other, please specify ____________________________

* Please send me a sample of handouts you give to your clients.

12. Do you get 3rd-party payments on your own signature?

   Yes  No

13. If no, do you get 3rd-party payments some other way?

   Please specify ____________________________

I am proposing to prepare a handbook on ethics and legal issues for Arizona mental health counselors.

14. Judging from the attached table of contents, would such a handbook be useful to you in your practice?  yes  no

15. If not, why not? ____________________________

16. What information would you like to see added to the proposed contents of the handbook?

   ____________________________

17. What kind of practice do you have?

_____ Private
_____ In partnership with others
_____ I currently work in an agency
_____ Other, please specify ____________________________

18. How long have you been practicing counseling? ________

19. What is your highest degree in the counseling field? ________

20. In which city do you practice? ____________________________

Please return by January 18, 1991 in the envelope provided.
Thank you for your response.
APPENDIX F

COVER LETTER TO ADVISORY PANEL MEMBERS:
SECOND EVALUATION
March 4, 1991

Dear

Thank you for your help in this second part of the handbook production. I am enclosing an evaluation sheet for each chapter of the handbook. Please complete them and return them to me. You may keep the enclosed copy of the handbook.

You will notice that the reference citations are in a strange code. If you would like an uncoded list of these references before the handbook becomes officially available please let me know and I will send it to you as soon as possible.

I would like to acknowledge your help on this project in the handbook. If I have your permission to include your name, please mark the appropriate box at the bottom of the first page of the evaluation form.

Please return your completed evaluation forms to me no later than Friday, March 15th. I realize that is less than two weeks away; if you are unable to complete it by then please call me. I will gladly pick up the evaluation forms from your office if you so request.

Please feel free to contact me if you wish to discuss the handbook.

Thank you again for your help.

Sincerely,

Elizabeth Christensen
4152 E. Coronado Drive
Tucson, Az 85718
577-6128
APPENDIX G

EVALUATION FORM
HANDBOOK EVALUATION FORM

Please return to Liz Christensen by Friday, March 15, 1991. Please call me if this is a problem. 577-6128

Send to:

Liz Christensen
4152 E. Coronado Drive
Tucson, AZ 85718

I give you permission to acknowledge my name in the handbook.

yes  no

If yes, please print your name and title as you would like them to appear.
1. Generally, I found the information: (please circle your response)

<table>
<thead>
<tr>
<th>Easy To Read</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Difficult To Read</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too Long</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Too Short</td>
</tr>
<tr>
<td>Fairly Clear</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Confusing In Parts</td>
</tr>
<tr>
<td>Informative</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Not Informative</td>
</tr>
</tbody>
</table>

2. The format is:

<table>
<thead>
<tr>
<th>Easy to Follow</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Difficult to Follow</th>
</tr>
</thead>
</table>

3. I would like more information about:

4. I would like less information about:

5. I would like more clarification on:

6. I would omit:

7. I would add:

Please use this space and the back for additional comments
SELECTED BIBLIOGRAPHY


Hamman v. County of Maricopa, 161 Ariz. 53 (App., 1987).


