Substance Abuse Counselor
Ethics, Confidentiality, and Boundaries

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Ethics for Professional Substance Abuse Counselors

(Based on various Codes of Ethics from Alcohol and Drug Boards throughout the U. S.)

NAADAC Code of Ethics

The Revised Code of Ethics is divided under major headings and standards. The sections utilized are:

I. The Counseling Relationship

It is the responsibility of the addiction professional to safeguard the integrity of the counseling relationship and to ensure that the client is provided with services that are most beneficial. The client will be provided access to effective treatment and referral giving consideration to individual educational, legal and financial resources needs. Addiction professionals also recognize their responsibility to the larger society and any specific legal obligations that may, on limited occasions, supersede loyalty to clients. The addiction professional shall provide the client and/or guardian with accurate and complete information regarding the extent of the potential professional relationship. In all areas of function, the addiction professional is likely to encounter individuals who are vulnerable and exploitable. In such relationships he/she seeks to nurture and support the development of a relationship of equals rather than to take unfair advantage. In personal relationships, the addiction professional seeks to foster self-sufficiency and healthy self-esteem in others. In relationships with clients he/she provides only that level and length of care that is necessary and acceptable.

Standard 1: Client Welfare

The addiction professional understands that the ability to do good is based on an underlying concern for the well being of others. The addiction professional will act for the good of others and exercise respect, sensitivity and insight. The addiction professional understands that the primary professional responsibility and loyalty is to the welfare of his or her clients, and will work

for the client irrespective of who actually pays his/her fees.

1. The addiction professional understands and supports actions that will assist clients to a better quality of life, greater freedom and true independence.
2. The addiction professional will support clients in accomplishing what they can readily do for themselves. Likewise, the addiction professional will not insist on pursuing treatment goals without incorporating what the client perceives as good and necessary.
3. The addiction professional understands that suffering is unique to a specific individual and not of some generalized or abstract suffering, such as might be found in the understanding of the disorder. On that basis, the action taken to relieve suffering must be uniquely suited to the suffering individual and not simply some universal prescription.
4. Services will be provided without regard to the compensation provided by the client or by a third party and shall render equally appropriate services to individuals whether they are paying a reduced fee or a full fee or are waived from fees.

Standard 2: Client Self Determination

The addiction professional understands and respects the fundamental human right of all individuals to self-determination and to make decisions that they consider in their own best interest. In that regard, the counselor will be open and clear about the nature, extent, probable effectiveness and cost of those services to allow each individual to make an informed decision about his or her care. The addiction professional works toward increased competence in all areas of professional functioning; recognizing that at the heart of all roles is an ethical commitment contributing greatly to the well-being and happiness of others. He/she is especially mindful of the need for faithful competence in those relationships that are termed fiduciary - relationships of special trust in which the clients generally do not have the resources to adequately judge competence.

1. The addiction professional will provide the client and/or guardian with accurate and complete information regarding the extent of the potential professional relationship, including the Code of Ethics and documentation regarding professional loyalties and responsibilities.

2. Addiction professionals will provide accurate information about the efficacy of treatment and referral options available to the client.
3. The addiction professional will terminate work with a client when services are no longer required or no longer serve the client's best interest.
4. The addiction professional will take reasonable steps to avoid abandoning clients who are in need of services. Referral will be made only after careful consideration of all factors to minimize adverse effects.
5. The addiction professional recognizes that there are clients with whom he/she cannot work effectively. In such cases, arrangements for consultation, co-therapy or referral are made.

6. The addiction professional may terminate services to a client for nonpayment if the financial contractual arrangements have been made clear to the client and if the client does not pose an imminent danger to self or others. The addiction professional will document discussion of the consequences of nonpayment with the client.

7. When an addiction professional must refuse to accept the client due to inability to pay for services, ethical standards support the addiction professional in attempting to identify other care options. Funding constraints might interfere with this standard.

8. The addiction professional will refer a client to an appropriate resource when the client's mental, spiritual, physical or chemical impairment status is beyond the scope of the addiction professional's expertise.

9. The addiction professional will foster self-sufficiency and healthy self-esteem in others. In relationships with clients, students, employees and supervisors, he/she strives to develop full creative potential and mature, independent functioning.

10. Informed Consent: The addiction professional understands the client's right to be informed about treatment. Informed consent information will be presented in clear and understandable language that informs the client or guardian of the purpose of the services, risks related to the services, limits of services due to requirements from a third party payer, relevant costs, reasonable alternatives and the client's right to refuse or withdraw consent within the time frames covered by the consent. When serving coerced clients, the addiction professional will provide information about the nature and extent of services, treatment options and the extent to which the client has the right to refuse services. When services are provided via technology such as computer, telephone or web-based counseling, clients are fully informed of the limitations and risks associated with these services. Client questions will be addressed within a reasonable time frame.

11. Clients will be provided with full disclosure including the guarantee of confidentiality if and when they are to receive services by a supervised person in training. The consent to treat will outline the boundaries of the client-supervisee relationship, the supervisee's training status and confidentiality issues. Clients will have the option of choosing not to engage in services provided by a trainee as determined by agency policies. Any disclosure forms will provide information about grievance procedures.

Standard 3: Dual Relationships

The addiction professional understands that the goal of treatment services is to nurture and support the development of a relationship of equals of individuals to ensure protection and fairness of all parties.

Addiction professionals will provide services to clients only in the context of a professional setting. In rural settings and in small communities, dual relationships are evaluated carefully and avoided as much as possible.

1. Because a relationship begins with a power differential, the addiction professional will not exploit relationships with current or former clients, current or former supervisees or colleagues for personal gain, including social or business relationships.
2. The addiction professional avoids situations that might appear to be or could be interpreted as a conflict of interest. Gifts from clients, other treatment organizations or the providers of materials or services used in the addiction professional's practice will not be accepted, except when refusal of such gift would cause irreparable harm to the client relationship. Gifts of value over $25 will not be accepted under any circumstances.
3. The addiction professional will not engage in professional relationships or commitments that conflict with family members, friends, close associates or others whose welfare might be jeopardized by such a dual relationship.
4. The addiction professional will not, under any circumstances, engage in sexual behavior with current or former clients.
5. The addiction professional will not accept as clients anyone with whom they have engaged in romantic or sexual relationships.
6. The addiction professional makes no request of clients that does not directly pertain to treatment (giving testimonials about the program or participating in interviews with reporters or students).
7. The addiction professional recognizes that there are situations in which dual relationships are difficult to avoid. Rural areas, small communities and other situations necessitate discussion of the counseling relationship and take steps to distinguish the counseling relationship from other interactions.
8. When the addiction professional works for an agency such as department of corrections, military, an HMO or as an employee of the client's employer, the obligations to external individuals and organizations are disclosed prior to delivering any services.
9. The addiction professional recognizes the challenges resulting from increased role of the criminal justice system in making referrals for addiction treatment. Consequently he/she strives to remove coercive elements of such referrals as quickly as possible to encourage engagement in the treatment and recovery process.
10. The addiction professional encourages self-sufficiency among clients in making daily choices related to the recovery process and self care.
11. The addiction professional shall avoid any action that might appear to impose on others' acceptance of their religious/spiritual, political or other personal beliefs while also encouraging and supporting participation in recovery support groups.

Standard 4: Group Standards

Much of the work conducted with substance use disorder clients is performed in group settings. Addiction professionals shall take steps to provide the required services while providing clients physical, emotional, spiritual and psychological health and safety..

1. Confidentiality standards are established for each counseling group by involving the addiction professional and the clients in setting confidentiality guidelines.

2. To the extent possible, addiction professionals will match clients to a group in which other clients have similar needs and goals.

Standard 5: Preventing Harm

The addiction professional understands that every decision and action has ethical implication leading either to benefit or harm, and will carefully consider whether decisions or actions have the potential to produce harm of a physical, psychological, financial, legal or spiritual nature before implementing them. The addiction professional recognizes that even in a life well lived, harm may be done to others by thoughtless words and actions, If he/she becomes aware that any word or action has done harm to anyone, he/she readily admits it and does what is possible to repair or ameliorate the harm except where doing so might cause greater harm.

1. The addiction professional counselor will refrain from using any methods that could be considered coercive such as threats, negative labeling and attempts to provoke shame or humiliation.
2. The addiction professional develops treatment plans as a negotiation with the client, soliciting the client's input about the identified issues/needs, the goals of treatment and the means of reaching treatment goals.
3. The addiction professional will make no requests of clients that are not necessary as part of the agreed treatment plan. At the beginning of each session, the client will be informed of the intent of the session. Collaborative effort between the client and the addiction professional will be maintained as much as possible.
4. The addiction professional will terminate the counseling or consulting relationship when it is reasonably clear that the client is not benefiting from the exchange.
5. The addiction professional understands the obligation to protect individuals, institutions and the profession from harm that might be done by others. Consequently there is awareness when the conduct of another individual is an actual or likely source of harm to clients, colleagues, institutions or the profession. The addiction professional will assume an ethical obligation to report such conduct to competent authorities.
6. The addiction professional defers to review by a human subjects committee (Institutional Review Board) to ensure that research protocol is free of coercion and that the informed consent process is followed. Confidentiality and deceptive practices are avoided except when such procedures are essential to the research protocol and are approved by the designated review board or committee.
7. When research is conducted, the addiction professional is careful to ensure that compensation to subjects is not as great or attractive as to distort the client's ability to make free decisions about participation.

II. Evaluation, Assessment and Interpretation of Client Data

The addiction professional uses assessment instruments as one component of the counseling/treatment process taking into account the client's personal and cultural background. The assessment process promotes the well-being of individual clients or groups. Addiction professionals base their recommendations/reports on approved evaluation instruments and procedures. The designated assessment instruments are ones for which reliability has been verified by research.

Standard 1: Scope of Competency
The addiction professional uses only those assessment instruments for which they have been adequately trained to administer and interpret.

Standard 2: Informed Consent
Addiction professionals obtain informed consent documentation prior to conducting the assessment except when such assessment is mandated by governmental or judicial entities and such mandate eliminates the requirement for informed consent.

When the services of an interpreter are required, addiction professionals must obtain informed consent documents and verification of confidentiality from the interpreter and client. Addiction professionals shall respect the client's right to know the results of assessments and the basis for conclusions and recommendations. Explanation of assessment results is provided to the client and/or guardian unless the reasons for the assessment preclude such disclosure or if it is deemed that such disclosure will cause harm to the client

Standard 3: Screening
The formal process of identifying individuals with particular issues/needs or those who are at risk for developing problems in certain areas is conducted as a preliminary procedure to determine whether or not further assessment is warranted at that time.

Standard 4: Basis for Assessment
Assessment tools are utilized to gain needed insight in the formulation of the most appropriate treatment plan. Assessment instruments are utilized with the goal of gaining an understanding of the extent of a person's issues/needs and the extent of addictive behaviors.

Standard 5: Release of Assessment Results
Addiction professionals shall consider the examinee's welfare, explicit understanding of the assessment process and prior agreements in determining where and when to report assessment results. The information shared shall include accurate and appropriate interpretations when individual or group assessment results are reported to another entity.

Standard 6: Release of Data to Qualified Professionals
Information related to assessments is released to other professionals only with a signed release of information form or such a release from the client's legal representative. Such information is released only to persons recognized as qualified to interpret the data.

Standard 7: Diagnosis of Mental Health Disorders
Diagnosis of mental health disorders shall be performed only by an authorized mental health professional licensed or certified to conduct mental health assessments or by a licensed or certified addictions counselor who has completed graduate level specific education on diagnosis of mental health disorders.

Standard 8: Unsupervised Assessments
Unless the assessment instrument being used is designed, intended and validated for self-administration and/or scoring, Addiction professional administered tests will be chosen and scored following the recommended methodology.

Standard 9: Assessment Security
Addiction professionals maintain the integrity and security of tests and other assessment procedures consistent with legal and contractual obligations.

Standard 10: Outdated Assessment Results
Addiction professionals avoid reliance on outdated or obsolete assessment instruments. Professionals will seek out and engage in timely training and/or education on the administration, scoring and reporting of data obtained through assessment and testing procedures. Intake data and other documentation obtained from clients to be used in recommending treatment level and in treatment planning are reviewed and approved by an authorized mental health professional or a licensed or qualified addiction professional with specific education on assessment and testing.

Standard 11: Cultural Sensitivity Diagnosis
Addiction professionals recognize that cultural background and socioeconomic status impact the manner in which client issues/needs are defined. These factors are carefully considered when making a clinical diagnosis. Assessment procedures are chosen carefully to ensure appropriate assessment of specific client populations During assessment the addiction professional shall take appropriate steps to evaluate the assessment results while considering the culture and ethnicity of the persons being evaluated.

Standard 12: Social Prejudice
Addiction professionals recognize the presence of social prejudices in the diagnosis of substance use disorders and are aware of the long term impact of recording such diagnoses. Addiction professionals refrain from making and/or reporting a diagnosis if they think it would cause harm to the client or others.

III. Confidentiality/Privileged Communication and Privacy

Addiction professionals shall provide information to clients regarding confidentiality and any reasons for releasing information in adherence with confidentiality laws. When providing services to families, couples or groups, the limits and exceptions to confidentiality must be reviewed and a written document describing confidentiality must be provided to each person. Once private information is obtained by the addiction professional, standards of confidentiality apply. Confidential information is disclosed when appropriate with valid consent from a client or guardian. Every effort is made to protect the confidentiality of client information, except in very specific cases or situations.

1. The addiction professional will inform each client of the exceptions to confidentiality and only make a disclosure to prevent or minimize harm to another person or group, to prevent abuse of protected persons, when a legal court order is presented, for purpose of research, audit, internal agency communication or in a medical emergency. In each situation, only the information essential to satisfy the reason for the disclosure is provided.
2. The addiction professional will do everything possible to safeguard the privacy and confidentiality of client information, except where the client has given specific, written, informed and limited consent or when the client poses a risk of harm to themselves or others.
3. The addiction professional will inform the client of his/her confidentiality rights in writing as a part of informing the client of any areas likely to affect the client's confidentiality.
4. The addiction professional will explain the impact of electronic records and use of electronic devices to transmit confidential information via fax, email or other electronic means. When client information is transmitted electronically, the addiction professional will, as much as possible, utilize secure, dedicated telephone lines or encryption programs to ensure confidentiality.
5. Clients are to be notified when a disclosure is made, to whom the disclosure was made and for what purposes.
6. The addiction professional will inform the client and obtain the client's agreement in areas likely to affect the client's participation including the recording of an interview, the use of interview material for training purposes and/or observation of an interview by another person.

7. The addiction professional will inform the client(s) of the limits of confidentiality prior to

recording an interview or prior to using information from a session for training purposes.

IV. Professional Responsibility

The addiction professional espouses objectivity and integrity and maintains the highest standards in the services provided. The addiction professional recognizes that effectiveness in his/her profession is based on the ability to be worthy of trust. The professional has taken time to reflect on the ethical implications of clinical decisions and behavior using competent authority as a guide. Further, the addiction professional recognizes that those who assume the role of assisting others to live a more responsible life take on the ethical responsibility of living a life that is more than ordinarily responsible. The addiction professional recognizes that even in a life well-lived, harm might be done to others by words and actions. When he/she becomes aware that any work or action has done harm, he/she admits the error and does what is possible to repair or ameliorate the harm except when to do so would cause greater harm. Professionals recognize the many ways in which they influence clients and others within the community and take this fact into consideration as they make decisions in their personal conduct.

Standard 1: Counselor Attributes

1. Addiction professionals will maintain respect for institutional policies and management functions of the agencies and institutions within which the services are being performed, but will take initiative toward improving such policies when it will better serve the interest of the client.

2. The addiction professional, as an educator, has a primary obligation to help others acquire knowledge and skills in treating the disease of substance use disorders.
3. The addiction professional, as an advocate for his or her clients, understands that he/she has an obligation to support legislation and public policy that recognizes treatment as the first intervention of choice for non-violent substance-related offenses.
4. The addiction professional practices honesty and congruency in all aspects of practice including accurate billing for services, accurate accounting of expenses, faithful and accurate reporting of interactions with clients and accurate reporting of professional activities.
5. The addiction professional recognizes that much of the property in the substance use disorder profession is intellectual in nature. In this regard, the addiction professional is careful to give appropriate credit for the ideas, concepts and publications of others when speaking or writing as a professional and as an individual.
6. The addiction professional is aware that conflicts can arise among the duties and rights that are applied to various relationships and commitments of his/her life. Priorities are set among those relationships and family, friends and associates are informed to the priorities established in order to balance these relationships and the duties flowing from them.

7. When work involves addressing the needs of potentially violent clients, the addiction professional will ensure that adequate safeguards are in place to protect clients and staff from harm.

8. Addiction professionals shall continually seek out new and effective approaches to enhance their professional abilities including continuing education research, and participation in activities with professionals in other disciplines. Addiction professionals have a commitment to lifelong learning and continued education and skills to better serve clients and the community.

9. The addiction professional respects the differing perspectives that might arise from professional training and experience other than his/her own. In this regard, common ground is sought rather than striving for ascendance of one opinion over another.

10. Addiction professionals, whether they profess to be in recovery or not, must be cognizant of ways in which their use of psychoactive chemicals in public or in private might adversely affect the opinion of the public at large, the recovery community, other members of the addiction professional community or, most particularly, vulnerable individuals seeking treatment for their own problematic use of psychoactive chemicals. Addiction professionals who profess to be in recovery will avoid impairment in their professional or personal lives due to psychoactive chemicals. If impairment occurs, they are expected to immediately report their impairment, to take immediate action to discontinue professional practice and to take immediate steps to address their impairment through professional assistance. (See Standard 2, item 3 below).

Standard 2: Legal and Ethical Standards

Addiction professionals will uphold the legal and ethical standards of the profession by being fully cognizant of all federal laws and laws that govern practice of substance use disorder counseling in their respective state. Furthermore, addiction professionals will strive to uphold not just the letter of the law and the Code, but will espouse aspirational ethical standards such as autonomy, beneficence, non-malfeasance, justice, fidelity and veracity.

1. Addiction professionals will honestly represent their professional qualifications, affiliations, credentials and experience.

2. Any services provided shall be identified and described accurately with no unsubstantiated claims for the efficacy of the services. Substance use disorders are to be described in terms of information that has been verified by scientific inquiry.

3. The addiction professional strives for a better understanding of substance use disorders and refuses to accept supposition and prejudice as if it were the truth.

4. The impact of impairment on professional performance is recognized; addiction professionals will seek appropriate treatment for him/herself or for a colleague. Addiction professionals support the work of peer assistance programs to assist in the recovery of colleagues or themselves.

5. The addiction professional will ensure that products or services associated with or provided by the member by means of teaching, demonstration, publications or other types of

media meet the ethical standards of this code.

6. The addiction professional who is in recovery will maintain a support system outside the work setting to enhance his/her own well-being and personal growth as well as promoting continued work in the professional setting.

7. The addiction professional will maintain appropriate property, life and malpractice insurance policies that serve to protect personal and agency assets.

Standard 3: Records and Data

The addiction professional maintains records of professional services rendered, research conducted, interactions with other individuals, agencies, legal and medical entities regarding professional responsibilities to clients and to the profession as a whole.

1. The addiction professional creates, maintains, disseminates, stores, retains and disposes of records related to research, practice, payment for services, payment of debts and other work in accordance with legal standards and in a manner that permits/satisfies the ethics standards established. Documents will include data relating to the date, time and place of client contact, the services provided, referrals made, disclosures of confidential information, consultation regarding the client, notation of supervision meetings and the outcome of every service provided.

2. Client records are maintained and disposed of in accordance with law and in a manner that meets the current ethical standards.

3. Records of client interactions including group and individual counseling services are maintained in a document separate from documents recording financial transactions such as client payments, third party payments and gifts or donations.

4. Records shall be kept in a locked file cabinet or room that is not easily accessed by professionals other than those performing essential services in the care of clients or the operation of agency.

5. Electronic records shall be maintained in a manner that assures consistent service and confidentiality to clients.

6. Steps shall be taken to ensure confidentiality of all electronic data and transmission of data to other entities.

7. Notes kept by the addiction professional that assist the professional in making appropriate decisions regarding client care but are not relevant to client services shall be maintained in separate, locked locations.

Standard 4: Interprofessional Relationships

The addiction professional shall treat colleagues with respect, courtesy, fairness and good faith and shall afford the same to other professionals.

1. Addiction professionals shall refrain from offering professional services to a client in counseling with another professional except with the knowledge of the other professional or after the termination of the client's relationship with the other professional.
2. The addiction professional shall cooperate with duly constituted professional ethics committees and promptly supply necessary information unless constrained by the demands of confidentiality.
3. The addiction professional shall not in any way exploit relationships with supervisees, employees, students, research participants or volunteers.

V. Working in a Culturally Diverse World

Addiction professionals, understand the significance of the role that ethnicity and culture plays in an individual's perceptions and how he or she lives in the world. Addiction professionals shall remain aware that many individuals have disabilities which may or may not be obvious. Some disabilities are invisible and unless described might not appear to inhibit expected social, work and health care interactions. Included in the invisible disabled category are those persons who are hearing impaired, have a learning disability, have a history of brain or physical injuries and those affected by chronic illness. Persons having such limitations might be younger than age 65. Part of the intake and assessment must then include a question about any additional factor that must be considered when working with the client.

1. Addiction professionals do not discriminate either in their professional or personal lives against other persons with respect to race, ethnicity, national origin, color, gender, sexual orientation, veteran status, gender identity or expression, age, marital status, political beliefs, religion, immigration status and mental or physical challenges.
2. Accommodations are made as needed for clients who are physically, mentally, educationally challenged or are experiencing emotional difficulties or speak a different language than the clinician.

VI. Workplace Standards

The addiction professional recognizes that the profession is founded on national standards of competency which promote the best interests of society, the client, the individual addiction professional and the profession as a whole. The addiction professional recognizes the need for ongoing education as a component of professional competency and development.

1. The addiction professional recognizes boundaries and limitations of their own

competencies and does not offer services or use techniques outside of their own professional competencies.

2. Addiction professionals recognize the impact of impairment on professional performance and shall be willing to seek appropriate treatment for oneself or for a colleague.

Working Environment

Addiction professionals work to maintain a working/therapeutic environment in which clients, colleagues and employees can be safe. The working environment should be kept in good condition through maintenance, meeting sanitation needs and addressing structural defects.

1. The addiction professional seeks appropriate supervision/consultation to ensure conformance with workplace standards.
2. The clerical staff members of the treatment agency hired and supervised by addiction professionals are competent, educated in confidentiality standards and respectful of clients seeking services.
3. Private work areas that ensure confidentiality will be maintained.

VII. Supervision and Consultation

Addiction professionals who supervise others accept the obligation to facilitate further professional development of these individuals by providing accurate and current information, timely evaluations and constructive consultation. Counseling supervisors are aware of the power differential in their relationships with supervisees and take precautions to maintain ethical standards. In relationships with students, employees and supervisees he/she strives to develop full creative potential and mature independent functioning.

1. Addiction professionals must take steps to ensure appropriate resources are available when providing consultation to others. Consulting counselors use clear and understandable language to inform all parties involved of the purpose and expectations related to consultation.

2. Addiction professionals who provide supervision to employees, trainees and other counselors must have completed education and training specific to clinical and/or administrative supervision. The addiction professional who supervises counselors in training shall ensure that counselors in training adhere to policies regarding client care.
3. Addiction professionals serving as supervisors shall clearly define and maintain ethical professional, personal and social relationships with those they supervise. If other professional roles must be assumed, standards must be established to minimize potential conflicts.
4. Sexual, romantic or personal relationships with current supervisees are prohibited.
5. Supervision of relatives, romantic partners or friends is prohibited.
6. Supervision meetings are conducted at specific regular intervals and documentation of

each meeting is maintained.

7. Supervisors are responsible for incorporating the principles of informed consent into the supervision relationship.

8. Addiction professionals who serve as supervisors shall establish and communicate to supervisees the procedures for contacting them, or in their absence alternative on-call supervisors.

9. Supervising addiction professionals will assist those they supervise in identifying counter-transference and transference issues. When the supervisee is in need of counseling to address issues related to professional work or personal challenges, appropriate referrals shall be provided.

VIII. Resolving Ethical Issues

The addiction professional shall behave in accordance with legal, ethical and moral standards for his or her work. To this end, professionals will attempt to resolve ethical dilemmas with direct and open communication among all parties involved and seek supervision and/or consultation as appropriate.

1. When ethical responsibilities conflict with law, regulations or other governing legal authority, addiction professionals should take steps to resolve the issue through consultation and supervision.

2. When addiction professionals have knowledge that another counselor might be acting in an unethical manner, they are obligated to take appropriate action based, as appropriate, on the standards of this code of ethics, their state ethics committee and the National Certification Commission.

3. When an ethical dilemma involving a person not following the ethical standards cannot be resolved informally, the matter shall be referred to the state ethics committee and the National Certification Commission.

4. Addiction professionals will cooperate with investigations, proceedings and requirements of ethics committees.

IX. Communication and Published Works

The addiction professional who submits for publication or prepares handouts for clients, students or for general distribution shall be aware of and adhere to copyright laws.

1. The addiction professional honestly respects the limits of present knowledge in public statements related to alcohol and drug abuse. Statements of fact will be based on what has been empirically validated as fact. Other opinions, speculations and conjectures related to the addictive process shall be represented as less than scientifically validated.
2. The addiction professional recognizes contributions of other persons to their written documents.
3. When a document is based on cooperative work, all contributors are recognized in documents or during a presentation.
4. The addiction professional who reviews material submitted for publication, research or other scholarly purposes must respect the confidentiality and proprietary rights of the authors.

X. Policy and Political Involvement

Standard 1: Societal Obligations

The addiction professional is strongly encouraged to the best of his/her ability, actively engage the legislative processes, educational institutions and the general public to change public policy and legislation to make possible opportunities and choice of service for all human beings of any ethnic or social background whose lives are impaired by alcoholism and drug abuse.

1. The addiction professional understands that laws and regulations exist for the good ordering of society and for the restraint of harm and evil and will follow them, while reserving the right to commit civil disobedience.
2. The one exception to this principle is a law or regulation that is clearly unjust, where compliance leads to greater harm than breaking a law.
3. The addiction professional understands that the determination that a law or regulation is unjust is not a matter of preference or opinion but a matter of rational investigation, deliberation and dispute, and will willingly accept that there may be a penalty for justified civil disobedience.

Standard 2: Public Participation

The addiction professional is strongly encouraged to actively participate in community activities designed to shape policies and institutions that impact on substance use disorders. Addiction professionals will provide appropriate professional services in public emergencies to the greatest extent possible.

Standard 3: Social and Political Action

The addiction professional is strongly encouraged to understand that personal and professional commitments and relationships create a network of rights and corresponding duties and will work to safeguard the natural and consensual rights of each individual within their community. The addiction professional, understands that social and political actions and opinions are an individual's right and will not work to impose their social or political views on individuals with whom they have a professional relationship.

This resource was designed to provide an ethics code and ethical standards that will be used by counseling professionals. These principles of ethical conduct outline the importance of having ethical standards and the importance of adhering to those standards. These principles can help professionals face ethical dilemmas in their practice and explore ways to avoid them.

Please use this resource and share it with your colleagues. For more information contact naadac@naadac.org or 800.548.0497.

Revised March 28, 2011
Page updated June 27, 2013.

CCBADC-ALCOHOL/DRUG COUNSELORS

CODE OF ETHICS/CONDUCT

(For all Alcohol/Drug Counselors: Certificants and Registrants)

Principle 1: Non-discrimination

The alcoholism and drug abuse counselor/registrant must not discriminate against clients or professionals based upon race, religion, age, sex, handicaps, national ancestry, sexual orientation or economic condition.

Principle 2: Responsibility

The alcoholism and drug abuse counselor/registrant must espouse objectivity and integrity, and maintain the highest standards in the services the counselor offers.

a. The alcoholism and drug counselor/registrant, as teacher, must recognize the counselor's primary obligation to help others acquire knowledge and skill in dealing with the disease of chemical dependency.
b. The alcoholism and drug abuse counselor/registrant, as practitioner, must accept the professional challenge and responsibility deriving from the counselor's work.
c. The alcoholism and drug counselor/registrant, who supervises others, accepts the obligation to facilitate further professional development of these individuals by providing accurate and current information, timely evaluations and constructive consultation.

Principle 3: Competence

The alcoholism and drug abuse counselor/registrant must recognize that the profession is founded on national standards of competence which promote the best interests of society, of the client, of the counselor and of the profession as a whole. The counselor/registrant must recognize the need for ongoing education as a component of professional competency.

a. The alcoholism and drug abuse counselor/registrant must prevent the practice of alcoholism and drug abuse counseling by unqualified and unauthorized persons.
b. The alcoholism and drug abuse counselor/registrant who is aware of unethical conduct or of unprofessional modes of practice must report such violations to the appropriate certifying authority.
c. The alcoholism and drug abuse counselor/registrant must recognize boundaries and limitations of counselor's competencies and not offer services or use techniques outside of these professional competencies.
d. The alcoholism and drug abuse counselor/registrant must recognize the effect of professional impairment on professional performance and must be willing to seek appropriate treatment for oneself or for a colleague. The counselor/registrant must support peer assistance programs in this respect.

Principle 4: Legal Standards and Moral Standards

The alcoholism and drug abuse counselor/registrant must uphold the legal and accepted moral codes, which pertain to professional conduct.

a. The alcoholism and drug abuse counselor/registrant must not claim directly or by implication, professional qualifications/affiliations that the counselor does not possess.
b. The alcoholism and drug abuse counselor/registrant must not use the affiliation with the California Certification Board of Alcohol/Drug Counselors (and/or CAADAC) for purposes that are not consistent with the stated purposes of the Association.
c. The alcoholism and drug abuse counselor/registrant must not associate with or permit the counselor's name to be used in connection with any services or products in a way that is incorrect or misleading.

d. The alcoholism and drug abuse counselor/registrant must not associate with the development or promotion of books or other products offered for commercial sale must be responsible for ensuring that such books or products are presented in a professional and factual way.

e. The alcoholism and drug abuse counselor/registrant must not attempt to secure certification or registration (or certification renewal) by fraud, deceit, or misrepresentation on any application or other documents submitted to the certifying organization whether engaged in by an applicant for certification or registration or in support of any application for certification or registration. Any altered documents as identified by staff in the application or renewal process will be denied immediately and reapplication may be required and the CCBADC Chairperson may deny application or reapplication as a result of such fraudulent activity.
f. The alcoholism and drug abuse counselor/registrant must not violate, attempt to violate, or conspire to violate any regulation or law adopted by the California Alcohol and Drug Program Administration or CCBADC Policies and/or Code of Ethics.

Principle 5: Public Statements

The alcoholism and drug abuse counselor/ registrant must respect the limits of present knowledge in public statements concerning alcoholism and other forms of drug addiction.

a. The alcoholism and drug abuse counselor/registrant who represents the field of AOD counseling to clients, other professionals, or to the general public must report fairly and accurately the appropriate information.
b. The alcoholism and drug abuse counselor/registrant must acknowledge and document materials and techniques used.
c. The alcoholism and drug abuse counselor/registrant who conducts training in alcoholism or drug abuse counseling skills or techniques must indicate to the audience the requisite training/qualifications required to properly perform these skills and techniques.

Principle 6: Publication Credit

The alcoholism and drug abuse counselor/registrant must assign credit to all who have contributed to the published material and for the work upon which the publication is based.

a. The alcoholism and drug abuse counselor/registrant must recognize joint authorship, major contributions of a professional character, made by several persons to a common project. The author who has made the principle contribution to a publication must be identified as a first listed.
b. The alcoholism and drug abuse counselor/registrant must acknowledge in footnotes or an introductory statement minor contributions of a professional character, extensive clerical or similar assistance and other minor contributions.
d. The alcoholism and drug abuse counselor/registrant must acknowledge, through specific citations, unpublished, as well as published material, that has directly influences the research or writing.
e. The alcoholism and drug abuse counselor/registrant who complies and edits for publication the contributions of others must list oneself as editor, along with the names of those who have contributed.

Principle 7: Client Welfare

The alcoholism and drug abuse counselor/registrant must respect the integrity and protect the welfare of the person or group with whom the counselor is working.

a. The alcoholism and drug abuse counselor/registrant must define for self and others the nature and direction of loyalties and responsibilities and keep all parties concerned informed of these commitments.
b. The alcoholism and drug abuse counselor/registrant, in the presence of professional conflict must be concerned primarily with the welfare of the client.

c. The alcoholism and drug abuse counselor/registrant must terminate a counseling or consulting relationship when it is reasonably clear that the client is not benefiting from it.
d. The alcoholism and drug abuse counselor/registrant, in referral cases, must assume the responsibility for the client's welfare either by termination by mutual agreement and/or by the client becoming engaged with another professional. In situations when a client refuses treatment, referral or recommendations, the alcohol and drug abuse counselor/registrant must carefully consider the welfare of the client by weighing the benefits of continued treatment or termination and must act in the best interest of the client.
e. The alcoholism and drug abuse counselor/registrant who asks a client to reveal personal information from other professionals or allows information to be divulged must inform the client of the nature of such transactions. The information released or obtained with informed consent must be used for expressed purposes only.
f. The alcoholism and drug abuse counselor/registrant must not use a client in a demonstration role in a workshop setting where such participation would potentially harm the client.
g. The alcoholism and drug abuse counselor/registrant must ensure the presence of an appropriate setting for clinical work to protect the client from harm and the counselor and the profession from censure.
h. The alcoholism and drug abuse counselor/registrant must collaborate with other health care professional(s) in providing a supportive environment for the client who is receiving prescribed medications.

Principle 8: Confidentiality

The alcoholism and drug abuse counselor/registrant must embrace, as a primary obligation, the duty of protecting the privacy of clients and must not disclose confidential information acquired, in teaching, practice or investigation.

a. The alcoholism and drug abuse counselor/registrant must inform the client and obtain agreement in areas likely to affect the client's participation including the recording of an interview, the use of interview material for training purposes, and observation of an interview by another person.
b. The alcoholism and drug abuse counselor/registrant must make provisions for the maintenance of confidentiality and the ultimate disposition of confidential records.
c. The alcoholism and drug abuse counselor/registrant must reveal information received in confidence only when there is clear and imminent danger to the client or to other persons, and then only to appropriate professional workers or public authorities.
d. The alcoholism and drug abuse counselor/registrant must discuss the information obtained in clinical or consulting relationships only in appropriate settings, and only for professional purposes clearly concerned with the case. Written and oral reports must present only data germane to the purpose of the evaluation and every effort must be made to avoid undue invasion of privacy.
e. The alcoholism and drug abuse counselor/registrant must use clinical and other material in classroom teaching and writing only when the identity of the persons involved is adequately disguised.

Principle 9: Client Relationships

The alcoholism and drug abuse counselor/registrant must inform the prospective client of the important aspects of the potential relationship.

a. The alcoholism and drug abuse counselor/registrant must inform the client and obtain the client's agreement in areas likely to affect the client's participation including the recording of an interview, the use of interview material for training purposes, and/or observation of an interview by another person.
b. The alcoholism and drug abuse counselor/registrant must inform the designated guardian or responsible person of the circumstances, which may influence the relationship, when the client is a minor or incompetent.
c. Dual Relationships:

i. The alcoholism and drug abuse counselor/registrant must seek to nurture and support the development of a relationship with clients as equals rather than to take advantage of individuals who are vulnerable and exploitable.
ii. The alcoholism and drug abuse counselor/registrant must not engage in professional relationships or commitments that conflict with family members, friends, close associates or others whose welfare might be jeopardized by such a dual relationship.
iii. Because all relationship begins with a power differential, the alcoholism and drug abuse counselor/registrant must not exploit relationships with current or former clients for personal gain, including social or business relationships.
iv. Engaging in sexual relations with a client or with a former client within two years from the termination date of therapy with the client, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of an alcohol and other drug counselor/registrant.
v. The alcoholism and drug abuse counselor/registrant must not accept gifts from clients, other treatment organizations or the providers of materials or services used in practice.

Principle 10: Inter-professional Relationships

The alcoholism and drug abuse counselor/registrant must treat colleagues with respect, courtesy and fairness, and must afford the same professional courtesy to other professionals.

a. The alcoholism and drug abuse counselor/registrant must not offer professional services to a client in counseling with another professional except with the knowledge of the other professional or after the termination of the client's relationship with the other professional.
b. The alcoholism and drug abuse counselor/registrant must cooperate with duly constituted professional ethics committees, staff requests and promptly supply necessary information unless constrained by the demands of confidentiality. Failure to cooperate with the committee or staff may result in immediate suspension until such time cooperation is given. Additionally, the alcoholism and drug abuse counselor/registrant may not use threatening gestures, behaviors or other forms of coercion with the committee, colleagues, members, staff or other individuals.
c. The alcoholism and drug abuse counselor/registrant must not in any way exploit relationships with supervisees, employees, students, research participants or volunteers.

Principle 11: Remuneration

The alcoholism and drug abuse counselor/registrant must establish financial arrangements in professional practice and in accordance with the professional standards that safeguard the best interests of the client, of the counselor and of the profession.

a. The alcoholism and drug abuse counselor/registrant must inform the client of all financial policies. In circumstances where an agency dictates explicit provisions with its staff for private consultations, clients must be made fully aware of these policies.
b. The alcoholism and drug abuse counselor/registrant must not send or receive any commission or rebate or any other form of remuneration for referral of clients for professional services. The counselor must not engage in fee splitting.
c. The alcoholism and drug abuse counselor/registrant in clinical or counseling practice must not use one's relationship with clients to promote personal gain or the profit of an agency or commercial enterprise of any kind.
d. The alcoholism and drug abuse counselor/registrant must not accept a private fee or any other gift or gratuity for professional work with a person who is entitled to such services though an institution or agency. The policy of a particular agency may make explicit provisions for private work with its client by members of its staff, and in such instances the client must be fully apprised of all policies affecting the client.

Principle 12: Societal Obligations CCBADC

The alcoholism and drug abuse counselor/registrant must advocate changes in public policy and legislation to afford opportunity and choice for all persons whose lives are impaired by alcoholism and other forms of drug addiction. The counselors must inform the public through active civic and professional participation in community affairs of the effects of alcoholism and drug addiction and must act to guarantee that all persons, especially the needy and disadvantaged, have access to the necessary resources and services. The alcoholism and drug abuse counselor/registrant must adopt a personal and professional stance, which promotes the well being of all human beings.

The CCBADC is comprised of certified counselors who, as responsible health care professionals, believe in the dignity and worth of human beings. In practice of their profession they assert that the ethical principles of autonomy, beneficence and justice must guide their professional conduct. As professionals dedicated to the treatment of alcohol and drug dependent clients and their families, they believe that they can effectively treat its individual and families manifestations. CCBADC certified counselors dedicate themselves to promote the best interest of their society, of their clients, of their profession, and of their colleagues.

CALIFORNIA AOD COUNSELORS: CERTIFICANTS AND REGISTRANTS–UNIFORM CODE OF CONDUCT
FINAL VERSION JUNE 29, 2009

Note: This code of conduct does not replace the existing Code of Ethics as defined by the CCBADC it merely enhances it. Additionally, the ***CCBADC requires the most stringent rules be applied whether defined by CCBADC Code of Ethics or ADP's Uniform Code of Conduct.***

This Code of Conduct shall prohibit registrants and certified alcohol and other drug (AOD) counselors from:

1. Securing a certification or registration by fraud, deceit, or misrepresentation on any application submitted to the certifying organization whether engaged in by an applicant for certification or registration or in support of any application for certification or registration.
2. Administering to himself or herself any controlled substance as defined in section 4021 of the Business and Professions Code, or using any of the dangerous drugs or devices specified in section 4022 of the Business and Professions Code or using any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a certification or holding a registration or certification, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or certification to conduct with safety to the public the counseling authorized by the registration or certification.
3. Gross negligence or incompetence in the performance of alcohol and other drug counseling.
4. Violating, attempting to violate, or conspiring to violate any regulation adopted by ADP.
5. Misrepresentation as to the type or status of certification or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity, and failure to state proper certification or licensure initials and numbers on business cards, brochures, websites, etc.
6. Impersonation of another by any counselor or registrant, or applicant for a certification or registration, or, in the case of a counselor, allowing any other person to use his or her certification or registration.
7. Aiding or abetting any uncertified or unregistered person to engage in conduct for which certification or registration is required.
8. Providing services beyond the scope of his/he registration or certification as an AOD counselor or his or her professional license, if the individual is a licensed counselor as defined in Secton13015.
9. Intentionally or recklessly causing physical or emotional harm to any client.
10. The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a counselor or registrant.
11. Engaging in sexual relations with a client or with a former client within two years from the termination date of therapy with the client, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of an alcohol and other drug counselor.

12. Engaging in a social or business relationship with clients, program participants, patients, or residents or other persons significant to them while they are in treatment and exploiting former clients, program participants, patients, or residents.
13. Verbally, physically or sexually harassing, threatening, or abusing any participant, patient, resident, their family members, other persons who are significant to them, or other staff members.
14. Failure to maintain confidentiality, except as otherwise required or permitted by law, including but not limited to Code of Federal Regulations, Title 42, Part 2.
15. Advertising that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived; makes a claim either of professional superiority or of performing services in a superior manner, unless that claim is relevant to the service being performed and can be substantiated with objective scientific evidence; makes a scientific claim that cannot be substantiated by reliable, peer reviewed, published scientific studies.
16. Failure to keep records consistent with sound professional judgment, the standards of the profession, and the nature of the services being rendered.
17. Willful denial of access to client records as otherwise provided by law.

CALIFORNIA CERTIFICATION BOARD OF ALCOHOL & DRUG COUNSELORS (CCBADC)

REGISTERED RECOVERY WORKER

SCOPE OF PRACTICE

PURPOSE

A. To assure a consistent standard of quality education, training and experience for the Registered Recovery Worker (RRW.)

B. Registration is necessary to safeguard the public health, safety, and welfare, and to protect the public from unauthorized service delivery by unqualified alcohol and drug service providers and unprofessional contact by alcohol and drug service requirements.

REQUIREMENTS

A. Competency requirements shall include the below listed functions taken from TAP 21 as listed below:
- Screening
- Intake
- Orientation
- Referral
- Consultation
- Case Management
- Crisis Intervention
- Client, Family & Community Education
- Reports & Record Keeping

B. The Registered Recovery Worker, as previously described, must renew registration annually by meeting the following criteria:
1. Documentation at a minimum of ten (10) contact hours of Personal Development skills.
2. Will ascribe to the RRW Code of Ethics and the RRW Scope of Practice/Uniform Code of Conduct at each registration renewal period.
3. The Registered Recovery Worker is required to become certified as an Alcohol and Drug Counselor within 5 years of the date of the initial registration.

ROLE OF THE REGISTERED RECOVERY WORKER

Under general supervision of appropriately qualified staff, the Registered Recovery Worker shall:

A. Assist and support clients with alcohol/drug abuse or dependence, their family members and others to:
1. attain and maintain abstinence as appropriate,
2. develop a program tailored to the individual in support of a recovery process,
3. affect an improved quality of living.

Under general supervision of appropriately qualified staff, the Registered Recovery Worker shall:

B. Provide quality assistance and support for clients with alcohol/drug abuse or dependence, their family members and others by the following means:
   1 . Providing current and accurate information and education on the disease of alcoholism and other drug dependency issues and recovery processes,
   2. Assisting in identifying and understanding the defense mechanisms that support addiction,
   3. Facilitating in self-exploration the consequences of alcoholism and other drug dependence,
   4. Utilizing the skills and knowledge in screening, intake, orientation, referral, consultation, case management, crisis intervention, client, family & community education, and report & record keeping,
   5. Assisting in relapse prevention planning and recognizing relapse symptoms and behavior patterns,
   6. Providing current and accurate information and education to identify and understand the roles of family members and others in the alcoholism/drug dependency system,
   7. Educating on how self-help groups, such as Alcoholics Anonymous, Al-Anon, Women for Sobriety, Narcotics Anonymous, Secular Organization for Sobriety, Co-dependents Anonymous, etc., complement alcoholism/drug addiction or dependency treatment as well as the unique role of each in the recovery process,
   8. Assisting clients in establishing life management skills to support a recovery process,
   9. Facilitating problem solving and the development of alternatives to alcohol/drug use or abuse and related problems of family members and others,
   10. Utilizing the appropriate skills to assist in developing sobriety life management and communication skills that support recovery, including:

Active Listening	Intervention	Leading	Confrontation
Summarizing	Feedback	Reflection	Concreteness
Empathy	Education		

   11. Maintaining appropriate records in a confidential manner,
   12. Providing all services in accordance with the Registering Authority (California Certification Board for Alcohol and Drug Abuse Counselors) signed Code of Ethics and Scope of Practice/Uniform Code of Conduct for Registered Recovery Workers.

C. Providing support as part of a treatment team and referring clients, family members and others to other appropriate health professionals as needed.

SETTING FOR DELIVERY OF SERVICES

A. The Registered Recovery Worker may provide the identified services to individuals with alcohol/drug addiction or dependence, their family members and others in:
   1. Hospitals,
   2. Agencies,
   3. Other facilities where alcohol and/or drug services are delivered.

DEFINITIONS

A. The RRW is a person who must be in the process of becoming certified and has five years from the date of registering with the Certifying Organization (CCBADC) received the required education which encompasses a competency-based core of knowledge and skills to assist alcohol/drug-affected persons, as well as those affected by the alcohol/drug affected person.

Certified Prevention Specialist Code of Ethics

(Adapted from the International Certification & Reciprocity Consortium)

PREAMBLE

The Principles of Ethics are a model of standards of exemplary professional conduct. These Principles of the Code of Ethical Conduct for Prevention Professionals express the professional's recognition of his or her responsibilities to the public, to service recipients, and to colleagues. They guide members in the performance of their professional responsibilities and express the basic tenets of ethical and professional conduct. The Principles call for commitment to honorable behavior, even at the sacrifice of personal advantage. These principles should not be regarded as limitations or restrictions, but as goals toward which Prevention Professionals should constantly strive. They are guided by core values and competencies that have emerged with the development of the field.

PRINCIPLE 1: Non-Discrimination

Prevention Specialists shall not discriminate against service recipients or colleagues based on race, religion, national origin, sex, age, sexual orientation, economic condition, or physical, medical, or mental disability. Prevention Specialists should broaden her/his understanding and acceptance of cultural and individual differences, and, in so doing, render services and provide information sensitive to those differences.

PRINCIPLE 2: Competence

Prevention Specialists shall observe the profession's technical and ethical standards, strive continually to improve personal competence and quality of service delivery, and discharge professional responsibility to the best of his/her ability. Competence is derived from a synthesis of education and experience. It begins with the mastery of a body of knowledge and skill competencies. The maintenance of competence requires a commitment to learning and professional improvement that must continue throughout the professional's life.

a. Prevention Specialists should be diligent in discharging responsibilities. Diligence imposes the responsibility to render services carefully and promptly, to be thorough, and to observe applicable technical and ethical standards.

b. Due care requires a Prevention Specialist to plan and supervise adequately and evaluate, to the extent possible, any professional activity for which she/he is responsible.

c. A Prevention Specialist should recognize limitations and boundaries of competencies and not use techniques or offer services outside of his/her competencies. Each professional is responsible for assessing the adequacy of her/his own competence for the responsibility to be assumed.

d. Ideally, Certified Prevention Specialists should supervise Prevention Specialists. When this is not available, Prevention Specialists should seek peer supervision or mentoring from other competent prevention professionals.

e. When a Prevention Specialist has knowledge of unethical conduct or practice on the part of an agency or Prevention Specialist, he/she has an ethical responsibility to report the conduct or practices to appropriate funding or regulatory bodies or to the public.

f. A Prevention Specialist should recognize the effect of impairment on professional performance and should be willing to seek appropriate treatment for her/himself.

PRINCIPLE 3: Integrity

To maintain and broaden public confidence, Prevention Specialists should perform all responsibilities with the highest sense of integrity. Personal gain and advantage should not subordinate service and the public trust. Integrity can accommodate the inadvertent error and the honest difference of opinion. It cannot accommodate deceit or subordination of principle.

a. All information should be presented fairly and accurately. Each Prevention Specialist should document and assign credit to all contributing sources used in published material or public statements.

b. Prevention Specialists should not misrepresent either directly or by implication professional qualifications or affiliations.

c. Where there is evidence of impairment in a colleague or a service recipient, a Prevention Specialist should be supportive of assistance or treatment.

d. A Prevention Specialist should not be associated directly or indirectly with any service, products, individuals, and organization in a way that is misleading.

PRINCIPLE 4: Nature of Services

Practices shall do no harm to service recipients. Services provided by Prevention Specialists shall be respectful and non-exploitive.

a. Services should be provided in a way which preserves the protective factors inherent in each culture and individual.

b. Prevention Specialists should use formal and informal structures to receive and incorporate input from service recipients in the development, implementation, and evaluation of prevention services.

c. Where there is suspicion of abuse of children or vulnerable adults, the Prevention Specialist shall report the evidence to the appropriate agency and follow up to ensure that appropriate action has been taken.

PRINCIPLE 5: Confidentiality

Confidential information acquired during service delivery shall be safeguarded from disclosure, including – but not limited to – verbal disclosure, unsecured maintenance of records, or recording of an activity or presentation without appropriate releases. Prevention Professionals are responsible for knowing the confidentiality regulations relevant to their prevention specialty.

PRINCIPLE 6: Ethical Obligations for Community and Society

According to their consciences, Prevention Specialists should be proactive on public policy and legislative issues. The public welfare and the individual's right to services and personal wellness should guide the efforts of Prevention Specialists to educate the general public and policy makers. Prevention Specialists should adopt a personal and professional stance that promotes health.

CALIFORNIA ASSOCIATION FOR
ALCOHOL/DRUG EDUCATORS
CODE OF ETHICS

Certified Addictions Treatment Counselor
(CATC, CATC-I, REGISTRANT, CPS, CCS)

The following Code of Ethics applies to the following individuals: certified AOD counselors holding a Certified Addictions Treatment Counselor (hereinafter referred to as "CATC") credential at any and all tier levels (I, II, III, IV, V and N); Certified Addictions Treatment Counselor Interns (hereinafter referred to as CATC-I); individuals registered to obtain certification by the California Association for Alcohol/Drug Educators (hereinafter referred to as "Registrant"); and individuals holding a CAADE Prevention Specialist (hereinafter referred to as "CPS") Credential and; individuals holding a Certified Clinical Supervisor (CCS) Credential.

Ethical Standards
Revised July 29, 2011

SPECIFIC PRINCIPLES

Principle 1: Non-Discrimination
The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS, shall not discriminate against clients or professionals based on race, religion, age, gender, disability, national ancestry, sexual orientation or economic condition.

A. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall be knowledgeable about disabling conditions, demonstrate empathy in interactions with clients with disabilities, and make available physical, sensory, and cognitive accommodations that allow clients with disabilities to receive services.

Principle 2: Responsibility
The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall espouse objectivity and integrity, and maintain the highest standards in the services the CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS offers.

A. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall maintain respect for institutional policies and management functions of the agencies and institutions within which the services are being performed, but may take appropriate initiative toward improving such policies when it will better serve the interest of the client.

B. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, and/or CPS shall not verbally, physically, or sexually harass, threaten, or abuse another staff member.

C. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, and/or CPS who is aware of unethical conduct or unprofessional modes of practice shall report such inappropriate behavior to the appropriate authority.

D. An applicant who sits for the CATC examination shall be responsible for assuring that he/she has met all of the requirements for certification except passage of that examination, and that he/she has appropriately documented his/her compliance.

Principle 3: Competence
The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall recognize that the profession is founded on national standards of competency which promote the best interests of society, of the client, of the CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS and of the profession as a whole. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall recognize the need for ongoing education and clinical supervision as a component of professional competency.

A. The CATC (I, II, III, IV, V, N), Registrant, and/or C.P.S shall recognize professional boundaries and limitations of the CATC's, Registrant's, and/or CPS' competencies and only offer/provide services or use techniques within the scope of his/her registration or certification as an AOD counselor.

B. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall be sensitive to the potential harm to clients of any personal impairment and shall be willing to seek appropriate treatment for himself/herself. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall support employee assistance programs in this respect.

Principle 3.5: Supervision
Any experience obtained under the supervision of a spouse or relative by blood or marriage shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has a personal relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience.

Principle 4: Legal and Ethical Standards
The CATC (I, II, III, IV, V, N), Registrant, and/or C.P.S shall abide by and uphold the ethical standards contained in this Code of Conduct.

A. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall be fully cognizant and abide by all state and federal laws and laws governing the practice of alcoholism and drug abuse counseling, including but not limited to regulations protecting participant's, patient's, or resident's rights to confidentiality in accordance with the Code of Federal Regulations, Title 42, Part 2, Sections 2.1 et seq., and the Counselor Certification Regulations in the California Code of Regulations, Title 9, Sections 13000 et seq.

B. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall not claim either directly, or by implication, professional qualifications/affiliations that the CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS does not possess.

C. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS will not use, possess, or be under the influence of alcohol or illicit drugs on program premises or while attending or conducting program services.

D. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS and/or CCS shall cooperate with investigations into alleged violations of this Code of Conduct, whether initiated by the California Department of Alcohol and Drug Programs, or the California Association of Alcohol/Drug Educators, and shall supply information requested during the course of any investigation unless disclosure of the information would violate the confidentiality requirements of the Code of Federal Regulations, Title 42,

Part 2, Sections 2.1 et seq. By registering with, or being certified by CAADE, Registrant, CATC (I, II, III, IV, V, N), and/or CPS authorizes CAADE to release any and all information CAADE, its board, or its agents possess, and hereby releases CAADE, its board, or its agents from any liability therefor.

Principle 5: Publication Credit
The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall assign credit to all who have contributed to the published material and for the work upon which the publication is based.

A. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS who publishes books or articles and/or makes professional presentations will assure that all sources of information and contributions are properly cited.

Principle 6: Client Welfare
The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall hold the welfare of the client paramount when making any decisions or recommendations concerning referral, treatment procedures or termination of treatment.

A. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall disclose to clients that she/he operates under a code of ethics and that same shall be made available to the client if requested.

B. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall terminate a counseling or consulting relationship when it is reasonably clear to the CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS that the client is not benefiting from the relationship.

C. The CATC (I, II, III, IV, V, N)I, CATC-I, Registrant, CPS, and/or CCS shall not use or encourage a client's participation in any demonstration, research, or other non-treatment activities when such participation would have potential harmful consequences for the client or when the client is not fully informed.

D. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall take care to provide services in an environment that will ensure the privacy and safety of the client at all times, and ensures the appropriateness of service delivery.

E. The CATC (I, II, III, IV, V, N), Registrant, and/or CPS shall not verbally, physically, or sexually harass, threaten, or abuse a client, a client's family members, or any other person known to be significant to the client.

Principle 7: Confidentiality
The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS working in the best interest of the client shall embrace, as a primary obligation, the duty of protecting client's rights under confidentiality and shall not disclose confidential information acquired in teaching, practice, or investigation without appropriately executed consent.

A. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall provide the client his/her rights regarding confidentiality, in writing, as part of informing the client in any areas likely to affect the client's confidentiality. This includes the recording of the clinical interview, the use of material for insurance purposes, and the use of material for training or observation by another party.

B. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall make appropriate provisions for the maintenance of confidentiality and the ultimate disposition of confidential records. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall ensure that data obtained, including any form of electronic communication, are secured by the available security methodology. Data shall be limited to information that is necessary and appropriate to the services being provided, and shall be accessible only to appropriate personnel.

C. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall adhere to all federal and state laws regarding confidentiality and the CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS' responsibility to report clinical information in specific circumstances, such as child or elder abuse or duty to warn, to the appropriate authorities and their supervisor.

D. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall discuss the information obtained in clinical, consulting, or observational relationships only in appropriate settings for professional purposes and on a need-to-know basis. Written and oral reports must present only data germane and pursuant to the purpose of evaluation, diagnosis, progress, and compliance. Every effort shall be made to avoid undue invasion of privacy.

E. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall use clinical and other material in teaching and/or writing only when there is no identifying information used about the parties involved.

Principle 8: Client Relationships
It is the responsibility of the CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS to safeguard the integrity of the counseling relationship and to ensure that the client has reasonable access to effective treatment. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall provide the client and/or guardian with accurate and complete information regarding the extent of the potential professional relationship.

A. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall inform the client and obtain the client's agreement in areas likely to affect the client's participation, including the recording of an interview, the use of interview material for training purposes, and/or observation of an interview by another person.

B. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall not engage in dual relationships with clients that have any significant probability of causing harm to the client, or the counseling relationship. A dual relationship occurs when a CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS and his/her client engage in a separate and distinct relationship, either simultaneously with the therapeutic relationship or within two years following the termination of the professional relationship. As a general rule, a CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS should not provide services to friends, family members, or any person with whom they have or have had a social, business, or financial relationship.

C. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall not exploit relationships with current or former clients for personal or financial gain, including social or business relationships. This could include, but not be limited to, borrowing from or loaning money to clients; accepting gifts from clients; accepting favors from clients such as volunteer labor; or accepting goods or

services in lieu of payment.

D. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall not under any circumstances engage in sexual behavior (both verbal and non-verbal) with clients, clients' family members, or other persons known to be significant to the client, either simultaneously with the therapeutic relationship or within two years following the termination of the professional relationship.

(i)The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS does not engage in sexual intimacies with former clients even after a two-year interval except in the most unusual circumstances. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS who engages in such activity after the two years following cessation or termination of counseling and of having no sexual contact with the former client bears the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since counseling terminated; (2) the nature, duration, and intensity of the counseling; (3) the circumstances of termination; (4) the client's personal history; (5) the client's current mental status; (6) the likelihood of adverse impact on the client; and (7) any statements or actions made by the CATC (I, II, III, IV, V, N), CATC-I, during the course of counseling suggesting or inviting the possibility of a post-termination sexual or romantic relationship with the client.

E. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall not accept as clients anyone with whom they have engaged in sexual behavior.

F. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS will avoid dual relationships with current or past clients in self-help based recovery groups (such as A.A., N.A., Al-Anon, Smart Recovery, etc.) by not sponsoring a current or former client; by not having as a client a former sponsor or sponsee; by avoiding meetings, whenever possible, where clients are present; and by maintaining clear and distinct boundaries between the professional counselor and self-help sponsor roles.

G. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS will refrain from promoting or advocating any particular religious orientation or from utilizing any particular religious doctrine as part of a treatment program, except in those circumstances where such a religious orientation is an accepted part of the program's mission and clients have voluntarily agreed to participate in such a program.

Principle 9: Interprofessional Relationships
The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall treat colleagues with respect, courtesy, fairness, and good faith and shall afford the same to other professionals.

A. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall refrain from offering professional services to a client in counseling with another professional except with the knowledge of the other professional or after the termination of the client's relationship with the other professional.

B. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall cooperate with duly constituted professional ethics committees and promptly supply necessary information unless constrained by the demands of confidentiality.

C. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall not in any way exploit relationships with supervisees, employees, students, research participants, volunteers, or clients.

D. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall seek resolution of workplace or professional issues in an appropriately assertive, understanding, and sensitive manner, utilizing established protocols when such exist.

Principle 10: Financial Arrangements

A. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall inform the client of all financial policies.

B. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall consider the ability of a client to meet the financial cost in establishing rates for professional services (sliding fee scale).

C. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall not engage in fee splitting. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall not send or receive any commission or rebate or any other form of remuneration for referral of clients for professional services.

D. The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS, in the practice of counseling, shall not at any time use one's relationship with clients for personal gain or for the profit of an agency or any commercial enterprise of any kind.

Principle 11: Societal Obligations

The CATC (I, II, III, IV, V, N), CATC-I, Registrant, CPS, and/or CCS shall to the best of his/her ability actively engage the legislative processes, educational institutions, and the general public to change public policy and legislation to make possible opportunities and choice of service for all human beings of any ethnic or social background whose lives are impaired by alcoholism and/or drug abuse.

Preamble:

The Florida Certification Board (referred to herein as "the Board" or "FCB") provides certification for substance abuse counselors, prevention specialists, behavioral health technicians, and criminal justice professionals in the State of Florida. The purpose of the FCB's voluntary certification process is to assure consumers, the public, and employers that individuals certified by FCB are capable and competent, have been through a certain organized set of experiences, and have been judged to be qualified. FCB is dedicated to the principle that professionals in the field of alcohol and drug treatment must conform their behavior to the highest standards of ethical practice. To that end, the FCB has adopted this *Certified Professional Code of Ethics* (referred to herein as "the Code" or "the Code of Ethics"), to be applied to all professionals, certified or seeking certification.

The Board is committed to investigate and sanction those certified professionals or those seeking certification who breach this Code. Certified professionals or those seeking certification are therefore encouraged to thoroughly familiarize himself/herself with the Code and to guide their behavior according to the Rules set forth within this Code.

The FCB's Disciplinary Procedures are available for download at http://www.flcertificationboard.org/Ethics.cfm. Complaint Forms and Procedures may also be found at this site.

Glossary

Consumer	Any person seeking or assigned the services of a FCB certified professional or person seeking certification, regardless of the certified professional or person seeking certification's work setting.
Complainant	A person who files a formal complaint with the FCB against a certified professional or a person seeking certification under FCB jurisdiction.
Certified Professional	Any person who holds any credential issued by FCB.
Ethics Committee	FCB standing committee charged with the responsibility of sanctioning certified professionals or persons seeking certification who breach the Code of Ethics, as well as amending and reviewing all appropriate documentation, and charged with all other responsibilities deemed necessary.
Hearing Officer	A non-voting member of a Hearing Committee appointed by the Board who presides over a Respondent's appeal hearing. The Hearing Officer may or may not be a certified professional.
Immediate Family	A spouse, child, parents, parent-in-laws, siblings, grandchild, grandparents, and other household members of the Certified Professional or Person Seeking Certification.

Person Seeking Certification	Any individual who has an application for certification, at any level, on file with the FCB.
Respondent	A certified professional or person seeking certification who is the subject of a formal complaint alleging a breach of the Code of Ethics.
Sexual Misconduct	When a certified professional or person seeking certification engages, attempts to engage, or offers to engage a consumer in sexual behavior, or any behavior, whether verbal or physical, which is intended to be sexually arousing, including kissing; sexual intercourse, either genital or anal; cunnilingus; fellatio; or the touching by either the professional or person seeking certification or the consumer of the other's breasts, genital areas, buttocks, or thighs, whether clothed or unclothed.
Supervisee	An individual that works under the direct supervision of a certified professional, and works in the capacity of delivering direct services to consumers of addiction services.

Rules of Conduct

The following Rules of Conduct, adopted by the Florida Certification Board, set forth the minimum standards of conduct which all certified professionals or those seeking certification are expected to honor. Failure to comply with an obligation or prohibition set forth in the Rules may result in discipline by the FCB.

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

1. Applicability

1.1 The rules within this FCB *Certified Professional Code of Ethics* apply to all professionals certified by or seeking certification through FCB.

2. Professional Standards

2.1 A certified professional or person seeking certification shall meet and comply with all terms, conditions, or limitations of any professional certification or license which they hold.

2.2 A certified professional or person seeking certification shall not perform services outside of their area of training, expertise, competence, or scope of practice.

2.3 A certified professional or person seeking certification shall not fail to obtain an appropriate consultation or make an appropriate referral when the consumer's problem is beyond the area of training, expertise, competence, or scope of practice of the certified professional or person seeking certification.

2.4 A certified professional or person seeking certification shall not in any way participate in discrimination on the basis of race, color, sex, sexual orientation, age, religion, national origin, socio-economic status, political belief, psychiatric or psychological impairment, physical disability, or the amount of previous therapeutic or treatment occurrences.

2.5 Through the awareness of the negative impact of racial, sexual, religious, gender, marital status, nationality or physical stereotyping and discrimination, the addiction professional guards the individual rights and personal dignity of the client and/or participant(s). When client/participant(s) possess diverse or non-familiar cultural and ethnic backgrounds, addiction professionals are motivated to learn about cultural and ethnic sensitivities in order to provide the highest level of care.

2.6 A certified professional or person seeking certification shall seek therapy for any psychoactive substance abuse or dependence, psychiatric or psychological impairment, emotional distress, or for any other physical health related adversity that interferes with their professional functioning, and where any such conditions exist and impede their ability to function competently, a certified professional or person seeking certification shall request inactive status for medical reasons for so long as is necessary.

2.7 A certified professional or person seeking certification has a responsibility both to the client and/or participant(s) and to the organization within which the service is performed to maintain a high standard of ethical conduct. The moral, ethical and legal standards of behavior of the certified professional or person seeking certification 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 addiction professionals or those seeking certification held by the general public. This includes:

a. Awareness of the prevailing community standards and of the possible impact upon the quality of professional services provided by their conformance to or deviation from these standards;

b. Serve as a role model in the certified professionals or person seeking certifications' use of alcohol or other mood altering drugs.

c. Reporting to an employer, supervisor, colleague or the addiction professional or person seeking certification's intervention program when difficulty with mood altering substance(s) are experienced

2.8 The certified professional or person seeking certification shall not discontinue professional services to a consumer nor shall the certified professional or person seeking certification abandon the consumer without facilitating an appropriate therapeutic closure of professional services for the consumer.

2.9 A certified professional or person seeking certification shall not reveal confidential information obtained as the result of a professional relationship, without the prior written consent from the recipient of services, except as authorized or required by law.

3. Unlawful Conduct

3.1 Being convicted or found guilty, regardless of adjudication, or entering a plea of nolo contendere to any crime relating to the certified professional or person seeking certification's ability to practice the substance abuse counseling profession to include intervention, prevention, and criminal justice services shall be grounds for disciplinary action.

3.2 A certified professional or person seeking certification shall not use, possess, or sell any controlled or psychoactive substance. Being convicted or found guilty, regardless of adjudication, or entering a plea of nolo contendere to any crime which involves the use of any controlled or psychoactive substance shall be grounds for disciplinary action.

3.3 If a certified professional or person seeking certification is reprimanded by any agency or organization through any administrative proceedings, this may be grounds for disciplinary action by this body.

4. Sexual Misconduct

4.1 A certified professional or person seeking certification shall not engage in any form of sexual contact/behavior (as defined in Section I, *Sexual Misconduct*) with consumers. The prohibition shall apply with respect to any consumer of the agency by which the certified professional or person seeking certification is employed, regardless of whether or not the consumer is on their caseload. For the purposes of determining the existence of sexual misconduct the professional-consumer relationship, once established, is deemed to continue for a minimum of 2 years after the termination of services or the date of the last professional contact with the consumer.

4.2 A certified professional or person seeking certification shall not:

a. Engage a supervisee in sexual misconduct (as defined in the Code's Glossary) during the period a supervisory relationship exists.

b. Engage in sexual misconduct (as defined in the Code's Glossary) with any immediate family member or guardian of a consumer during the period of time services are being rendered to the consumer, during the entire professional consumer relationship pursuant to rule 4.1.

5. Fraud-Related Conduct

5.1 A certified professional or person seeking certification shall not:

a. Present or cause to be presented a false or fraudulent claim, or any proof in support of such claim, to be paid under any contract or certificate of insurance;

b. Prepare, make or subscribe to a false or fraudulent account, certificate, affidavit, proof of loss or other document or writing, with knowledge that the same may be presented or used in support of a claim for payment under a policy of insurance; or

c. Present or cause to be presented a false or fraudulent claim or benefit application, or any false or fraudulent proof in support of such a claim or benefit application, or false or fraudulent information which would affect a

future claim or benefit application, to be paid under any employee benefit program.

5.2 A certified professional or person seeking certification shall not use misrepresentation in the preparation of an application for certified professional certification or in the procurement of certification or recertification as an alcohol or drug certified professional, or assist another in the preparation of an application for certification or in the procurement of registration, certification or re-certification through misrepresentation. The term "misrepresentation" includes but is not limited to the misrepresentation of professional qualifications, certification, accreditation, affiliations, employment experience, educational experience, the plagiarism of application and recertification materials, or the falsification of references.

5.3 A certified professional or person seeking certification shall not use a title designation, credential or license, firm name, letterhead, publication, term, title, or document which states or implies an ability, relationship, or qualification that does not exist.

5.4 A certified professional or person seeking certification shall not practice under a false name or under a name other than the name under which his or her certification or license is held.

5.5 A certified professional or person seeking certification shall not sign or issue in the professional capacity a document or a statement that the certified professional or person seeking certification knows or should have known to contain a false or misleading statement.

5.6 A certified professional or person seeking certification shall not produce, publish, create, or partake in the creation of any false, fraudulent, deceptive, or misleading advertisement.

6. Exploitation of Consumers

6.1 A certified professional or person seeking certification shall not develop, implement, or maintain exploitative relationships with current or past consumers.

6.2 A certified professional or person seeking certification shall not misappropriate property from a consumer.

6.3 A certified professional or person seeking certification shall not enter into a relationship with a consumer which involves financial gain to the certified professional or person seeking certification or a third party resulting from the promotion or the sale of services unrelated to treatment or of goods, property, or any psychoactive substance.

6.4 A certified professional or person seeking certification shall not promote to a consumer for personal gain, any unnecessary, ineffective or unsafe psychoactive substance, or any unnecessary, ineffective or unsafe device, treatment, procedure, product or service.

6.5 A certified professional or person seeking certification shall not solicit gifts or favors from consumers.

6.6 A certified professional or person seeking certification shall not offer, give, or receive commissions, rebates, or any other forms of remuneration for a consumer referral.

7. Safety & Welfare

7.1 In circumstances where the certified professional or person seeking certification becomes aware, during the course of providing or supervising professional services, that a condition of clear and imminent danger exists that a consumer may inflict serious bodily harm on another person or persons, the certified professional or person seeking certification shall, consistent with federal and state regulations concerning the confidentiality of alcohol and drug counseling records, take reasonable steps to warn any likely victims of the consumer's behavior.

7.2 In circumstances where the certified professional or person seeking certification becomes aware, during the course of providing or supervising professional services, that a condition of clear and imminent danger exists that a consumer may inflict serious bodily harm to himself or herself, the certified professional or person seeking certification shall, consistent with federal and state regulations concerning the confidentiality of alcohol and drug counseling records, take reasonable steps to protect that consumer.

7.3 A certified professional or person seeking certification shall not administer to himself or herself any psychoactive substance to the extent or in such manner as to be dangerous or injurious to a consumer of services, to any other person, or to the extent that such use of any psychoactive substance impairs the ability of the certified professional or person seeking certification to safely and competently provide professional counseling services.

8. Records Management

8.1 A certified professional or person seeking certification shall not falsify, amend, knowingly make incorrect entries, or fail to make timely essential entries into the consumer record.

8.2 A certified professional or person seeking certification shall follow all Federal and State regulations regarding consumer records.

9. Assisting Unlicensed Practice

9.1 A certified professional or person seeking certification shall not refer a consumer to a person that the certified professional or person seeking certification knows or should know is not qualified by training, experience, certification, or license to perform the delegated professional responsibility.

10. Discipline in Other Jurisdictions

10.1 A certified professional or person seeking certification shall not practice substance abuse counseling during the period of any denial, suspension, revocation, probation, or other restriction or discipline on certification, license,

or other authorization to practice issued by any certification authority or any state, province, territory, tribe, or the federal government.

11. Cooperation with the Board

11.1 A certified professional or person seeking certification shall cooperate in any investigation conducted pursuant to this Code of Ethics and a certified professional or person seeking certification shall not interfere with an investigation or a disciplinary proceeding or attempt to prevent a disciplinary proceeding or other legal action from being filed, prosecuted, or completed. Interference attempts may include but are not limited to:

a. the willful misrepresentation of facts before the disciplining authority or its authorized representative;
b. the use of threats or harassment against, or an inducement to, any consumer or witness in an effort to prevent them from providing evidence in a disciplinary proceeding or any other legal action;
c. the use of threats or harassment against, or an inducement to, any person in an effort to prevent or attempt to prevent a disciplinary proceeding or other legal action from being filed, prosecuted or completed.

11.2 A certified professional or person seeking certification shall report any violation of the Code of Ethics. Failure to report a violation may be grounds for discipline.

11.3 A certified professional or person seeking certification who has firsthand knowledge of the actions of a respondent or a complainant shall cooperate with a FCB complaint investigation or disciplinary proceeding. Failure or an unwillingness to cooperate in a FCB complaint investigation or disciplinary proceeding shall be grounds for disciplinary action.

11.4 A certified professional or person seeking certification shall not file a complaint or provide information to the FCB which the certified professional or person seeking certification knows or should have known is false or misleading.

11.5 In submitting any information to the Board, a certified professional or person seeking certification shall comply with any requirements pertaining to the disclosure of consumer information established by the federal or state government.

APPENDIX A
DISCUSSIONS

Rule 2.2 Discussion

A certified professional or person seeking certification should not use a modality or a technique if the certified professional or person seeking certification does not have the education, training, or skills to perform a modality or a technique in a competent or qualified manner.

Rule 2.3 Discussion

Most certified professionals or those seeking certification strive to achieve and maintain the highest level of professional competence. In order to provide the highest standard of therapy for consumers, certified professionals or those seeking certification must maintain the commitment to assess their own personal strengths, limitations, biases, and effectiveness. When a certified professional or person seeking certification recognizes that a consumer's therapeutic needs exceed their education, training, and capabilities, the certified professional or person seeking certification must pursue advice and counsel from colleagues and supervisors. When a consumer's therapeutic issues are outside their level of professional functioning or scope of practice, the certified professional or person seeking certification must refer the consumer to another professional who will provide the appropriate therapeutic approach for the consumer.

Rule 2.7 Discussion

Private conduct of a certified professional or person seeking certification remains a personal matter to the same degree as any other person. However, when conduct compromises the fulfillment of professional responsibilities, the certified professional or person seeking certification bears the responsibility for any misconduct in all areas of their professional life. When a certified professional or person seeking certification's personal life begins to adversely affect professional performance, affecting the quality of service delivered, and thus putting the consumer at risk, the certified professional or person seeking certification must take sufficient and immediate action to resolve any personal adversity that interferes with their professional functioning. This may include but is not limited to seeking professional assistance or requesting inactive status for medical reasons.

The certified professional or person seeking certification should expect his or her employer to intervene when the certified professional or person seeking certification's personal problems begin to adversely affect their professional performance with consumers and coworkers

Rule 2.8
Discussion

The certified professional or person seeking certification shall not discontinue professional services to a consumer unless:
services have been completed;
the consumer requests the discontinuation;
alternative or replacement services are arranged; or the consumer is given reasonable opportunity to arrange alternative or replacement services.

Rule 2.9
Discussion

Except as may otherwise be indicated in this Code, certified professionals or those seeking certification are expected to preserve all consumer confidences and refrain from revealing confidential information obtained as a result of the certified professional-consumer or person seeking certification-consumer relationship, except as may be authorized by the consumer or required or authorized by law. Certified professionals or those seeking certification are expected to be familiar with and act in accordance with federal and state regulations concerning confidentiality of participant records and identifying information.

Rule 3.3
Discussion

Any public record pertaining to an arrest, charge, disposition or sentencing of a certified professional or person seeking certification, shall be deemed as conclusive evidence of guilt of the felony or misdemeanor for which he or she has been convicted. If that felony or misdemeanor relates to the individual's ability to practice the substance abuse counseling profession, the fact of conviction shall also be proof of violation of this Rule. Some specific examples within this section include but are not limited to crimes involving violence, use or sale of drugs, fraud, theft, sexual misconduct, or other felonies. All proceedings in which the sentence has been deferred, suspended, adjudication withheld, or a conviction expunged shall be deemed a conviction within the meaning of this section. For example, an AHCA investigation of a certified professional or person seeking certification could provide the independent grounds for an investigation.

Rule 4.1
Discussion

The Board finds that the effects of the certified professional-consumer or person seeking certification-consumer relationship can be powerful and subtle and that consumers can be influenced consciously and subconsciously by the unequal distribution of power inherent in such relationships. Furthermore, the Board finds that the effects of the establishment of a professional-consumer relationship can endure after services cease to be rendered. The certified professional or person seeking certification is responsible for acting in the best interest of the consumer even after the termination of services. The professional shall not engage in or request sexual contact with a former consumer at any time if engaging with that consumer would be exploitative, abusive or detrimental to that consumer's welfare. A certified professional-consumer or person seeking certification-consumer relationship is established between a professional and a person once a professional renders, or purports to render addictions, prevention, or criminal justice services including but not limited to, counseling, assessment, or treatment to that person. A formal contractual relationship, the scheduling of professional appointments or payment of a fee for services are not necessary conditions for the establishment of a professional-consumer relationship, although each of these may be evidence that such a relationship exists.

Rule 5.1
Discussion

The term "fraudulent claim" includes but is not limited to charging a consumer or a third-party payer for a service not performed or submitting an account or charge for services that is false or misleading. It does not include charging for an unkept appointment.

Rule 6.1
Discussion

Certified professionals or those seeking certification must remain "honest and self-searching in determining the impact of their behavior on the consumer. Ethical problems are often raised when a certified professional or person seeking certification blends his or her professional relationship with a consumer with another kind of relationship. Behavior is unethical when it reflects a lack of awareness or concern about the impact of the behavior on the consumers. Certified professionals or those seeking certification who engage in more than one role with consumers may be trying to meet their own financial, social, or emotional needs." (1993, Corey G., Corey M., and Callanan P.)

The nature of the consumer-professional relationship is such that the consumer remains vulnerable to the real or perceived influences of the certified professional or person seeking certification. Certified professionals or those seeking certification, who are in a position to influence a consumer's behavior, may impose their own desires upon the consumer.

Rule 6.5
Discussion

When a certified professional or person seeking certification "plays" or "preys" upon the consumer's gratitude for counseling services; or covertly or overtly implies or states that the consumer remains indebted to the certified professional or person seeking certification and should "repay" him or her through gifts or other favors, their unique position of trust and responsibility with the consumer not only becomes jeopardized, but the certified professional or person seeking certification has also engaged in actions antithetical to the counseling profession.

Rule 6.6
Discussion

Notwithstanding this provision, a certified professional or person seeking certification may pay an independent advertising or marketing agent compensation for advertising or marketing services rendered on their behalf by such agent, including compensation for referrals of consumers identified through such services on a per consumer basis.

Rule 7.1
Discussion

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

Rule 7.2
Discussion

If during the course of treating a participant, a certified professional or person seeking certification becomes aware that a consumer intends or is likely to inflict serious bodily harm to himself or herself and that there is a clear and imminent danger of such harm occurring, the certified professional or person seeking certification has a duty to take reasonable steps to protect the consumer. In doing so, the certified professional or person seeking certification should be aware that state and federal regulations set forth rules concerning the confidentiality of certified professional-consumer or person seeking certification-consumer communications and consumer records and identifying information.

Under those rules, it may be permissible in some cases to communicate information about an individual if done in a manner that does not disclose the individual's status as a participant in alcohol or drug abuse counseling. In other cases, however, in order to protect the consumer, it may be necessary for the certified professional or person seeking certification or their agency to make an emergency application to a court for an order permitting disclosure of information concerning the consumer or communications from the consumer before such information can be disclosed.

Rule 11.5
Discussion

The primary commitment of the certified professional or person seeking certification is to the health, welfare, and safety of a consumer. As an advocate for the consumer, the certified professional or person seeking certification must take appropriate action to report instances of incompetent, unethical, or illegal practice by other certified professionals or those seeking certification that places the rights or best interests of the consumer in jeopardy.

Iowa Board of Certification

CODE OF ETHICS
FOR ALCOHOL AND DRUG COUNSELORS

INTRODUCTION

All counselors must subscribe to the IBC Code of Ethics upon application for certification. This Code of Ethics is adopted to aid in the delivery of the highest quality of professional care to persons seeking chemical dependency services. It is hoped that these standards will assist the counselor to determine the propriety of his or her conduct in relationships with clients, colleagues, members of allied professions, and the public.

The Board is committed to investigate and sanction those who breach this Code of Ethics. Alcohol and drug counselors, therefore, are encouraged to thoroughly familiarize themselves with the Code of Ethics and to guide their behavior according to the principles set forth below.

Violation of the IBC Code of Ethics shall be deemed as grounds for discipline. Engaging in unethical conduct includes, in addition to violation of the Principles enumerated herein, any other violation that is harmful or detrimental to the profession or to the public.

SUBSCRIPTION TO CODE OF ETHICS

Persons applying for certification must subscribe to the Iowa Board of Certification's Code of Ethics for Alcohol and Drug Counselors and so indicate by signing Form 02. This subscription will be in effect until their certification is no longer valid. In the event the applicant did not successfully complete the certification process, the subscription shall be in effect until the application period expires. IBC can provide specific information regarding these time-frames.

SPECIFIC PRINCIPLES

PRINCIPLE I. Responsibility to clients. Alcohol and drug counselors respect the rights of those persons seeking their assistance and make reasonable efforts to ensure that their services are used appropriately.

A. Alcohol and drug counselors do not discriminate against or refuse professional service to anyone on the basis of race, gender, religion, national origin or sexual orientation.

1. Alcohol and drug counselors avoid bringing personal or professional issues into the
   counseling relationship. Through an awareness of the impact of stereotyping and discrimination, the counselor guards the individual rights and personal dignity of clients.

2. Alcohol and drug counselors are knowledgeable about disabling conditions, demonstrate empathy and personal emotional comfort in interactions with clients with disabilities, and make available physical, sensory, and cognitive accommodations that allow clients with disabilities to receive services.

B. Alcohol and drug counselors do not use their professional relationships with clients to further their own interests.

C. Alcohol and drug counselors respect the right of clients to make decisions and help them to understand the consequences of these decisions.

D. Alcohol and drug counselors continue therapeutic relationships only as long as it is reasonably clear that clients are benefiting from the relationship.

E. Alcohol and drug counselors assist persons in obtaining other therapeutic services if the counselor is unable or unwilling to provide professional help.

F. Alcohol and drug counselors do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of such treatment.

G. Alcohol and drug counselors obtain written, informed consent from clients before videotaping, audio recording, or permitting third-party observation.

H. Alcohol and drug counselors respect the integrity and protect the welfare of the client. The counselor, in the presence of professional conflict, is concerned primarily with the welfare of the client.

I. Alcohol and drug counselors ensure the presence of an appropriate setting for clinical work to protect the client from harm and the counselor and professional from censure.

J. Alcohol and drug counselors do not continue to practice while having a physical or mental disability which renders the counselor unable to practice the occupation or profession with reasonable skill or which may endanger the health and safety of the persons under the counselor's care.

K. Alcohol and drug counselors do not engage in the conduct of one's practice while suffering from a contagious disease involving risk to the client's or public's health without taking adequate precautions including, but not limited to, informed consent, protective gear or cessation of practice.

PRINCIPLE II. Dual relationships.

A. Alcohol and drug counselors are aware of their influential position with respect to clients, and they avoid exploiting the trust and dependency of such persons. Counselors, therefore, make every effort to avoid dual relationships with clients that could impair professional judgment or increase the risk of exploitation. When a dual relationship cannot be avoided, counselors take appropriate professional precautions to ensure judgment is not impaired and no exploitation occurs. Examples of such dual relationships include, but are not limited to, business or close personal relationships with clients and/or their family members.

1. Soliciting and/or engaging in sexual conduct with clients is prohibited; this includes the five years following the termination of services.

2. Alcohol and drug counselors do not accept as clients anyone with whom they have engaged in sexual conduct.

3. Alcohol & Drug Counselors are aware of their professionalism and healthy boundaries with clients when it comes to social networking for at least a period of one year following the termination of services.

    a. Alcohol & Drug Counselors do not “friend” their own clients, past or present, or clients of an agency for which they work, on Facebook or other social media sites.

    b. Alcohol & Drug Counselors use professional and ethical judgment when including photos and/or comments on social media sites.

    c. Alcohol & Drug Counselors do not provide their personal contact information to clients, i.e. home/personal cell phone number, personal email, Skype, Twitter, etc. nor engage in communication with clients through these mediums except in cases of agency/professional business

B. Alcohol and drug counselors are aware of their influential position with respect to students, employees, and supervisees, and they avoid exploiting the trust and dependency of such persons. Counselors, therefore, make every effort to avoid dual relationships that could impair professional judgment or increase the risk of exploitation. When a dual relationship cannot be avoided, counselors take appropriate professional precautions to ensure judgment is

not impaired and no exploitation occurs. Examples of such dual relationships include, but are not limited to, business or close personal relationships with students, employees or supervisees.

1. Provision of therapy to students, employees, or supervisees is prohibited.
2. Sexual conduct with students or supervisees is prohibited.

PRINCIPLE III. Confidentiality. Alcohol and drug counselors embrace, as primary obligation, the duty of protecting the privacy of clients and do not disclose confidential information acquired in teaching, practice or investigation without appropriately executed consent.

A. Alcohol and drug counselors make appropriate provisions for the maintenance of confidentiality and the ultimate disposition of confidential records. Counselors ensure that data obtained, including any form of electronic communication, are secured by the available security methodology. Data shall be limited to information that is necessary to and appropriate to the services being provided and be accessible only to appropriate personnel.

B. Alcohol and drug counselors adhere to all federal, state, and local laws regarding confidentiality and the counselor's responsibility to report clinical information in specific circumstances to the appropriate authorities.
C. Alcohol and drug counselors discuss the information obtained in clinical, consulting, or observational relationships only in the appropriate settings for professional purposes that are in the client's best interest. Written and oral reports present only data germane and pursuant to the purpose of evaluation, diagnosis, progress, and compliance. Every effort is made to avoid undue invasion of privacy.

D. Alcohol and drug counselors reveal information received in confidence only when there is a clear and imminent danger to the client or other persons, and then only to appropriate workers, public authorities, and threatened parties.

PRINCIPLE IV. Professional competence and integrity. Alcohol and drug counselors maintain high standards of professional competence and integrity.

A. Alcohol and drug counselors seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment.

B. Alcohol and drug counselors, as teachers, supervisors, and researchers, are dedicated to high standards of scholarship and present accurate information.

C. Alcohol and drug counselors do not engage in sexual or other harassment or exploitation of clients, students, trainees, supervisees, employees, colleagues, research subjects, or actual or potential witnesses or complainants in investigations and ethical proceedings.

D. Alcohol and drug counselors do not diagnose, treat, or advise on problems outside the recognized boundaries of their competence.

E. Alcohol and drug counselors do not engage in conduct which does not meet the generally accepted standards of practice for the alcohol and drug profession including, but not limited to, incompetence, negligence or malpractice.

1. Falsifying, amending or making incorrect essential entries or failing to make essential entries of client record.

2. A substantial lack of knowledge or ability to discharge professional obligations within the scope of the alcohol and drug profession.

3. A substantial deviation from the standards of skill ordinarily possessed and applied by professional peers in the state of Iowa acting in the same or similar circumstances.

4. Acting in such a manner as to present a danger to public health or safety, or to any client including, but not limited to, impaired behavior, incompetence, negligence or malpractice.

5. Failing to comply with a term, condition or limitation on a certification or license.

6. Failing to obtain an appropriate consultation or make an appropriate referral when the problem of the client is beyond the alcohol and drug counselor's training, experience or competence.

7. Suspension, revocation, probation or other restrictions on any professional certification or licensure imposed by any state or jurisdiction, unless such action has been satisfied and/or reversed.

8. Administering to oneself any controlled substance, or aiding and abetting the use of any controlled substance by another person.

9. Using any drug or alcoholic beverage to the extent or in such manner as to be dangerous or injurious to self or others, or to the extent that such use impairs the ability of such person to safely provide professional services.

10. Using alcohol or any dangerous drug or controlled substance while providing professional services.

11. Refusing to seek evaluation and follow through with the recommended treatment for chemical dependency or a mental health problem which impairs professional performance.

F. Alcohol & Drug Counselors who provide services via electronic media shall inform the client/patient of the limitations and risks associated with such services and shall document in the client/patient case record that such notice has been provided.

PRINCIPLE V. Responsibility to students, employees, and supervisees. Alcohol and drug counselors do not exploit the trust and dependency of students, employees, and supervisees.

A. Alcohol and drug counselors do not permit students, employees, or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience and competence.

B. Alcohol and drug counselors who supervise others accept the obligation to facilitate
further professional development of these individuals by providing accurate and current information, timely evaluations, and constructive consultation.

PRINCIPLE VI. Responsibility to the profession. Counselors respect the rights and responsibilities of professional colleagues.

A. Counselors treat colleagues with respect, courtesy, and fairness and afford the same professional courtesy to other professionals.

1. Alcohol and drug counselors do not offer professional services to a client in counseling with another professional except with the knowledge of the other professional or after the termination of the client's relationship with the other professional.

2. Alcohol and drug counselors cooperate with duly constituted professional ethics committees and promptly supply necessary information unless constrained by the demands of confidentiality.

3. Alcohol and drug counselors report the unethical conduct or practice of others in the profession to the appropriate certifying authority.

4. Alcohol and drug counselors do not knowingly file a false report against another professional concerning an ethics violation.

B. As employees or members of organizations, alcohol and drug counselors refuse to participate in an employer's practices which are inconsistent with the ethical standards enumerated in this Code.

C. Alcohol and drug counselors assign publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with customary professional publication practices.

D. Alcohol and drug counselors who are the authors of books or other materials that are published or distributed cite persons to whom credit for original ideas is due.

PRINCIPLE VII. Financial arrangements. Alcohol and drug counselors make financial arrangements for services with clients and third-party payers that are reasonably understandable and conform to accepted professional practices.

A. Alcohol and drug counselors do not offer, give or receive commissions, rebates or other forms of remuneration for the referral of clients.

B. Alcohol and drug counselors do not charge excessive fees for services.

C. Alcohol and drug counselors disclose their fees to clients at the beginning of services.

D. Alcohol and drug counselors do not enter into personal financial arrangements.

E. Alcohol and drug counselors represent facts truthfully to clients and third-party payers, regarding services rendered.

F. Alcohol and drug counselors do not accept a private fee or any other gift or gratuity for professional work.

PRINCIPLE VIII. Advertising. Alcohol and drug counselors engage in appropriate informational activities, including those that enable lay persons to choose professional services on an informed basis.

A. Alcohol and drug counselors accurately represent their competence, education, training, and experience.

B. Alcohol and drug counselors do not use a firm name, letterhead, publication, term, title designation or document which states or implies an ability, relationship or qualification which the counselor does not have.

C. Alcohol and drug counselors do not use any professional identification (such as a business card, office sign, letterhead, or telephone or association directory listing) if it includes a statement or claim that is false, fraudulent, misleading, or deceptive. A statement is false, fraudulent, misleading, or deceptive if it:

1. contains a material misrepresentation of fact;
2. fails to state any material fact necessary to make the statement, in light of all circumstances, not misleading; or
3. is intended to or is likely to create an unjustified expectation.

PRINCIPLE IX. Legal and Moral Standards. Alcohol and drug counselors uphold the law and have high morals in both professional and personal conduct.

Grounds for discipline under this principle include, but are not limited to, the following:

1. Conviction of any felony or misdemeanor, excluding minor traffic offenses, whether or not the case is pending an appeal. A plea or verdict of guilty or a conviction following an Alford Plea, or any other plea which is treated by the court as a plea of guilty and all the proceedings in which the sentence was deferred or suspended, or the conviction expunged shall be deemed a conviction within the meaning of this section.

2. Permitting, aiding, abetting, assisting, hiring or conspiring with an individual to violate or circumvent any of the laws relating to licensure or certification under any licensing or certification act.

3. Fraud-related conduct under this principle includes, but is not limited to, the following:

    a. Publishing or causing to be published any advertisement that is false, fraudulent, deceptive or misleading.

    b. Engaging in fraud, misrepresentation, deception or concealment of material fact in:

        1. Applying for or assisting in securing certification or certification renewal.

        2. Taking any examination provided for #1 above including fraudulently procured credentials.

    c. Making misleading, deceptive, untrue or fraudulent representation in the practice or the conduct of the alcohol and drug profession or practicing fraud or deceit, either alone or as a conspirator.

    d. Failing to cooperate with an investigation by interfering with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representatives; by use of threats or harassment against, or inducement to any patient, client or witness to prevent them from providing evidence in a disciplinary proceeding or any person to prevent or attempt to prevent a disciplinary proceeding or other legal action from being filed,

prosecuted or completed. Failing to cooperate with a board investigation in any material respect.

e. Committing a fraudulent insurance act.

f. Signing or issuing, in the certified alcohol and drug counselor's capacity, a document or statement that the counselor knows, or ought to know, contains a false or misleading statement.

g. Using a firm name, letterhead, publication, term, title designation or document which states or implies an ability, relationship or qualification which the counselor does not have.

h. Practicing the profession under a false name or name other than the name under which the certification is held.

i. Impersonating any certified professional or representing oneself as a certified professional for which one has no current certification.

j. Charging a client or a third party payer for a service not performed, or submitting an account or charge for services that is false or misleading. This does not apply to charging for an unkept appointment by a client.

k. Charging a fee that is excessive in relation to the service or product for which it is charged.

l. Offering, giving or promising anything of value or benefit to any federal, state, or local employee or official for the purpose of influencing that employee or official to circumvent federal, state, or local law, regulation or ordinance governing the certified counselor or the alcohol and drug profession.

4. Engaging in sexual conduct, as defined in the Iowa Code, with a client during a period of time in which a professional relationship exists and for five years after that period of time.

ELECTRONIC CODE OF FEDERAL REGULATIONS

e-CFR Data is current as of April 16, 2014

Title 42: Public Health

PART 2—CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

Contents

Subpart E—Court Orders Authorizing Disclosure and Use

AUTHORITY: Sec. 408 of Pub. L. 92-255, 86 Stat. 79, as amended by sec. 303 (a), (b) of Pub L. 93-282, 83 Stat. 137, 138; sec. 4(c)(5)(A) of Pub. L. 94-237, 90 Stat. 244; sec. 111(c)(3) of Pub. L. 94-581, 90 Stat. 2852; sec. 509 of Pub. L. 96-88, 93 Stat. 695; sec. 973(d) of Pub. L. 97-35, 95 Stat. 598; and transferred to sec. 527 of the Public Health Service Act by sec. 2(b)(16)(B) of Pub. L. 98-24, 97 Stat. 182 and as amended by sec. 106 of Pub. L. 99-401, 100 Stat. 907 (42 U.S.C. 290ee-3) and sec. 333 of Pub. L. 91-616, 84 Stat. 1853, as amended by sec. 122(a) of Pub. L. 93-282, 88 Stat. 131; and sec. 111(c)(4) of Pub. L. 94-581, 90 Stat. 2852 and transferred to sec. 523 of the Public Health Service Act by sec. 2(b)(13) of Pub. L. 98-24, 97 Stat. 181 and as amended by sec. 106 of Pub. L. 99-401, 100 Stat. 907 (42 U.S.C. 290dd-3), as amended by sec. 131 of Pub. L. 102-321, 106 Stat. 368, (42 U.S.C. 290dd-2).

SOURCE: 52 FR 21809, June 9, 1987, unless otherwise noted.

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Subpart A—Introduction

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§2.1 Statutory authority for confidentiality of drug abuse patient records.

The restrictions of these regulations upon the disclosure and use of drug abuse patient records were initially authorized by section 408 of the Drug Abuse Prevention, Treatment, and Rehabilitation Act (21 U.S.C. 1175). That section as amended was transferred by Pub. L. 98-24 to section 527 of the Public Health Service Act which is codified at 42 U.S.C. 290ee-3. The amended statutory authority is set forth below:

§290ee-3. CONFIDENTIALITY OF PATIENT RECORDS.

(a) *Disclosure authorization*

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) *Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent*

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this

section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) *Prohibition against use of record in making criminal charges or investigation of patient*

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) *Continuing prohibition against disclosure irrespective of status as patient*

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) *Armed Forces and Veterans' Administration; interchange of records; report of suspected child abuse and neglect to State or local authorities*

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or witrhin those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) *Penalty for first and subsequent offenses*

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not nore than $5,000 in the case of each subsequent offense.

(g) *Regulations; interagency consultations; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders*

Except as provided in subsection (h) of this section, the Secretary, after consultation with the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected thereby, shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(Subsection (h) was superseded by section 111(c)(3) of Pub. L. 94-581. The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of drug abuse patient records under Title 38 was moved from 21 U.S.C. 1175 to 38 U.S.C. 4134.)

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§2.2 Statutory authority for confidentiality of alcohol abuse patient records.

The restrictions of these regulations upon the disclosure and use of alcohol abuse patient records were initially authorized by section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4582). The section as amended was transferred by Pub. L. 98-24 to section 523 of the Public Health Service Act which is codified at 42 U.S.C. 290dd-3. The amended statutory authority is set forth below:

§290dd-3. Confidentiality of patient records

(a) *Disclosure authorization*

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) *Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent*

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) *Prohibition against use of record in making criminal charges or investigation of patient*

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) *Continuing prohibition against disclosure irrespective of status as patient*

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) *Armed Forces and Veterans' Administration; interchange of record of suspected child abuse and neglect to State or local authorities*

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) *Penalty for first and subsequent offenses*

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(g) *Regulations of Secretary; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders*

Except as provided in subsection (h) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection(b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(Subsection (h) was superseded by section 111(c)(4) of Pub. L. 94-581. The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of alcohol abuse patient records under Title 38 was moved from 42 U.S.C. 4582 to 38 U.S.C. 4134.)

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§2.3 Purpose and effect.

(a) *Purpose.* Under the statutory provisions quoted in §§2.1 and 2.2, these regulations impose restrictions upon the disclosure and use of alcohol and drug abuse patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program. The regulations specify:

(1) Definitions, applicability, and general restrictions in subpart B (definitions applicable to §2.34 only appear in that section);

(2) Disclosures which may be made with written patient consent and the form of the written consent in subpart C;

(3) Disclosures which may be made without written patient consent or an authorizing court order in subpart D; and

(4) Disclosures and uses of patient records which may be made with an authorizing court order and the procedures and criteria for the entry and scope of those orders in subpart E.

(b) *Effect.* (1) These regulations prohibit the disclosure and use of patient records unless certain circumstances exist. If any circumstances exists under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure but it does not compel disclosure. Thus, the regulations do not require disclosure under any circumstances.

(2) These regulations are not intended to direct the manner in which substantive functions such as research, treatment, and evaluation are carried out. They are intended to insure that an alcohol or drug abuse patient in a federally assisted alcohol or drug abuse program is not made more vulnerable by reason of the availability of his or her patient record than an individual who has an alcohol or drug problem and who does not seek treatment.

(3) Because there is a criminal penalty (a fine—see 42 U.S.C. 290ee-3(f), 42 U.S.C. 290dd-3(f) and 42 CFR 2.4) for violating the regulations, they are to be construed strictly in favor of the potential violator in the same manner as a criminal statute (see *M. Kraus & Brothers* v. *United States,* 327 U.S. 614, 621-22, 66 S. Ct. 705, 707-08 (1946)).

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§2.4 Criminal penalty for violation.

Under 42 U.S.C. 290ee-3(f) and 42 U.S.C. 290dd-3(f), any person who violates any provision of those statutes or these regulations shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

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§2.5 Reports of violations.

(a) The report of any violation of these regulations may be directed to the United States Attorney for the judicial district in which the violation occurs.

(b) The report of any violation of these regulations by a methadone program may be directed to the Regional Offices of the Food and Drug Administration.

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Subpart B—General Provisions

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§2.11 Definitions.

For purposes of these regulations:

Alcohol abuse means the use of an alcoholic beverage which impairs the physical, mental, emotional, or social well-being of the user.

Drug abuse means the use of a psychoactive substance for other than medicinal purposes which impairs the physical, mental, emotional, or social well-being of the user.

Diagnosis means any reference to an individual's alcohol or drug abuse or to a condition which is identified as having been caused by that abuse which is made for the purpose of treatment or referral for treatment.

Disclose or disclosure means a communication of patient indentifying information, the affirmative verification of another person's communication of patient identifying information, or the communication of any information from the record of a patient who has been identified.

Informant means an individual:

(a) Who is a patient or employee of a program or who becomes a patient or employee of a program at the request of a law enforcement agency or official: and

(b) Who at the request of a law enforcement agency or official observes one or more patients or employees of the program for the purpose of reporting the information obtained to the law enforcement agency or official.

Patient means any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine that individual's eligibility to participate in a program.

Patient identifying information means the name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a number assigned to a patient by a program, if that number does not consist of, or contain numbers (such as a social security, or driver's license number) which could be used to identify

a patient with reasonable accuracy and speed from sources external to the program.

Person means an individual, partnership, corporation, Federal, State or local government agency, or any other legal entity.

Program means:

(a) An individual or entity (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or

(b) An identified unit within a general medical facility which holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or

(c) Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers. (See §2.12(e)(1) for examples.)

Program director means:

(a) In the case of a program which is an individual, that individual:

(b) In the case of a program which is an organization, the individual designated as director, managing director, or otherwise vested with authority to act as chief executive of the organization.

Qualified service organization means a person which:

(a) Provides services to a program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and

(b) Has entered into a written agreement with a program under which that person:

(1) Acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the progams, it is fully bound by these regulations; and

(2) If necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations.

Records means any information, whether recorded or not, relating to a patient received or acquired by a federally assisted alcohol or drug program.

Third party payer means a person who pays, or agrees to pay, for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of his family or on the basis of the patient's eligibility for Federal, State, or local governmental benefits.

Treatment means the management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient.

Undercover agent means an officer of any Federal, State, or local law enforcement agency who enrolls in or becomes an employee of a program for the purpose of investigating a suspected violation of law or who pursues that purpose after enrolling or becoming employed for other purposes.

[52 FR 21809, June 9, 1987, as amended at 60 FR 22297, May 5, 1995]

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§2.12 Applicability.

(a) *General*—(1) *Restrictions on disclosure.* The restrictions on disclosure in these regulations apply to any information, whether or not recorded, which:

(i) Would identify a patient as an alcohol or drug abuser either directly, by reference to other publicly available information, or through verification of such an identification by another person; and

(ii) ls drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972, or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or if obtained before the pertinent date, is maintained by a federally assisted alcohol or drug abuse program after that date as part of an ongoing treatment episode which extends past that date) for the purpose of treating alcohol or drug abuse, making a diagnosis for that treatment, or making a referral for that treatment.

(2) *Restriction on use.* The restriction on use of information to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient (42 U.S.C. 290ee-3(c), 42 U.S.C. 290dd-3(c)) applies to any information, whether or not recorded which is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972, or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or if obtained before the pertinent date, is maintained by a federally assisted alcohol or drug abuse program after that date as part of an ongoing treatment episode which extends past that date), for the purpose of treating alcohol or drug abuse, making a diagnosis for the treatment, or making a referral for the treatment.

(b) *Federal assistance.* An alcohol abuse or drug abuse program is considered to be federally assisted if:

(1) It is conducted in whole or in part, whether directly or by contract or otherwise by any department or agency of the United States (but see paragraphs (c)(1) and (c)(2) of this section relating to the Veterans' Administration and the Armed Forces);

(2) It is being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States including but not limited to:

(i) Certification of provider status under the Medicare program;

(ii) Authorization to conduct methadone maintenance treatment (see 21 CFR 291.505); or

(iii) Registration to dispense a substance under the Controlled Substances Act to the extent the controlled substance is used in the treatment of alcohol or drug abuse;

(3) It is supported by funds provided by any department or agency of the United States by being:

(i) A recipient of Federal financial assistance in any form, including financial assistance which does not directly pay for the alcohol or drug abuse diagnosis, treatment, or referral activities; or

(ii) Conducted by a State or local government unit which, through general or special revenue sharing or other forms of assistance, receives Federal funds which could be (but are not necessarily) spent for the alcohol or drug abuse program; or

(4) It is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program or through the granting of tax exempt status to the program.

(c) *Exceptions*—(1) *Veterans' Administration.* These regulations do not apply to information on alcohol and drug abuse patients maintained in connection with the Veterans' Administration provisions of hospital care, nursing home care, domiciliary care, and medical services under title 38, United States Code. Those records are governed by 38 U.S.C. 4132 and regulations issued under that

authority by the Administrator of Veterans' Affairs.

(2) *Armed Forces.* These regulations apply to any information described in paragraph (a) of this section which was obtained by any component of the Armed Forces during a period when the patient was subject to the Uniform Code of Military Justice except:

(i) Any interchange of that information within the Armed Forces; and

(ii) Any interchange of that information between the Armed Forces and those components of the Veterans Administration furnishing health care to veterans.

(3) *Communication within a program or between a program and an entity having direct administrative control over that program.* The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse if the communications are

(i) Within a program or

(ii) Between a program and an entity that has direct administrative control over the program.

(4) *Qualified Service Organizations.* The restrictions on disclosure in these regulations do not apply to communications between a program and a qualified service organization of information needed by the organization to provide services to the program.

(5) *Crimes on program premises or against program personnel.* The restrictions on disclosure and use in these regulations do not apply to communications from program personnel to law enforcement officers which—

(i) Are directly related to a patient's commission of a crime on the premises of the program or against program personnel or to a threat to commit such a crime; and

(ii) Are limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

(6) *Reports of suspected child abuse and neglect.* The restrictions on disclosure and use in these regulations do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities. However, the restrictions continue to apply to the original alcohol or drug abuse patient records maintained by the program including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

(d) *Applicability to recipients of information*—(1) *Restriction on use of information.* The restriction on the use of any information subject to these regulations to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient applies to any person who obtains that information from a federally assisted alcohol or drug abuse program, regardless of the status of the person obtaining the information or of whether the information was obtained in accordance with these regulations. This restriction on use bars, among other things, the introduction of that information as evidence in a criminal proceeding and any other use of the information to investigate or prosecute a patient with respect to a suspected crime. Information obtained by undercover agents or informants (see §2.17) or through patient access (see §2.23) is subject to the restriction on use.

(2) *Restrictions on disclosures—Third party payers, administrative entities, and others.* The restrictions on disclosure in these regulations apply to:

(i) Third party payers with regard to records disclosed to them by federally assisted alcohol or drug

abuse programs;

(ii) Entities having direct administrative control over programs with regard to information communicated to them by the program under §2.12(c)(3); and

(iii) Persons who receive patient records directly from a federally assisted alcohol or drug abuse program and who are notified of the restrictions on redisclosure of the records in accordance with §2.32 of these regulations.

(e) *Explanation of applicability*—(1) *Coverage.* These regulations cover any information (including information on referral and intake) about alcohol and drug abuse patients obtained by a program (as the terms “patient” and “program” are defined in §2.11) if the program is federally assisted in any manner described in §2.12(b). Coverage includes, but is not limited to, those treatment or rehabilitation programs, employee assistance programs, programs within general hospitals, school-based programs, and private practitioners who hold themselves out as providing, and provide alcohol or drug abuse diagnosis, treatment, or referral for treatment. However, these regulations would not apply, for example, to emergency room personnel who refer a patient to the intensive care unit for an apparent overdose, unless the primary function of such personnel is the provision of alcohol or drug abuse diagnosis, treatment or referral and they are identified as providing such services or the emergency room has promoted itself to the community as a provider of such services.

(2) *Federal assistance to program required.* If a patient's alcohol or drug abuse diagnosis, treatment, or referral for treatment is not provided by a program which is federally conducted, regulated or supported in a manner which constitutes Federal assistance under §2.12(b), that patient's record is not covered by these regulations. Thus, it is possible for an individual patient to benefit from Federal support and not be covered by the confidentiality regulations because the program in which the patient is enrolled is not federally assisted as defined in §2.12(b). For example, if a Federal court placed an individual in a private for-profit program and made a payment to the program on behalf of that individual, that patient's record would not be covered by these regulations unless the program itself received Federal assistance as defined by §2.12(b).

(3) *Information to which restrictions are applicable.* Whether a restriction is on use or disclosure affects the type of information which may be available. The restrictions on disclosure apply to any information which would identify a patient as an alcohol or drug abuser. The restriction on use of information to bring criminal charges against a patient for a crime applies to any information obtained by the program for the purpose of diagnosis, treatment, or referral for treatment of alcohol or drug abuse. (Note that restrictions on use and disclosure apply to recipients of information under §2.12(d).)

(4) *How type of diagnosis affects coverage.* These regulations cover any record of a diagnosis identifying a patient as an alcohol or drug abuser which is prepared in connection with the treatment or referral for treatment of alcohol or drug abuse. A diagnosis prepared for the purpose of treatment or referral for treatment but which is not so used is covered by these regulations. The following are not covered by these regulations:

(i) Diagnosis which is made solely for the purpose of providing evidence for use by law enforcement authorities; or

(ii) A diagnosis of drug overdose or alcohol intoxication which clearly shows that the individual involved is not an alcohol or drug abuser (e.g., involuntary ingestion of alcohol or drugs or reaction to a prescribed dosage of one or more drugs).

[52 FR 21809, June 9, 1987; 52 FR 42061, Nov. 2, 1987, as amended at 60 FR 22297, May 5, 1995]

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§2.13 Confidentiality restrictions.

(a) *General.* The patient records to which these regulations apply may be disclosed or used only as permitted by these regulations and may not otherwise be disclosed or used in any civil, criminal, administrative, or legislative proceedings conducted by any Federal, State, or local authority. Any disclosure made under these regulations must be limited to that information which is necessary to carry out the purpose of the disclosure.

(b) *Unconditional compliance required.* The restrictions on disclosure and use in these regulations apply whether the holder of the information believes that the person seeking the information already has it, has other means of obtaining it, is a law enforcement or other official, has obtained a subpoena, or asserts any other justification for a disclosure or use which is not permitted by these regulations.

(c) *Acknowledging the presence of patients: Responding to requests.* (1) The presence of an identified patient in a facility or component of a facility which is publicly identified as a place where only alcohol or drug abuse diagnosis, treatment, or referral is provided may be acknowledged only if the patient's written consent is obtained in accordance with subpart C of these regulations or if an authorizing court order is entered in accordance with subpart E of these regulations. The regulations permit acknowledgement of the presence of an identified patient in a facility or part of a facility if the facility is not publicy identified as only an alcohol or drug abuse diagnosis, treatment or referral facility, and if the acknowledgement does not reveal that the patient is an alcohol or drug abuser.

(2) Any answer to a request for a disclosure of patient records which is not permissible under these regulations must be made in a way that will not affirmatively reveal that an identified individual has been, or is being diagnosed or treated for alcohol or drug abuse. An inquiring party may be given a copy of these regulations and advised that they restrict the disclosure of alcohol or drug abuse patient records, but may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient. The regulations do not restrict a disclosure that an identified individual is not and never has been a patient.

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§2.14 Minor patients.

(a) *Definition of minor.* As used in these regulations the term “minor” means a person who has not attained the age of majority specified in the applicable State law, or if no age of majority is specified in the applicable State law, the age of eighteen years.

(b) *State law not requiring parental consent to treatment.* If a minor patient acting alone has the legal capacity under the applicable State law to apply for and obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations may be given only by the minor patient. This restriction includes, but is not limited to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. These regulations do not prohibit a program from refusing to provide treatment until the minor patient consents to the disclosure necessary to obtain reimbursement, but refusal to provide treatment may be prohibited under a State or local law requiring the program to furnish the service irrespective of ability to pay.

(c) *State law requiring parental consent to treatment.* (1) Where State law requires consent of a parent, guardian, or other person for a minor to obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations must be given by both the minor and his or her parent, guardian, or other person authorized under State law to act in the minor's behalf.

(2) Where State law requires parental consent to treatment the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with subpart C of these

regulations or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the program director under paragraph (d) of this section.

(d) *Minor applicant for services lacks capacity for rational choice.* Facts relevant to reducing a threat to the life or physical well being of the applicant or any other individual may be disclosed to the parent, guardian, or other person authorized under State law to act in the minor's behalf if the program director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under subpart C of these regulations to his or her parent, guardian, or other person authorized under State law to act in the minor's behalf, and

(2) The applicant's situation poses a substantial threat to the life or physical well being of the applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf.

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§2.15 Incompetent and deceased patients.

(a) *Incompetent patients other than minors*—(1) *Adjudication of incompetence.* In the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his or her own affairs, any consent which is required under these regulations may be given by the guardian or other person authorized under State law to act in the patient's behalf.

(2) *No adjudication of incompetency.* For any period for which the program director determines that a patient, other than a minor or one who has been adjudicated incompetent, suffers from a medical condition that prevents knowing or effective action on his or her own behalf, the program director may exercise the right of the patient to consent to a disclosure under subpart C of these regulations for the sole purpose of obtaining payment for services from a third party payer.

(b) *Deceased patients*—(1) *Vital statistics.* These regulations do not restrict the disclosure of patient identifying information relating to the cause of death of a patient under laws requiring the collection of death or other vital statistics or permitting inquiry into the cause of death.

(2) *Consent by personal representative.* Any other disclosure of information identifying a deceased patient as an alcohol or drug abuser is subject to these regulations. If a written consent to the disclosure is required, that consent may be given by an executor, administrator, or other personal representative appointed under applicable State law. If there is no such appointment the consent may be given by the patient's spouse or, if none, by any responsible member of the patient's family.

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§2.16 Security for written records.

(a) Written records which are subject to these regulations must be maintained in a secure room, locked file cabinet, safe or other similar container when not in use; and

(b) Each program shall adopt in writing procedures which regulate and control access to and use of written records which are subject to these regulations.

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§2.17 Undercover agents and informants.

(a) *Restrictions on placement.* Except as specifically authorized by a court order granted under §2.67 of these regulations, no program may knowingly employ, or enroll as a patient, any undercover agent or informant.

(b) *Restriction on use of information.* No information obtained by an undercover agent or informant, whether or not that undercover agent or informant is placed in a program pursuant to an authorizing court order, may be used to criminally investigate or prosecute any patient.

[52 FR 21809, June 9, 1987; 52 FR 42061, Nov. 2, 1987]

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§2.18 Restrictions on the use of identification cards.

No person may require any patient to carry on his or her person while away from the program premises any card or other object which would identify the patient as an alcohol or drug abuser. This section does not prohibit a person from requiring patients to use or carry cards or other identification objects on the premises of a program.

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§2.19 Disposition of records by discontinued programs.

(a) *General.* If a program discontinues operations or is taken over or acquired by another program, it must purge patient identifying information from its records or destroy the records unless—

(1) The patient who is the subject of the records gives written consent (meeting the requirements of §2.31) to a transfer of the records to the acquiring program or to any other program designated in the consent (the manner of obtaining this consent must minimize the likelihood of a disclosure of patient identifying information to a third party); or

(2) There is a legal requirement that the records be kept for a period specified by law which does not expire until after the discontinuation or acquisition of the program.

(b) *Procedure where retention period required by law.* If paragraph (a)(2) of this section applies, the records must be:

(1) Sealed in envelopes or other containers labeled as follows: “Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date]”; and

(2) Held under the restrictions of these regulations by a responsible person who must, as soon as practicable after the end of the retention period specified on the label, destroy the records.

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§2.20 Relationship to State laws.

The statutes authorizing these regulations (42 U.S.C. 290ee-3 and 42 U.S.C. 290dd-3) do not preempt the field of law which they cover to the exclusion of all State laws in that field. If a disclosure permitted under these regulations is prohibited under State law, neither these regulations nor the authorizing statutes may be construed to authorize any violation of that State law. However, no State law may either authorize or compel any disclosure prohibited by these regulations.

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§2.21 Relationship to Federal statutes protecting research subjects against compulsory

disclosure of their identity.

(a) *Research privilege description.* There may be concurrent coverage of patient identifying information by these regulations and by administrative action taken under: Section 303(a) of the Public Health Service Act (42 U.S.C. 242a(a) and the implementing regulations at 42 CFR part 2a); or section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c) and the implementing regulations at 21 CFR 1316.21). These “research privilege” statutes confer on the Secretary of Health and Human Services and on the Attorney General, respectively, the power to authorize researchers conducting certain types of research to withhold from all persons not connected with the research the names and other identifying information concerning individuals who are the subjects of the research.

(b) *Effect of concurrent coverage.* These regulations restrict the disclosure and use of information about patients, while administrative action taken under the research privilege statutes and implementing regulations protects a person engaged in applicable research from being compelled to disclose any identifying characteristics of the individuals who are the subjects of that research. The issuance under subpart E of these regulations of a court order authorizing a disclosure of information about a patient does not affect an exercise of authority under these research privilege statutes. However, the research privilage granted under 21 CFR 291.505(g) to treatment programs using methadone for maintenance treatment does not protect from compulsory disclosure any imformation which is permitted to be disclosed under those regulations. Thus, if a court order entered in accordance with subpart E of these regulations authorizes a methadone maintenance treatment program to disclose certain information about its patients, that program may not invoke the research privilege under 21 CFR 291.505(g) as a defense to a subpoena for that information.

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§2.22 Notice to patients of Federal confidentiality requirements.

(a) *Notice required.* At the time of admission or as soon threreafter as the patient is capable of rational communication, each program shall:

(1) Communicate to the patient that Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records; and

(2) Give to the patient a summary in writing of the Federal law and regulations.

(b) *Required elements of written summary.* The written summary of the Federal law and regulations must include:

(1) A general description of the limited circumstances under which a program may acknowledge that an individual is present at a facility or disclose outside the program information identifying a patient as an alcohol or drug abuser.

(2) A statement that violation of the Federal law and regulations by a program is a crime and that suspected violations may be reported to appropriate authorities in accordance with these regulations.

(3) A statement that information related to a patient's commission of a crime on the premises of the program or against personnel of the program is not protected.

(4) A statement that reports of suspected child abuse and neglect made under State law to appropriate State or local authorities are not protected.

(5) A citation to the Federal law and regulations.

(c) *Program options.* The program may devise its own notice or may use the sample notice in paragraph (d) to comply with the requirement to provide the patient with a summary in writing of the Federal law and regulations. In addition, the program may include in the written summary information

concerning State law and any program policy not inconsistent with State and Federal law on the subject of confidentiality of alcohol and drug abuse patient records.

(d) *Sample notice.*

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser *Unless:*

(1) The patient consents in writing:

(2) The disclosure is allowed by a court order; or

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations.)

(Approved by the Office of Management and Budget under control number 0930-0099)

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§2.23 Patient access and restrictions on use.

(a) *Patient access not prohibited.* These regulations do not prohibit a program from giving a patient access to his or her own records, including the opportunity to inspect and copy any records that the program maintains about the patient. The program is not required to obtain a patient's written consent or other authorization under these regulations in order to provide such access to the patient.

(b) *Restriction on use of information.* Information obtained by patient access to his or her patient record is subject to the restriction on use of his information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient as provided for under §2.12(d)(1).

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Subpart C—Disclosures With Patient's Consent

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§2.31 Form of written consent.

(a) *Required elements.* A written consent to a disclosure under these regulations must include:

(1) The specific name or general designation of the program or person permitted to make the disclosure.

(2) The name or title of the individual or the name of the organization to which disclosure is to be made.

(3) The name of the patient.

(4) The purpose of the disclosure.

(5) How much and what kind of information is to be disclosed.

(6) The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under §2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under §2.15 in lieu of the patient.

(7) The date on which the consent is signed.

(8) A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.

(9) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

(b) *Sample consent form.* The following form complies with paragraph (a) of this section, but other elements may be added.

1. I (name of patient) □ Request □ Authorize:

2. (name or general designation of program which is to make the disclosure)

---

3. To disclose: (kind and amount of information to be disclosed)

---

4. To: (name or title of the person or organization to which disclosure is to be made)

---

5. For (purpose of the disclosure)

---

6. Date (on which this consent is signed)

---

7. Signature of patient

---

8. Signature of parent or guardian (where required)

---

9. Signature of person authorized to sign in lieu of the patient (where required)

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10. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon:

(specific date, event, or condition)

(c) *Expired, deficient, or false consent.* A disclosure may not be made on the basis of a consent which:

(1) Has expired;

(2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;

(3) Is known to have been revoked; or

(4) Is known, or through a reasonable effort could be known, by the person holding the records to be materially false.

(Approved by the Office of Management and Budget under control number 0930-0099)

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§2.32 Prohibition on redisclosure.

Notice to accompany disclosure. Each disclosure made with the patient's written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

[52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

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§2.33 Disclosures permitted with written consent.

If a patient consents to a disclosure of his or her records under §2.31, a program may disclose those records in accordance with that consent to any individual or organization named in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of §§2.34 and 2.35, respectively.

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§2.34 Disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs.

(a) *Definitions.* For purposes of this section:

Central registry means an organization which obtains from two or more member progams patient identifying information about individuals applying for maintenance treatment or detoxification treatment for the purpose of avoiding an individual's concurrent enrollment in more than one program.

Detoxification treatment means the dispensing of a narcotic drug in decreasing doses to an individual in order to reduce or eliminate adverse physiological or psychological effects incident to withdrawal from the sustained use of a narcotic drug.

Maintenance treatment means the dispensing of a narcotic drug in the treatment of an individual

for dependence upon heroin or other morphine-like drugs.

Member program means a detoxification treatment or maintenance treatment program which reports patient identifying information to a central registry and which is in the same State as that central registry or is not more than 125 miles from any border of the State in which the central registry is located.

(b) *Restrictions on disclosure.* A program may disclose patient records to a central registry or to any detoxification or maintenance treatment program not more than 200 miles away for the purpose of preventing the multiple enrollment of a patient only if:

(1) The disclosure is made when:

(i) The patient is accepted for treatment;

(ii) The type or dosage of the drug is changed; or

(iii) The treatment is interrupted, resumed or terminated.

(2) The disclosure is limited to:

(i) Patient identifying information;

(ii) Type and dosage of the drug; and

(iii) Relevant dates.

(3) The disclosure is made with the patient's written consent meeting the requirements of §2.31, except that:

(i) The consent must list the name and address of each central registry and each known detoxification or maintenance treatment program to which a disclosure will be made; and

(ii) The consent may authorize a disclosure to any detoxification or maintenance treatment program established within 200 miles of the program after the consent is given without naming any such program.

(c) *Use of information limited to prevention of multiple enrollments.* A central registry and any detoxification or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not redisclose or use patient identifying information for any purpose other than the prevention of multiple enrollments unless authorized by a court order under subpart E of these regulations.

(d) *Permitted disclosure by a central registry to prevent a multiple enrollment.* When a member program asks a central registry if an identified patient is enrolled in another member program and the registry determines that the patient is so enrolled, the registry may disclose—

(1) The name, address, and telephone number of the member program(s) in which the patient is already enrolled to the inquiring member program; and

(2) The name, address, and telephone number of the inquiring member program to the member program(s) in which the patient is already enrolled. The member programs may communicate as necessary to verify that no error has been made and to prevent or eliminate any multiple enrollment.

(e) *Permitted disclosure by a detoxification or maintenance treatment program to prevent a multiple enrollment.* A detoxification or maintenance treatment program which has received a disclosure under this section and has determined that the patient is already enrolled may communicate as necessary with the program making the disclosure to verify that no error has been made and to

prevent or eliminate any multiple enrollment.

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§2.35 Disclosures to elements of the criminal justice system which have referred patients.

(a) A program may disclose information about a patient to those persons within the criminal justice system which have made participation in the program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:

(1) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress (e.g., a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or posttrial release, probation or parole officers responsible for supervision of the patient); and

(2) The patient has signed a written consent meeting the requirements of §2.31 (except paragraph (a)(8) which is inconsistent with the revocation provisions of paragraph (c) of this section) and the requirements of paragraphs (b) and (c) of this section.

(b) *Duration of consent.* The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

(1) The anticipated length of the treatment;

(2) The type of criminal proceeding involved, the need for the information in connection with the final disposition of that proceeding, and when the final disposition will occur; and

(3) Such other factors as the program, the patient, and the person(s) who will receive the disclosure consider pertinent.

(c) *Revocation of consent.* The written consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

(d) *Restrictions on redisclosure and use.* A person who receives patient information under this section may redisclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

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Subpart D—Disclosures Without Patient Consent

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§2.51 Medical emergencies.

(a) *General Rule.* Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.

(b) *Special Rule.* Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

(c) *Procedures.* Immediately following disclosure, the program shall document the disclosure in the patient's records, setting forth in writing:

(1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;

(2) The name of the individual making the disclosure;

(3) The date and time of the disclosure; and

(4) The nature of the emergency (or error, if the report was to FDA).

(Approved by the Office of Management and Budget under control number 0930-0099)

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§2.52 Research activities.

(a) Patient identifying information may be disclosed for the purpose of conducting scientific research if the program director makes a determination that the recipient of the patient identifying information:

(1) Is qualified to conduct the research;

(2) Has a research protocol under which the patient identifying information:

(i) Will be maintained in accordance with the security requirements of §2.16 of these regulations (or more stringent requirements); and

(ii) Will not be redisclosed except as permitted under paragraph (b) of this section; and

(3) Has provided a satisfactory written statement that a group of three or more individuals who are independent of the research project has reviewed the protocol and determined that:

(i) The rights and welfare of patients will be adequately protected; and

(ii) The risks in disclosing patient identifying information are outweighed by the potential benefits of the research.

(b) A person conducting research may disclose patient identifying information obtained under paragraph (a) of this section only back to the program from which that information was obtained and may not identify any individual patient in any report of that research or otherwise disclose patient identities.

[52 FR 21809, June 9, 1987, as amended at 52 FR 41997, Nov. 2, 1987]

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§2.53 Audit and evaluation activities.

(a) *Records not copied or removed.* If patient records are not copied or removed, patient identifying information may be disclosed in the course of a review of records on program premises to any person who agrees in writing to comply with the limitations on redisclosure and use in paragraph (d) of this section and who:

(1) Performs the audit or evaluation activity on behalf of:

(i) Any Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

(ii) Any private person which provides financial assistance to the program, which is a third party payer covering patients in the program, or which is a quality improvement organization performing a utilization or quality control review; or

(2) Is determined by the program director to be qualified to conduct the audit or evaluation activities.

(b) *Copying or removal of records.* Records containing patient identifying information may be copied or removed from program premises by any person who:

(1) Agrees in writing to:

(i) Maintain the patient identifying information in accordance with the security requirements provided in §2.16 of these regulations (or more stringent requirements);

(ii) Destroy all the patient identifying information upon completion of the audit or evaluation; and

(iii) Comply with the limitations on disclosure and use in paragraph (d) of this section; and

(2) Performs the audit or evaluation activity on behalf of:

(i) Any Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

(ii) Any private person which provides financial assistance to the program, which is a third part payer covering patients in the program, or which is a quality improvement organization performing a utilization or quality control review.

(c) *Medicare or Medicaid audit or evaluation.* (1) For purposes of Medicare or Medicaid audit or evaluation under this section, audit or evaluation includes a civil or administrative investigation of the program by any Federal, State, or local agency responsible for oversight of the Medicare or Medicaid program and includes administrative enforcement, against the program by the agency, of any remedy authorized by law to be imposed as a result of the findings of the investigation.

(2) Consistent with the definition of program in §2.11, program includes an employee of, or provider of medical services under, the program when the employee or provider is the subject of a civil investigation or administrative remedy, as those terms are used in paragraph (c)(1) of this section.

(3) If a disclosure to a person is authorized under this section for a Medicare or Medicaid audit or evaluation, including a civil investigation or administrative remedy, as those terms are used in paragraph (c)(1) of this section, then a quality improvement organization which obtains the information under paragraph (a) or (b) may disclose the information to that person but only for purposes of Medicare or Medicaid audit or evaluation.

(4) The provisions of this paragraph do not authorize the agency, the program, or any other person to disclose or use patient identifying information obtained during the audit or evaluation for any purposes other than those necessary to complete the Medicare or Medicaid audit or evaluation activity as specified in this paragraph.

(d) *Limitations on disclosure and use.* Except as provided in paragraph (c) of this section, patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by a court order entered under §2.66 of these regulations.

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Subpart E—Court Orders Authorizing Disclosure and Use

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§2.61 Legal effect of order.

(a) *Effect.* An order of a court of competent jurisdiction entered under this subpart is a unique kind of court order. Its only purpose is to authorize a disclosure or use of patient information which would otherwise be prohibited by 42 U.S.C. 290ee-3, 42 U.S.C. 290dd-3 and these regulations. Such an order does not compel disclosure. A subpoena or a similar legal mandate must be issued in order to compel disclosure. This mandate may be entered at the same time as and accompany an authorizing court order entered under these regulations.

(b) *Examples.* (1) A person holding records subject to these regulations receives a subpoena for those records: a response to the subpoena is not permitted under the regulations unless an authorizing court order is entered. The person may not disclose the records in response to the subpoena unless a court of competent jurisdiction enters an authorizing order under these regulations.

(2) An authorizing court order is entered under these regulations, but the person authorized does not want to make the disclosure. If there is no subpoena or other compulsory process or a subpoena for the records has expired or been quashed, that person may refuse to make the disclosure. Upon the entry of a valid subpoena or other compulsory process the person authorized to disclose must disclose, unless there is a valid legal defense to the process other than the confidentiality restrictions of these regulations.

[52 FR 21809, June 9, 1987; 52 FR 42061, Nov. 2, 1987]

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§2.62 Order not applicable to records disclosed without consent to researchers, auditors and evaluators.

A court order under these regulations may not authorize qualified personnel, who have received patient identifying information without consent for the purpose of conducting research, audit or evaluation, to disclose that information or use it to conduct any criminal investigation or prosecution of a patient. However, a court order under §2.66 may authorize disclosure and use of records to investigate or prosecute qualified personnel holding the records.

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§2.63 Confidential communications.

(a) A court order under these regulations may authorize disclosure of confidential communications made by a patient to a program in the course of diagnosis, treatment, or referral for treatment only if:

(1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties;

(2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect; or

(3) The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

(b) [Reserved]

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§2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.

(a) *Application.* An order authorizing the disclosure of patient records for purposes other than criminal investigation or prosecution may be applied for by any person having a legally recognized interest in the disclosure which is sought. The application may be filed separately or as part of a pending civil action in which it appears that the patient records are needed to provide evidence. An application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the patient is the applicant or has given a written consent (meeting the requirements of these regulations) to disclosure or the court has ordered the record of the proceeding sealed from public scrunity.

(b) *Notice.* The patient and the person holding the records from whom disclosure is sought must be given:

(1) Adequate notice in a manner which will not disclose patient identifying information to other persons; and

(2) An opportunity to file a written response to the application, or to appear in person, for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order.

(c) *Review of evidence: Conduct of hearing.* Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceeding, the patient, or the person holding the record, unless the patient requests an open hearing in a manner which meets the written consent requirements of these regulations. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria for entry of order.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find that:

(1) Other ways of obtaining the information are not available or would not be effective; and

(2) The public interest and need for the disclosure outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.

(e) *Content of order.* An order authorizing a disclosure must:

(1) Limit disclosure to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those persons whose need for information is the basis for the order; and

(3) Include such other measures as are necessary to limit disclosure for the protection of the patient, the physician-patient relationship and the treatment services; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

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§2.65 Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients.

(a) *Application.* An order authorizing the disclosure or use of patient records to criminally

investigate or prosecute a patient may be applied for by the person holding the records or by any person conducting investigative or prosecutorial activities with respect to the enforcement of criminal laws. The application may be filed separately, as part of an application for a subpoena or other compulsory process, or in a pending criminal action. An application must use a fictitious name such as John Doe, to refer to any patient and may not contain or otherwise disclose patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice and hearing.* Unless an order under §2.66 is sought with an order under this section, the person holding the records must be given:

(1) Adequate notice (in a manner which will not disclose patient identifying information to third parties) of an application by a person performing a law enforcement function;

(2) An opportunity to appear and be heard for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order; and

(3) An opportunity to be represented by counsel independent of counsel for an applicant who is a person performing a law enforcement function.

(c) *Review of evidence: Conduct of hearings.* Any oral argument, review of evidence, or hearing on the application shall be held in the judge's chambers or in some other manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceedings, the patient, or the person holding the records. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria.* A court may authorize the disclosure and use of patient records for the purpose of conducting a criminal investigation or prosecution of a patient only if the court finds that all of the following criteria are met:

(1) The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect.

(2) There is a reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.

(3) Other ways of obtaining the information are not available or would not be effective.

(4) The potential injury to the patient, to the physician-patient relationship and to the ability of the program to provide services to other patients is outweighed by the public interest and the need for the disclosure.

(5) If the applicant is a person performing a law enforcement function that:

(i) The person holding the records has been afforded the opportunity to be represented by independent counsel; and

(ii) Any person holding the records which is an entity within Federal, State, or local government has in fact been represented by counsel independent of the applicant.

(e) *Content of order.* Any order authorizing a disclosure or use of patient records under this section must:

(1) Limit disclosure and use to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those law enforcement and prosecutorial officials who are responsible for, or are conducting, the investigation or prosecution, and limit their use of the records to investigation and

prosecution of extremely serious crime or suspected crime specified in the application; and

(3) Include such other measures as are necessary to limit disclosure and use to the fulfillment of only that public interest and need found by the court.

[52 FR 21809, June 9, 1987; 52 FR 42061, Nov. 2, 1987]

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§2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a program or the person holding the records.

(a) *Application.* (1) An order authorizing the disclosure or use of patient records to criminally or administratively investigate or prosecute a program or the person holding the records (or employees or agents of that program or person) may be applied for by any administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency having jurisdiction over the program's or person's activities.

(2) The application may be filed separately or as part of a pending civil or criminal action against a program or the person holding the records (or agents or employees of the program or person) in which it appears that the patient records are needed to provide material evidence. The application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny or the patient has given a written consent (meeting the requirements of §2.31 of these regulations) to that disclosure.

(b) *Notice not required.* An application under this section may, in the discretion of the court, be granted without notice. Although no express notice is required to the program, to the person holding the records, or to any patient whose records are to be disclosed, upon implementation of an order so granted any of the above persons must be afforded an opportunity to seek revocation or amendment of that order, limited to the presentation of evidence on the statutory and regulatory criteria for the issuance of the court order.

(c) *Requirements for order.* An order under this section must be entered in accordance with, and comply with the requirements of, paragraphs (d) and (e) of §2.64 of these regulations.

(d) *Limitations on disclosure and use of patient identifying information:* (1) An order entered under this section must require the deletion of patient identifying information from any documents made available to the public.

(2) No information obtained under this section may be used to conduct any investigation or prosecution of a patient, or be used as the basis for an application for an order under §2.65 of these regulations.

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§2.67 Orders authorizing the use of undercover agents and informants to criminally investigate employees or agents of a program.

(a) *Application.* A court order authorizing the placement of an undercover agent or informant in a program as an employee or patient may be applied for by any law enforcement or prosecutorial agency which has reason to believe that employees or agents of the program are engaged in criminal misconduct.

(b) *Notice.* The program director must be given adequate notice of the application and an opportunity to appear and be heard (for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order), unless the application asserts a belief that:

(1) The program director is involved in the criminal activities to be investigated by the undercover agent or informant; or

(2) The program director will intentionally or unintentionally disclose the proposed placement of an undercover agent or informant to the employees or agents who are suspected of criminal activities.

(c) *Criteria.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find:

(1) There is reason to believe that an employee or agent of the program is engaged in criminal activity;

(2) Other ways of obtaining evidence of this criminal activity are not available or would not be effective; and

(3) The public interest and need for the placement of an undercover agent or informant in the program outweigh the potential injury to patients of the program, physician-patient relationships and the treatment services.

(d) *Content of order.* An order authorizing the placement of an undercover agent or informant in a program must:

(1) Specifically authorize the placement of an undercover agent or an informant;

(2) Limit the total period of the placement to six months;

(3) Prohibit the undercover agent or informant from disclosing any patient identifying information obtained from the placement except as necessary to criminally investigate or prosecute employees or agents of the program; and

(4) Include any other measures which are appropriate to limit any potential disruption of the program by the placement and any potential for a real or apparent breach of patient confidentiality; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

(e) *Limitation on use of information.* No information obtained by an undercover agent or informant placed under this section may be used to criminally investigate or prosecute any patient or as the basis for an application for an order under §2.65 of these regulations.

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Mission

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

Contents

ACA Code of Ethics Preamble

The American Counseling Association (ACA) is an educational, scientific, and professional organization whose members work in a variety of settings and serve in multiple capacities. Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals.

Professional values are an important way of living out an ethical commitment. The following are core professional values of the counseling profession:

1. enhancing human development throughout the life span;
2. honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts;
3. promoting social justice;
4. safeguarding the integrity of the counselor–client relationship; and
5. practicing in a competent and ethical manner.

These professional values provide a conceptual basis for the ethical principles enumerated below. These principles are the foundation for ethical behavior and decision making. The fundamental principles of professional ethical behavior are

- *autonomy*, or fostering the right to control the direction of one's life;
- *nonmaleficence*, or avoiding actions that cause harm;
- *beneficence*, or working for the good of the individual and society by promoting mental health and well-being;
- *justice*, or treating individuals equitably and fostering fairness and equality;
- *fidelity*, or honoring commitments and keeping promises, including fulfilling one's responsibilities of trust in professional relationships; and
- *veracity*, or dealing truthfully with individuals with whom counselors come into professional contact.

ACA Code of Ethics Purpose

The *ACA Code of Ethics* serves six main purposes:

1. The *Code* sets forth the ethical obligations of ACA members and provides guidance intended to inform the ethical practice of professional counselors.
2. The *Code* identifies ethical considerations relevant to professional counselors and counselors-in-training.
3. The *Code* enables the association to clarify for current and prospective members, and for those served by members, the nature of the ethical responsibilities held in common by its members.
4. The *Code* serves as an ethical guide designed to assist members in constructing a course of action that best serves those utilizing counseling services and establishes expectations of conduct with a primary emphasis on the role of the professional counselor.
5. The *Code* helps to support the mission of ACA.
6. The standards contained in this *Code* serve as the basis for processing inquiries and ethics complaints concerning ACA members.

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

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

Each section of the *ACA Code of Ethics* begins with an introduction. The introduction to each section describes the ethical behavior and responsibility to which counselors aspire. The introductions help set the tone for each particular section and provide a starting point that invites reflection on the ethical standards contained in each part of the *ACA Code of Ethics*. The standards outline professional responsibilities and provide direction for fulfilling those ethical responsibilities.

When counselors are faced with ethical dilemmas that are difficult to resolve, they are expected to engage in a carefully considered ethical decision-making process, consulting available resources as needed. Counselors acknowledge that resolving ethical issues is a process; ethical reasoning includes consideration of professional values, professional ethical principles, and ethical standards.

Counselors' actions should be consistent with the spirit as well as the letter of these ethical standards. No specific ethical decision-making model is always most effective, so counselors are expected to use a credible model of decision making that can bear public scrutiny of its application. Through a chosen ethical decision-making process and evaluation of the context of the situation, counselors work collaboratively with clients to make decisions that promote clients' growth and development. A breach of the standards and principles provided herein does not necessarily constitute legal liability or violation of the law; such action is established in legal and judicial proceedings.

The glossary at the end of the *Code* provides a concise description of some of the terms used in the *ACA Code of Ethics*.

Section A

The Counseling Relationship

Introduction

Counselors facilitate client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relationships. Trust is the cornerstone of the counseling relationship, and counselors have the responsibility to respect and safeguard the client's right to privacy and confidentiality. Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve. Counselors also explore their own cultural identities and how these affect their values and beliefs about the counseling process. Additionally, counselors are encouraged to contribute to society by devoting a portion of their professional activities for little or no financial return (*pro bono publico*).

A.1. Client Welfare

A.1.a. Primary Responsibility

The primary responsibility of counselors is to respect the dignity and promote the welfare of clients.

A.1.b. Records and Documentation

Counselors create, safeguard, and maintain documentation necessary for rendering professional services. Regardless of the medium, counselors include sufficient and timely documentation to facilitate the delivery and continuity of services. Counselors take reasonable steps to ensure that documentation accurately reflects client progress and services provided. If amendments are made to records and documentation, counselors take steps to properly note the amendments according to agency or institutional policies.

A.1.c. Counseling Plans

Counselors and their clients work jointly in devising counseling plans that offer reasonable promise of success and are consistent with the abilities, temperament, developmental level, and circumstances of clients. Counselors and clients regularly review and revise counseling plans to assess their continued viability and effectiveness, respecting clients' freedom of choice.

A.1.d. Support Network Involvement

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

A.2. Informed Consent in the Counseling Relationship

A.2.a. Informed Consent

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

A.2.b. Types of Information Needed

Counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials, relevant experience, and approach to counseling; continuation of services upon the incapacitation or death of the counselor; the role of technology; and other pertinent information. Counselors take steps to ensure that clients understand the implications of diagnosis and the intended use of tests and reports. Additionally, counselors inform clients about fees and billing arrangements, including procedures for nonpayment of fees. Clients have the right to confidentiality and to be provided with an explanation of its limits (including how supervisors and/or treatment or interdisciplinary team professionals are involved), to obtain clear information about their records, to participate in the ongoing counseling plans, and to refuse any services or modality changes and to be advised of the consequences of such refusal.

A.2.c. Developmental and Cultural Sensitivity

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

A.2.d. Inability to Give Consent

When counseling minors, incapacitated adults, or other persons unable to give voluntary consent, counselors seek the assent of clients to services and include them in decision making as appropriate. Counselors recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf.

A.2.e. Mandated Clients

Counselors discuss the required limitations to confidentiality when working with clients who have been mandated for counseling services. Counselors also explain what type of information and with whom that information is shared prior to the beginning of counseling. The client may choose to refuse services. In this case, counselors will, to the best of their ability, discuss with the client the potential consequences of refusing counseling services.

A.3. Clients Served by Others

When counselors learn that their clients are in a professional relationship with other mental health professionals, they request release from clients to inform the other professionals and strive to establish positive and collaborative professional relationships.

A.4. Avoiding Harm and Imposing Values

A.4.a. Avoiding Harm

Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm.

A.4.b. Personal Values

Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature.

A.5. Prohibited Noncounseling Roles and Relationships

A.5.a. Sexual and/or Romantic Relationships Prohibited

Sexual and/or romantic counselor–client interactions or relationships with current clients, their romantic partners, or their family members are prohibited. This prohibition applies to both in-person and electronic interactions or relationships.

A.5.b. Previous Sexual and/or Romantic Relationships

Counselors are prohibited from engaging in counseling relationships with persons with whom they have had a previous sexual and/or romantic relationship.

A.5.c. Sexual and/or Romantic Relationships With Former Clients

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

A.5.d. Friends or Family Members

Counselors are prohibited from engaging in counseling relationships with friends or family members with whom they have an inability to remain objective.

A.5.e. Personal Virtual Relationships With Current Clients

Counselors are prohibited from engaging in a personal virtual relationship with individuals with whom they have a current counseling relationship (e.g., through social and other media).

A.6. Managing and Maintaining Boundaries and Professional Relationships

A.6.a. Previous Relationships

Counselors consider the risks and benefits of accepting as clients those with whom they have had a previous relationship. These potential clients may include individuals with whom the counselor has had a casual, distant, or past relationship. Examples include mutual or past membership in a professional association, organization, or community. When counselors accept these clients, they take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs.

A.6.b. Extending Counseling Boundaries

Counselors consider the risks and benefits of extending current counseling relationships beyond conventional parameters. Examples include attending a client's formal ceremony (e.g., a wedding/commitment ceremony or graduation), purchasing a service or product provided by a client (excepting unrestricted bartering), and visiting a client's ill family member in the hospital. In extending these boundaries, counselors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no harm occurs.

A.6.c. Documenting Boundary Extensions

If counselors extend boundaries as described in A.6.a. and A.6.b., they must officially document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. When unintentional harm occurs to the client or former client, or to an individual significantly involved with the client or former client, the counselor must show evidence of an attempt to remedy such harm.

A.6.d. Role Changes in the Professional Relationship

When counselors change a role from the original or most recent contracted relationship, they obtain informed consent from the client and explain the client's right to refuse services related to the change. Examples of role changes include, but are not limited to

1. changing from individual to relationship or family counseling, or vice versa;
2. changing from an evaluative role to a therapeutic role, or vice versa; and
3. changing from a counselor to a mediator role, or vice versa.

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

A.6.e. Nonprofessional Interactions or Relationships (Other Than Sexual or Romantic Interactions or Relationships)

Counselors avoid entering into nonprofessional relationships with former clients, their romantic partners, or their family members when the interaction is potentially harmful to the client. This applies to both in-person and electronic interactions or relationships.

A.7. Roles and Relationships at Individual, Group, Institutional, and Societal Levels

A.7.a. Advocacy

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

A.7.b. Confidentiality and Advocacy

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

A.8. Multiple Clients

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

A.9. Group Work

A.9.a. Screening

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

A.9.b. Protecting Clients

In a group setting, counselors take reasonable precautions to protect clients from physical, emotional, or psychological trauma.

A.10. Fees and Business Practices

A.10.a. Self-Referral

Counselors working in an organization (e.g., school, agency, institution) that provides counseling services do not refer clients to their private practice unless the policies of a particular organization make explicit provisions for self-referrals. In such instances, the clients must be informed of other options open to them should they seek private counseling services.

A.10.b. Unacceptable Business Practices

Counselors do not participate in fee splitting, nor do they give or receive commissions, rebates, or any other form of remuneration when referring clients for professional services.

A.10.c. Establishing Fees

In establishing fees for professional counseling services, counselors consider the financial status of clients and locality. If a counselor's usual fees create undue hardship for the client, the counselor may adjust fees, when legally permissible, or assist the client in locating comparable, affordable services.

A.10.d. Nonpayment of Fees

If counselors intend to use collection agencies or take legal measures to collect fees from clients who do not pay for services as agreed upon, they include such information in their informed consent documents and also inform clients in a timely fashion of intended actions and offer clients the opportunity to make payment.

A.10.e. Bartering

Counselors may barter only if the bartering does not result in exploitation or harm, if the client requests it, and if such arrangements are an accepted practice among professionals in the community. Counselors consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract.

A.10.f. Receiving Gifts

Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and gratitude. When determining whether to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift.

A.11. Termination and Referral

A.11.a. Competence Within Termination and Referral

If counselors lack the competence to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors discontinue the relationship.

A.11.b. Values Within Termination and Referral

Counselors refrain from referring prospective and current clients based solely on the counselor's personally held values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature.

A.11.c. Appropriate Termination

Counselors terminate a counseling relationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, or is being harmed by continued counseling. Counselors may terminate counseling when in jeopardy of harm by the client or by another person with whom the client has a relationship, or when clients do not pay fees as agreed upon. Counselors provide pretermination counseling and recommend other service providers when necessary.

A.11.d. Appropriate Transfer of Services

When counselors transfer or refer clients to other practitioners, they ensure that appropriate clinical and administrative processes are completed and open communication is maintained with both clients and practitioners.

A.12. Abandonment and Client Neglect

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

Section B

Confidentiality and Privacy

Introduction

Counselors recognize that trust is a cornerstone of the counseling relationship. Counselors aspire to earn the trust of clients by creating an ongoing partnership, establishing and upholding appropriate boundaries, and maintaining confidentiality. Counselors communicate the parameters of confidentiality in a culturally competent manner.

B.1. Respecting Client Rights

B.1.a. Multicultural/Diversity Considerations

Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared.

B.1.b. Respect for Privacy

Counselors respect the privacy of prospective and current clients. Counselors request private information from clients only when it is beneficial to the counseling process.

B.1.c. Respect for Confidentiality

Counselors protect the confidential information of prospective and current clients. Counselors disclose information only with appropriate consent or with sound legal or ethical justification.

B.1.d. Explanation of Limitations

At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify situations in which confidentiality must be breached.

B.2. Exceptions

B.2.a. Serious and Foreseeable Harm and Legal Requirements

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

B.2.b. Confidentiality Regarding End-of-Life Decisions

Counselors who provide services to terminally ill individuals who are considering hastening their own deaths have the option to maintain confidentiality, depending on applicable laws and the specific circumstances of the situation and after seeking consultation or supervision from appropriate professional and legal parties.

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

When clients disclose that they have a disease commonly known to be both communicable and life threatening, counselors may be justified in disclosing information to identifiable third parties, if the parties are known to be at serious and foreseeable risk of contracting the disease. Prior to making a disclosure, counselors assess the intent of clients to inform the third parties about their disease or to engage in any behaviors that may be harmful to an identifiable third party. Counselors adhere to relevant state laws concerning disclosure about disease status.

B.2.d. Court-Ordered Disclosure

When ordered by a court to release confidential or privileged information without a client's permission, counselors seek to obtain written, informed consent from the client or take steps to prohibit the disclosure or have it limited as narrowly as possible because of potential harm to the client or counseling relationship.

B.2.e. Minimal Disclosure

To the extent possible, clients are informed before confidential information is disclosed and are involved in the disclosure decision-making process. When circumstances require the disclosure of confidential information, only essential information is revealed.

B.3. Information Shared With Others

B.3.a. Subordinates

Counselors make every effort to ensure that privacy and confidentiality of clients are maintained by subordinates, including employees, supervisees, students, clerical assistants, and volunteers.

B.3.b. Interdisciplinary Teams

When services provided to the client involve participation by an interdisciplinary or treatment team, the client will be informed of the team's existence and composition, information being shared, and the purposes of sharing such information.

B.3.c. Confidential Settings

Counselors discuss confidential information only in settings in which they can reasonably ensure client privacy.

B.3.d. Third-Party Payers

Counselors disclose information to third-party payers only when clients have authorized such disclosure.

B.3.e. Transmitting Confidential Information

Counselors take precautions to ensure the confidentiality of all information transmitted through the use of any medium.

B.3.f. Deceased Clients

Counselors protect the confidentiality of deceased clients, consistent with legal requirements and the documented preferences of the client.

B.4. Groups and Families

B.4.a. Group Work

In group work, counselors clearly explain the importance and parameters of confidentiality for the specific group.

B.4.b. Couples and Family Counseling

In couples and family counseling, counselors clearly define who is considered "the client" and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties regarding the confidentiality of information. In the absence of an agreement to the contrary, the couple or family is considered to be the client.

B.5. Clients Lacking Capacity to Give Informed Consent

B.5.a. Responsibility to Clients

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

B.5.b. Responsibility to Parents and Legal Guardians

Counselors inform parents and legal guardians about the role of counselors and the confidential nature of the counseling relationship, consistent with current legal and custodial arrangements. Counselors are sensitive to the cultural diversity of families and respect the inherent rights and responsibilities of parents/guardians regarding the welfare of their children/charges according to law. Counselors work to establish, as appropriate, collaborative relationships with parents/guardians to best serve clients.

B.5.c. Release of Confidential Information

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

B.6. Records and Documentation

B.6.a. Creating and Maintaining Records and Documentation

Counselors create and maintain records and documentation necessary for rendering professional services.

B.6.b. Confidentiality of Records and Documentation

Counselors ensure that records and documentation kept in any medium are secure and that only authorized persons have access to them.

B.6.c. Permission to Record

Counselors obtain permission from clients prior to recording sessions through electronic or other means.

B.6.d. Permission to Observe

Counselors obtain permission from clients prior to allowing any person to observe counseling sessions, review session transcripts, or view recordings of sessions with supervisors, faculty, peers, or others within the training environment.

B.6.e. Client Access

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

B.6.f. Assistance With Records

When clients request access to their records, counselors provide assistance and consultation in interpreting counseling records.

B.6.g. Disclosure or Transfer

Unless exceptions to confidentiality exist, counselors obtain written permission from clients to disclose or transfer records to legitimate third parties. Steps are taken to ensure that receivers of counseling records are sensitive to their confidential nature.

B.6.h. Storage and Disposal After Termination

Counselors store records following termination of services to ensure reasonable future access, maintain records in accordance with federal and state laws and statutes such as licensure laws and policies governing records, and dispose of client records and other sensitive materials in a manner that protects client confidentiality. Counselors apply careful discretion and deliberation before destroying records that may be needed by a court of law, such as notes on child abuse, suicide, sexual harassment, or violence.

B.6.i. Reasonable Precautions

Counselors take reasonable precautions to protect client confidentiality in the event of the counselor's termination of practice, incapacity, or death and appoint a records custodian when identified as appropriate.

B.7. Case Consultation

B.7.a. Respect for Privacy

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

B.7.b. Disclosure of Confidential Information

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

Section C

Professional Responsibility

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Introduction

Counselors aspire to open, honest, and accurate communication in dealing with the public and other professionals. Counselors facilitate access to counseling services, and they practice in a nondiscriminatory manner within the boundaries of professional and personal competence; they also have a responsibility to abide by the *ACA Code of Ethics*. Counselors actively participate in local, state, and national associations that foster the development and improvement of counseling. Counselors are expected to advocate to promote changes at the individual, group, institutional, and societal levels that improve the quality of life for individuals and groups and remove potential barriers to the provision or access of appropriate services being offered. Counselors have a responsibility to the public to engage in counseling practices that are based on rigorous research methodologies. Counselors are encouraged to contribute to society by devoting a portion of their professional activity to services for which there is little or no financial return (*pro bono publico*). In addition, counselors engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.

C.1. Knowledge of and Compliance With Standards

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

C.2. Professional Competence

C.2.a. Boundaries of Competence

Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population.

C.2.b. New Specialty Areas of Practice

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

C.2.c. Qualified for Employment

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

C.2.d. Monitor Effectiveness

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

C.2.e. Consultations on Ethical Obligations
Counselors take reasonable steps to consult with other counselors, the ACA Ethics and Professional Standards Department, or related professionals when they have questions regarding their ethical obligations or professional practice.

C.2.f. Continuing Education
Counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. Counselors maintain their competence in the skills they use, are open to new procedures, and remain informed regarding best practices for working with diverse populations.

C.2.g. Impairment
Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients.

C.2.h. Counselor Incapacitation, Death, Retirement, or Termination of Practice
Counselors prepare a plan for the transfer of clients and the dissemination of records to an identified colleague or records custodian in the case of the counselor's incapacitation, death, retirement, or termination of practice.

C.3. Advertising and Soliciting Clients

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

C.3.b. Testimonials
Counselors who use testimonials do not solicit them from current clients, former clients, or any other persons who may be vulnerable to undue influence. Counselors discuss with clients the implications of and obtain permission for the use of any testimonial.

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

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

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

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

C.4. Professional Qualifications

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

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

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

C.4.d. Implying Doctoral-Level Competence
Counselors clearly state their highest earned degree in counseling or a closely related field. Counselors do not imply doctoral-level competence when possessing a master's degree in counseling or a related field by referring to themselves as "Dr." in a counseling context when their doctorate is not in counseling or a related field. Counselors do not use "ABD" (all but dissertation) or other such terms to imply competency.

C.4.e. Accreditation Status
Counselors accurately represent the accreditation status of their degree program and college/university.

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

C.5. Nondiscrimination
Counselors do not condone or engage in discrimination against prospective or current clients, students, employees, supervisees, or research participants based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law.

C.6. Public Responsibility

C.6.a. Sexual Harassment
Counselors do not engage in or condone sexual harassment. Sexual harassment can consist of a single intense or severe act, or multiple persistent or pervasive acts.

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

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

1. the statements are based on appropriate professional counseling literature and practice,
2. the statements are otherwise consistent with the *ACA Code of Ethics*, and

3. the recipients of the information are not encouraged to infer that a professional counseling relationship has been established.

C.6.d. Exploitation of Others

Counselors do not exploit others in their professional relationships.

C.6.e. Contributing to the Public Good *(Pro Bono Publico)*

Counselors make a reasonable effort to provide services to the public for which there is little or no financial return (e.g., speaking to groups, sharing professional information, offering reduced fees).

C.7. Treatment Modalities

C.7.a. Scientific Basis for Treatment

When providing services, counselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation.

C.7.b. Development and Innovation

When counselors use developing or innovative techniques/procedures/modalities, they explain the potential risks, benefits, and ethical considerations of using such techniques/procedures/modalities. Counselors work to minimize any potential risks or harm when using these techniques/procedures/modalities.

C.7.c. Harmful Practices

Counselors do not use techniques/procedures/modalities when substantial evidence suggests harm, even if such services are requested.

C.8. Responsibility to Other Professionals

C.8.a. Personal Public Statements

When making personal statements in a public context, counselors clarify that they are speaking from their personal perspectives and that they are not speaking on behalf of all counselors or the profession.

Section D

Relationships With Other Professionals

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Introduction

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

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

D.1.a. Different Approaches

Counselors are respectful of approaches that are grounded in theory and/or have an empirical or scientific foundation but may differ from their own. Counselors acknowledge the expertise of other professional groups and are respectful of their practices.

D.1.b. Forming Relationships

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

D.1.c. Interdisciplinary Teamwork

Counselors who are members of interdisciplinary teams delivering multifaceted services to clients remain focused on how to best serve clients. They participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the counseling profession and those of colleagues from other disciplines.

D.1.d. Establishing Professional and Ethical Obligations

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

D.1.e. Confidentiality

When counselors are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, they clarify role expectations and the parameters of confidentiality with their colleagues.

D.1.f. Personnel Selection and Assignment

When counselors are in a position requiring personnel selection and/or assigning of responsibilities to others, they select competent staff and assign responsibilities compatible with their skills and experiences.

D.1.g. Employer Policies

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

D.1.h. Negative Conditions

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

D.1.i. Protection From Punitive Action

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

D.2. Provision of Consultation Services

D.2.a. Consultant Competency

Counselors take reasonable steps to ensure that they have the appropriate resources and competencies when providing consultation services. Counselors provide appropriate referral resources when requested or needed.

D.2.b. Informed Consent in Formal Consultation

When providing formal consultation services, counselors have an obligation to review, in writing and verbally, the rights and responsibilities of both counselors and consultees. Counselors use clear and understandable language to inform all parties involved about the purpose of the services to be provided, relevant costs, potential risks and benefits, and the limits of confidentiality.

Section E

Evaluation, Assessment, and Interpretation

Introduction

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

E.1. General

E.1.a. Assessment

The primary purpose of educational, mental health, psychological, and career assessment is to gather information regarding the client for a variety of purposes, including, but not limited to, client decision making, treatment planning, and forensic proceedings. Assessment may include both qualitative and quantitative methodologies.

E.1.b. Client Welfare

Counselors do not misuse assessment results and interpretations, and they take reasonable steps to prevent others from misusing the information provided. They respect the client's right to know the results, the interpretations made, and the bases for counselors' conclusions and recommendations.

E.2. Competence to Use and Interpret Assessment Instruments

E.2.a. Limits of Competence

Counselors use only those testing and assessment services for which they have been trained and are competent. Counselors using technology-assisted test interpretations are trained in the construct being measured and the specific instrument being used prior to using its technology-based application. Counselors take reasonable measures to ensure the proper use of assessment techniques by persons under their supervision.

E.2.b. Appropriate Use

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

E.2.c. Decisions Based on Results

Counselors responsible for decisions involving individuals or policies that are based on assessment results have a thorough understanding of psychometrics.

E.3. Informed Consent in Assessment

E.3.a. Explanation to Clients

Prior to assessment, counselors explain the nature and purposes of assessment and the specific use of results by potential recipients. The explanation will be given in terms and language that the client (or other legally authorized person on behalf of the client) can understand.

E.3.b. Recipients of Results

Counselors consider the client's and/or examinee's welfare, explicit understandings, and prior agreements in determining who receives the assessment results. Counselors include accurate and appropriate interpretations with any release of individual or group assessment results.

E.4. Release of Data to Qualified Personnel

Counselors release assessment data in which the client is identified only with the consent of the client or the client's legal representative. Such data are released only to persons recognized by counselors as qualified to interpret the data.

E.5. Diagnosis of Mental Disorders

E.5.a. Proper Diagnosis

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

E.5.b. Cultural Sensitivity

Counselors recognize that culture affects the manner in which clients' problems are defined and experienced. Clients' socioeconomic and cultural experiences are considered when diagnosing mental disorders.

E.5.c. Historical and Social Prejudices in the Diagnosis of Pathology

Counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and strive to become aware of and address such biases in themselves or others.

E.5.d. Refraining From Diagnosis

Counselors may refrain from making and/or reporting a diagnosis if they believe that it would cause harm to the client or others. Counselors carefully consider both the positive and negative implications of a diagnosis.

E.6. Instrument Selection

E.6.a. Appropriateness of Instruments

Counselors carefully consider the validity, reliability, psychometric limitations, and appropriateness of instruments when selecting assessments and, when possible, use multiple forms of assessment, data, and/or instruments in forming conclusions, diagnoses, or recommendations.

E.6.b. Referral Information

If a client is referred to a third party for assessment, the counselor provides specific referral questions and sufficient objective data about the client to ensure that appropriate assessment instruments are utilized.

E.7. Conditions of Assessment Administration

E.7.a. Administration Conditions

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

E.7.b. Provision of Favorable Conditions

Counselors provide an appropriate environment for the administration of assessments (e.g., privacy, comfort, freedom from distraction).

E.7.c. Technological Administration

Counselors ensure that technologically administered assessments function properly and provide clients with accurate results.

E.7.d. Unsupervised Assessments

Unless the assessment instrument is designed, intended, and validated for self-administration and/or scoring, counselors do not permit unsupervised use.

E.8. Multicultural Issues/ Diversity in Assessment

Counselors select and use with caution assessment techniques normed on populations other than that of the client. Counselors recognize the effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpretation, and they place test results in proper perspective with other relevant factors.

E.9. Scoring and Interpretation of Assessments

E.9.a. Reporting

When counselors report assessment results, they consider the client's personal and cultural background, the level of the client's understanding of the results, and the impact of the results on the client. In reporting assessment results, counselors indicate reservations that exist regarding validity or reliability due to circumstances of the assessment or inappropriateness of the norms for the person tested.

E.9.b. Instruments With Insufficient Empirical Data

Counselors exercise caution when interpreting the results of instruments not having sufficient empirical data to support respondent results. The specific purposes for the use of such instruments are stated explicitly to the examinee. Counselors qualify any conclusions, diagnoses, or recommendations made that are based on assessments or instruments with questionable validity or reliability.

E.9.c. Assessment Services

Counselors who provide assessment, scoring, and interpretation services to support the assessment process confirm the validity of such interpretations. They accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use. At all times, counselors maintain their ethical responsibility to those being assessed.

E.10. Assessment Security

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

E.11. Obsolete Assessment and Outdated Results

Counselors do not use data or results from assessments that are obsolete or outdated for the current purpose (e.g., noncurrent versions of assessments/ instruments). Counselors make every effort to prevent the misuse of obsolete measures and assessment data by others.

E.12. Assessment Construction

Counselors use established scientific procedures, relevant standards, and current professional knowledge for assessment design in the development, publication, and utilization of assessment techniques.

E.13. Forensic Evaluation: Evaluation for Legal Proceedings

E.13.a. Primary Obligations

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

E.13.b. Consent for Evaluation

Individuals being evaluated are informed in writing that the relationship is for the purposes of an evaluation and is not therapeutic in nature, and entities or individuals who will receive the evaluation report are identified. Counselors who perform forensic evaluations obtain written consent from those being evaluated or from their legal representative unless a court orders evaluations to be conducted without the written consent of the individuals being evaluated. When children or adults who lack the capacity to give voluntary consent are being evaluated, informed written consent is obtained from a parent or guardian.

E.13.c. Client Evaluation Prohibited

Counselors do not evaluate current or former clients, clients' romantic partners, or clients' family members for forensic purposes. Counselors do not counsel individuals they are evaluating.

E.13.d. Avoid Potentially Harmful Relationships

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

Section F

Supervision, Training, and Teaching

Introduction

Counselor supervisors, trainers, and educators aspire to foster meaningful and respectful professional relationships and to maintain appropriate boundaries with supervisees and students in both face-to-face and electronic formats. They have theoretical and pedagogical foundations for their work; have knowledge of supervision models; and aim to be fair, accurate, and honest in their assessments of counselors, students, and supervisees.

F.1. Counselor Supervision and Client Welfare

F.1.a. Client Welfare

A primary obligation of counseling supervisors is to monitor the services provided by supervisees. Counseling supervisors monitor client welfare and supervisee performance and professional development. To fulfill these obligations, supervisors meet regularly with supervisees to review the supervisees' work and help them become prepared to serve a range of diverse clients. Supervisees have a responsibility to understand and follow the *ACA Code of Ethics*.

F.1.b. Counselor Credentials

Counseling supervisors work to ensure that supervisees communicate their

qualifications to render services to their clients.

F.1.c. Informed Consent and Client Rights

Supervisors make supervisees aware of client rights, including the protection of client privacy and confidentiality in the counseling relationship. Supervisees provide clients with professional disclosure information and inform them of how the supervision process influences the limits of confidentiality. Supervisees make clients aware of who will have access to records of the counseling relationship and how these records will be stored, transmitted, or otherwise reviewed.

F.2. Counselor Supervision Competence

F.2.a. Supervisor Preparation

Prior to offering supervision services, counselors are trained in supervision methods and techniques. Counselors who offer supervision services regularly pursue continuing education activities, including both counseling and supervision topics and skills.

F.2.b. Multicultural Issues/ Diversity in Supervision

Counseling supervisors are aware of and address the role of multiculturalism/ diversity in the supervisory relationship.

F.2.c. Online Supervision

When using technology in supervision, counselor supervisors are competent in the use of those technologies. Supervisors take the necessary precautions to protect the confidentiality of all information transmitted through any electronic means.

F.3. Supervisory Relationship

F.3.a. Extending Conventional Supervisory Relationships

Counseling supervisors clearly define and maintain ethical professional, personal, and social relationships with their supervisees. Supervisors consider the risks and benefits of extending current supervisory relationships in any form beyond conventional parameters. In extending these boundaries, supervisors take appropriate professional precautions to ensure that judgment is not impaired and that no harm occurs.

F.3.b. Sexual Relationships

Sexual or romantic interactions or relationships with current supervisees are prohibited. This prohibition applies to both in-person and electronic interactions or relationships.

F.3.c. Sexual Harassment

Counseling supervisors do not condone or subject supervisees to sexual harassment.

F.3.d. Friends or Family Members

Supervisors are prohibited from engaging in supervisory relationships with individuals with whom they have an inability to remain objective.

F.4. Supervisor Responsibilities

F.4.a. Informed Consent for Supervision

Supervisors are responsible for incorporating into their supervision the principles of informed consent and participation. Supervisors inform supervisees of the policies and procedures to which supervisors are to adhere and the mechanisms for due process appeal of individual supervisor actions. The issues unique to the use of distance supervision are to be included in the documentation as necessary.

F.4.b. Emergencies and Absences

Supervisors establish and communicate to supervisees procedures for contacting supervisors or, in their absence, alternative on-call supervisors to assist in handling crises.

F.4.c. Standards for Supervisees

Supervisors make their supervisees aware of professional and ethical standards and legal responsibilities.

F.4.d. Termination of the Supervisory Relationship

Supervisors or supervisees have the right to terminate the supervisory relationship with adequate notice. Reasons for considering termination are discussed, and both parties work to resolve differences. When termination is warranted, supervisors make appropriate referrals to possible alternative supervisors.

F.5. Student and Supervisee Responsibilities

F.5.a. Ethical Responsibilities

Students and supervisees have a responsibility to understand and follow the *ACA Code of Ethics*. Students and supervisees have the same obligation to clients as those required of professional counselors.

F.5.b. Impairment

Students and supervisees monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They notify their faculty and/or supervisors and seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work.

F.5.c. Professional Disclosure

Before providing counseling services, students and supervisees disclose their status as supervisees and explain how this status affects the limits of confidentiality. Supervisors ensure that clients are aware of the services rendered and the qualifications of the students and supervisees rendering those services. Students and supervisees obtain client permission before they use any information concerning the counseling relationship in the training process.

F.6. Counseling Supervision Evaluation, Remediation, and Endorsement

F.6.a. Evaluation

Supervisors document and provide supervisees with ongoing feedback regarding their performance and schedule periodic formal evaluative sessions throughout the supervisory relationship.

F.6.b. Gatekeeping and Remediation

Through initial and ongoing evaluation, supervisors are aware of supervisee limitations that might impede performance. Supervisors assist supervisees in securing remedial assistance when needed. They recommend dismissal from training programs, applied counseling settings, and state or voluntary professional credentialing processes when those supervisees are unable to demonstrate that they can provide competent professional services to a range of diverse clients. Supervisors seek consultation and document their decisions to dismiss or refer supervisees for assistance. They ensure that supervisees are aware of options available to them to address such decisions.

F.6.c. Counseling for Supervisees

If supervisees request counseling, the supervisor assists the supervisee in identifying appropriate services. Supervisors do not provide counseling services to supervisees. Supervisors address interpersonal competencies in terms of the impact of these issues on clients, the supervisory relationship, and professional functioning.

F.6.d. Endorsements

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

F.7. Responsibilities of Counselor Educators

F.7.a. Counselor Educators

Counselor educators who are responsible for developing, implementing, and supervising educational programs are skilled as teachers and practitioners. They are knowledgeable regarding the ethical, legal, and regulatory aspects of the profession; are skilled in applying that knowledge; and make students and supervisees aware of their responsibilities. Whether in traditional, hybrid, and/or online formats, counselor educators conduct counselor education and training programs in an ethical manner and serve as role models for professional behavior.

F.7.b. Counselor Educator Competence

Counselors who function as counselor educators or supervisors provide instruction within their areas of knowledge and competence and provide instruction based on current information and knowledge available in the profession. When using technology to deliver instruction, counselor educators develop competence in the use of the technology.

F.7.c. Infusing Multicultural Issues/Diversity

Counselor educators infuse material related to multiculturalism/diversity into all courses and workshops for the development of professional counselors.

F.7.d. Integration of Study and Practice

In traditional, hybrid, and/or online formats, counselor educators establish education and training programs that integrate academic study and supervised practice.

F.7.e. Teaching Ethics

Throughout the program, counselor educators ensure that students are aware of the ethical responsibilities and standards of the profession and the ethical responsibilities of students to the profession. Counselor educators infuse ethical considerations throughout the curriculum.

F.7.f. Use of Case Examples

The use of client, student, or supervisee information for the purposes of case examples in a lecture or classroom setting is permissible only when (a) the client, student, or supervisee has reviewed the material and agreed to its presentation or (b) the information has been sufficiently modified to obscure identity.

F.7.g. Student-to-Student Supervision and Instruction

When students function in the role of counselor educators or supervisors, they understand that they have the same ethical obligations as counselor educators, trainers, and supervisors. Counselor educators make every effort to ensure that the rights of students are not compromised when their peers lead experiential counseling activities in traditional, hybrid, and/or online formats (e.g., counseling groups, skills classes, clinical supervision).

F.7.h. Innovative Theories and Techniques

Counselor educators promote the use of techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation. When counselor educators discuss developing or innovative techniques/procedures/modalities, they explain the potential risks, benefits, and ethical considerations of using such techniques/procedures/modalities.

F.7.i. Field Placements

Counselor educators develop clear policies and provide direct assistance within their training programs regarding appropriate field placement and other clinical experiences. Counselor educators provide clearly stated roles and responsibilities for the student or supervisee, the site supervisor, and the program supervisor. They confirm that site supervisors are qualified to provide supervision in the formats in which services are provided and inform site supervisors of their professional and ethical responsibilities in this role.

F.8. Student Welfare

F.8.a. Program Information and Orientation

Counselor educators recognize that program orientation is a developmental process that begins upon students' initial contact with the counselor education program and continues throughout the educational and clinical training of students. Counselor education faculty provide prospective and current students with information about the counselor education program's expectations, including

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

F.8.b. Student Career Advising

Counselor educators provide career advisement for their students and make them aware of opportunities in the field.

F.8.c. Self-Growth Experiences

Self-growth is an expected component of counselor education. Counselor educators are mindful of ethical principles when they require students to engage in self-growth experiences. Counselor educators and supervisors inform students that they have a right to decide what information will be shared or withheld in class.

F.8.d. Addressing Personal Concerns

Counselor educators may require students to address any personal concerns that have the potential to affect professional competency.

F.9. Evaluation and Remediation

F.9.a. Evaluation of Students

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

F.9.b. Limitations

Counselor educators, through ongoing evaluation, are aware of and address the inability of some students to achieve counseling competencies. Counselor educators do the following:

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

F.9.c. Counseling for Students

If students request counseling, or if counseling services are suggested as part of a remediation process, counselor educators assist students in identifying appropriate services.

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

F.10.a. Sexual or Romantic Relationships

Counselor educators are prohibited from sexual or romantic interactions or relationships with students currently enrolled in a counseling or related program and over whom they have power and authority. This prohibition applies to both in-person and electronic interactions or relationships.

F.10.b. Sexual Harassment

Counselor educators do not condone or subject students to sexual harassment.

F.10.c. Relationships With Former Students

Counselor educators are aware of the power differential in the relationship between faculty and students. Faculty members discuss with former students potential risks when they consider engaging in social, sexual, or other intimate relationships.

F.10.d. Nonacademic Relationships

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

F.10.e. Counseling Services

Counselor educators do not serve as counselors to students currently enrolled in a counseling or related program and over whom they have power and authority.

F.10.f. Extending Educator–Student Boundaries

Counselor educators are aware of the power differential in the relationship between faculty and students. If they believe that a nonprofessional relationship with a student may be potentially beneficial to the student, they take precautions similar to those taken by counselors when working with clients. Examples of potentially beneficial interactions or relationships include, but are not limited to, attending a formal ceremony; conducting hospital visits; providing support during a stressful event; or maintaining mutual membership in a professional association, organization, or community. Counselor educators discuss with students the rationale for such interactions, the potential benefits and drawbacks, and the anticipated consequences for the student. Educators clarify the specific nature and limitations of the additional role(s) they will have with the student prior to engaging in a nonprofessional relationship. Nonprofessional relationships with students should be time limited and/or context specific and initiated with student consent.

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

F.11.a. Faculty Diversity

Counselor educators are committed to recruiting and retaining a diverse faculty.

F.11.b. Student Diversity

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

F.11.c. Multicultural/Diversity Competence

Counselor educators actively infuse multicultural/diversity competency in their training and supervision practices. They actively train students to gain awareness, knowledge, and skills in the competencies of multicultural practice.

Section G

Research and Publication

Introduction

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

G.1. Research Responsibilities

G.1.a. Conducting Research

Counselors plan, design, conduct, and report research in a manner that is consistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research.

G.1.b. Confidentiality in Research

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

G.1.c. Independent Researchers

When counselors conduct independent research and do not have access to an institutional review board, they are bound to the same ethical principles and

federal and state laws pertaining to the review of their plan, design, conduct, and reporting of research.

G.1.d. Deviation From Standard Practice

Counselors seek consultation and observe stringent safeguards to protect the rights of research participants when research indicates that a deviation from standard or acceptable practices may be necessary.

G.1.e. Precautions to Avoid Injury

Counselors who conduct research are responsible for their participants' welfare throughout the research process and should take reasonable precautions to avoid causing emotional, physical, or social harm to participants.

G.1.f. Principal Researcher Responsibility

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

G.2. Rights of Research Participants

G.2.a. Informed Consent in Research

Individuals have the right to decline requests to become research participants. In seeking consent, counselors use language that

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

G.2.b. Student/Supervisee Participation

Researchers who involve students or supervisees in research make clear to them that the decision regarding participation in research activities does not affect their academic standing or supervisory relationship. Students or supervisees who choose not to participate in research are provided with an appropriate alternative to fulfill their academic or clinical requirements.

G.2.c. Client Participation

Counselors conducting research involving clients make clear in the informed consent process that clients are free to choose whether to participate in research activities. Counselors take necessary precautions to protect clients from adverse consequences of declining or withdrawing from participation.

G.2.d. Confidentiality of Information

Information obtained about research participants during the course of research is confidential. Procedures are implemented to protect confidentiality.

G.2.e. Persons Not Capable of Giving Informed Consent

When a research participant is not capable of giving informed consent, counselors provide an appropriate explanation to, obtain agreement for participation from, and obtain the appropriate consent of a legally authorized person.

G.2.f. Commitments to Participants

Counselors take reasonable measures to honor all commitments to research participants.

G.2.g. Explanations After Data Collection

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

G.2.h. Informing Sponsors

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

G.2.i. Research Records Custodian

As appropriate, researchers prepare and disseminate to an identified colleague or records custodian a plan for the transfer of research data in the case of their incapacitation, retirement, or death.

G.3. Managing and Maintaining Boundaries

G.3.a. Extending Researcher–Participant Boundaries

Researchers consider the risks and benefits of extending current research relationships beyond conventional parameters. When a nonresearch interaction between the researcher and the research participant may be potentially beneficial, the researcher must document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the research participant. Such interactions should be initiated with appropriate consent of the research participant. Where unintentional harm occurs to the research participant, the researcher must show evidence of an attempt to remedy such harm.

G.3.b. Relationships With Research Participants

Sexual or romantic counselor–research participant interactions or relationships with current research participants are prohibited. This prohibition applies to both in-person and electronic interactions or relationships.

G.3.c. Sexual Harassment and Research Participants

Researchers do not condone or subject research participants to sexual harassment.

G.4. Reporting Results

G.4.a. Accurate Results

Counselors plan, conduct, and report research accurately. Counselors do not engage in misleading or fraudulent research, distort data, misrepresent data, or deliberately bias their results. They describe the extent to which results are applicable for diverse populations.

G.4.b. Obligation to Report Unfavorable Results

Counselors report the results of any research of professional value. Results that reflect unfavorably on institutions, programs, services, prevailing opinions, or vested interests are not withheld.

G.4.c. Reporting Errors

If counselors discover significant errors in their published research, they take

reasonable steps to correct such errors in a correction erratum or through other appropriate publication means.

G.4.d. Identity of Participants

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

G.4.e. Replication Studies

Counselors are obligated to make available sufficient original research information to qualified professionals who may wish to replicate or extend the study.

G.5. Publications and Presentations

G.5.a. Use of Case Examples

The use of participants', clients', students', or supervisees' information for the purpose of case examples in a presentation or publication is permissible only when (a) participants, clients, students, or supervisees have reviewed the material and agreed to its presentation or publication or (b) the information has been sufficiently modified to obscure identity.

G.5.b. Plagiarism

Counselors do not plagiarize; that is, they do not present another person's work as their own.

G.5.c. Acknowledging Previous Work

In publications and presentations, counselors acknowledge and give recognition to previous work on the topic by others or self.

G.5.d. Contributors

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

G.5.e. Agreement of Contributors

Counselors who conduct joint research with colleagues or students/supervisors establish agreements in advance regarding allocation of tasks, publication credit, and types of acknowledgment that will be received.

G.5.f. Student Research

Manuscripts or professional presentations in any medium that are substantially based on a student's course papers, projects, dissertations, or theses are used only with the student's permission and list the student as lead author.

G.5.g. Duplicate Submissions

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

G.5.h. Professional Review

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

Section H

Distance Counseling, Technology, and Social Media

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Introduction

Counselors understand that the profession of counseling may no longer be limited to in-person, face-to-face interactions. Counselors actively attempt to understand the evolving nature of the profession with regard to distance counseling, technology, and social media and how such resources may be used to better serve their clients. Counselors strive to become knowledgeable about these resources. Counselors understand the additional concerns related to the use of distance counseling, technology, and social media and make every attempt to protect confidentiality and meet any legal and ethical requirements for the use of such resources.

H.1. Knowledge and Legal Considerations

H.1.a. Knowledge and Competency

Counselors who engage in the use of distance counseling, technology, and/or social media develop knowledge and skills regarding related technical, ethical, and legal considerations (e.g., special certifications, additional course work).

H.1.b. Laws and Statutes

Counselors who engage in the use of distance counseling, technology, and social media within their counseling practice understand that they may be subject to laws and regulations of both the counselor's practicing location and the client's place of residence. Counselors ensure that their clients are aware of pertinent legal rights and limitations governing the practice of counseling across state lines or international boundaries.

H.2. Informed Consent and Security

H.2.a. Informed Consent and Disclosure

Clients have the freedom to choose whether to use distance counseling, social media, and/or technology within the counseling process. In addition to the usual and customary protocol of informed consent between counselor and client for face-to-face counseling, the following issues, unique to the use of distance counseling, technology, and/or social media, are addressed in the informed consent process:

- distance counseling credentials, physical location of practice, and contact information;
- risks and benefits of engaging in the use of distance counseling, technology, and/or social media;
- possibility of technology failure and alternate methods of service delivery;
- anticipated response time;
- emergency procedures to follow when the counselor is not available;
- time zone differences;
- cultural and/or language differences that may affect delivery of services;

- possible denial of insurance benefits; and
- social media policy.

H.2.b. Confidentiality Maintained by the Counselor

Counselors acknowledge the limitations of maintaining the confidentiality of electronic records and transmissions. They inform clients that individuals might have authorized or unauthorized access to such records or transmissions (e.g., colleagues, supervisors, employees, information technologists).

H.2.c. Acknowledgment of Limitations

Counselors inform clients about the inherent limits of confidentiality when using technology. Counselors urge clients to be aware of authorized and/or unauthorized access to information disclosed using this medium in the counseling process.

H.2.d. Security

Counselors use current encryption standards within their websites and/or technology-based communications that meet applicable legal requirements. Counselors take reasonable precautions to ensure the confidentiality of information transmitted through any electronic means.

H.3. Client Verification

Counselors who engage in the use of distance counseling, technology, and/or social media to interact with clients take steps to verify the client's identity at the beginning and throughout the therapeutic process. Verification can include, but is not limited to, using code words, numbers, graphics, or other nondescript identifiers.

H.4. Distance Counseling Relationship

H.4.a. Benefits and Limitations

Counselors inform clients of the benefits and limitations of using technology applications in the provision of counseling services. Such technologies include, but are not limited to, computer hardware and/or software, telephones and applications, social media and Internet-based applications and other audio and/or video communication, or data storage devices or media.

H.4.b. Professional Boundaries in Distance Counseling

Counselors understand the necessity of maintaining a professional relationship with their clients. Counselors discuss and establish professional boundaries with clients regarding the appropriate use and/or application of technology and the limitations of its use within the counseling relationship (e.g., lack of confidentiality, times when not appropriate to use).

H.4.c. Technology-Assisted Services

When providing technology-assisted services, counselors make reasonable efforts to determine that clients are intellectually, emotionally, physically, linguistically, and functionally capable of using the application and that the application is appropriate for the needs of the client. Counselors verify that clients understand the purpose and operation of technology applications and follow up with clients to correct possible misconceptions, discover appropriate use, and assess subsequent steps.

H.4.d. Effectiveness of Services

When distance counseling services are deemed ineffective by the counselor or client, counselors consider delivering services face-to-face. If the counselor is not able to provide face-to-face services (e.g., lives in another state), the counselor assists the client in identifying appropriate services.

H.4.e. Access

Counselors provide information to clients regarding reasonable access to pertinent applications when providing technology-assisted services.

H.4.f. Communication Differences in Electronic Media

Counselors consider the differences between face-to-face and electronic communication (nonverbal and verbal cues) and how these may affect the counseling process. Counselors educate clients on how to prevent and address potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically.

H.5. Records and Web Maintenance

H.5.a. Records

Counselors maintain electronic records in accordance with relevant laws and statutes. Counselors inform clients on how records are maintained electronically. This includes, but is not limited to, the type of encryption and security assigned to the records, and if/for how long archival storage of transaction records is maintained.

H.5.b. Client Rights

Counselors who offer distance counseling services and/or maintain a professional website provide electronic links to relevant licensure and professional certification boards to protect consumer and client rights and address ethical concerns.

H.5.c. Electronic Links

Counselors regularly ensure that electronic links are working and are professionally appropriate.

H.5.d. Multicultural and Disability Considerations

Counselors who maintain websites provide accessibility to persons with disabilities. They provide translation capabilities for clients who have a different primary language, when feasible. Counselors acknowledge the imperfect nature of such translations and accessibilities.

H.6. Social Media

H.6.a. Virtual Professional Presence

In cases where counselors wish to maintain a professional and personal presence for social media use, separate professional and personal web pages and profiles are created to clearly distinguish between the two kinds of virtual presence.

H.6.b. Social Media as Part of Informed Consent

Counselors clearly explain to their clients, as part of the informed consent procedure, the benefits, limitations, and boundaries of the use of social media.

H.6.c. Client Virtual Presence

Counselors respect the privacy of their clients' presence on social media unless given consent to view such information.

H.6.d. Use of Public Social Media

Counselors take precautions to avoid disclosing confidential information through public social media.

Section I

Resolving Ethical Issues

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Introduction

Professional counselors behave in an ethical and legal manner. They are aware that client welfare and trust in

the profession depend on a high level of professional conduct. They hold other counselors to the same standards and are willing to take appropriate action to ensure that standards are upheld. Counselors strive to resolve ethical dilemmas with direct and open communication among all parties involved and seek consultation with colleagues and supervisors when necessary. Counselors incorporate ethical practice into their daily professional work and engage in ongoing professional development regarding current topics in ethical and legal issues in counseling. Counselors become familiar with the ACA Policy and Procedures for Processing Complaints of Ethical Violations[1] and use it as a reference for assisting in the enforcement of the *ACA Code of Ethics*.

I.1. Standards and the Law

I.1.a. Knowledge

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

I.1.b. Ethical Decision Making

When counselors are faced with an ethical dilemma, they use and document, as appropriate, an ethical decision-making model that may include, but is not limited to, consultation; consideration of relevant ethical standards, principles, and laws; generation of potential courses of action; deliberation of risks and benefits; and selection of an objective decision based on the circumstances and welfare of all involved.

I.1.c. Conflicts Between Ethics and Laws

If ethical responsibilities conflict with the law, regulations, and/or other governing legal authority, counselors make known their commitment to the *ACA Code of Ethics* and take steps to resolve the conflict. If the conflict cannot be resolved using this approach, counselors, acting in the best interest of the client, may adhere to the requirements of the law, regulations, and/or other governing legal authority.

I.2. Suspected Violations

I.2.a. Informal Resolution

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

I.2.b. Reporting Ethical Violations

If an apparent violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution or is not resolved properly, counselors take further action depending on the situation. Such action may include referral to state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or appropriate institutional authorities. The confidentiality rights of clients should be considered in all actions. This standard does not apply when counselors have been retained to review the work of another counselor whose professional conduct is in question (e.g., consultation, expert testimony).

I.2.c. Consultation

When uncertain about whether a particular situation or course of action may be in violation of the *ACA Code of Ethics*, counselors consult with other counselors who are knowledgeable about ethics and the *ACA Code of Ethics*, with colleagues, or with appropriate authorities, such as the ACA Ethics and Professional Standards Department.

I.2.d. Organizational Conflicts

If the demands of an organization with which counselors are affiliated pose a conflict with the *ACA Code of Ethics*, counselors specify the nature of such conflicts and express to their supervisors or other responsible officials their commitment to the *ACA Code of Ethics* and, when possible, work through the appropriate channels to address the situation.

I.2.e. Unwarranted Complaints

Counselors do not initiate, participate in, or encourage the filing of ethics complaints that are retaliatory in nature or are made with reckless disregard or willful ignorance of facts that would disprove the allegation.

I.2.f. Unfair Discrimination Against Complainants and Respondents

Counselors do not deny individuals employment, advancement, admission to academic or other programs, tenure, or promotion based solely on their having made or their being the subject of an ethics complaint. This does not preclude taking action based on the outcome of such proceedings or considering other appropriate information.

I.3. Cooperation With Ethics Committees

Counselors assist in the process of enforcing the *ACA Code of Ethics*. Counselors cooperate with investigations, proceedings, and requirements of the ACA Ethics Committee or ethics committees of other duly constituted associations or boards having jurisdiction over those charged with a violation.

[1]See the American Counseling Association web site at http://www.counseling.org/knowledge-center/ethics

Glossary of Terms

Abandonment – the inappropriate ending or arbitrary termination of a counseling relationship that puts the client at risk.

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

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

Assessment – the process of collecting in-depth information about a person in order to develop a comprehensive plan that will guide the collaborative counseling and service provision process.

Bartering – accepting goods or services from clients in exchange for counseling services.

Client – an individual seeking or referred to the professional services of a counselor.

Confidentiality – the ethical duty of counselors to protect a client's identity, identifying characteristics, and private communications.

Consultation – a professional relationship that may include, but is not limited to, seeking advice, information, and/or testimony.

Counseling – a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals.

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

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

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

Discrimination – the prejudicial treatment of an individual or group based on their actual or perceived membership in a particular group, class, or category.

Distance Counseling – The provision of counseling services by means other than face-to-face meetings, usually with the aid of technology.

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

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

Encryption – process of encoding information in such a way that limits access to authorized users.

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

Exploitation – actions and/or behaviors that take advantage of another for one's own benefit or gain.

Fee Splitting – the payment or acceptance of fees for client referrals (e.g., percentage of fee paid for rent, referral fees).

Forensic Evaluation – the process of forming professional opinions for court or other legal proceedings, based on professional knowledge and expertise, and supported by appropriate data.

Gatekeeping – the initial and ongoing academic, skill, and dispositional assessment of students' competency for professional practice, including remediation and termination as appropriate.

Impairment – a significantly diminished capacity to perform professional functions.

Incapacitation – an inability to perform professional functions.

Informed Consent – a process of information sharing associated with possible actions clients may choose to take, aimed at assisting clients in acquiring a full appreciation and understanding of the facts and implications of a given action or actions.

Instrument – a tool, developed using accepted research practices, that measures the presence and strength of a specified construct or constructs.

Interdisciplinary Teams – teams of professionals serving clients that may include individuals who may not share counselors' responsibilities regarding confidentiality.

Minors – generally, persons under the age of 18 years, unless otherwise designated by statute or regulation. In some jurisdictions, minors may have the right to consent to counseling without consent of the parent or guardian.

Multicultural/Diversity Competence – counselors' cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge are applied effectively in practice with clients and client groups.

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

Personal Virtual Relationship – engaging in a relationship via technology and/or social media that blurs the professional boundary (e.g., friending on social networking sites); using personal accounts as the connection point for the virtual relationship.

Privacy – the right of an individual to keep oneself and one's personal information free from unauthorized disclosure.

Privilege – a legal term denoting the protection of confidential information in a legal proceeding (e.g., subpoena, deposition, testimony).

Pro bono publico – contributing to society by devoting a portion of professional activities for little or no financial return (e.g., speaking to groups, sharing professional information, offering reduced fees).

Professional Virtual Relationship – using technology and/or social media in a professional manner and maintaining appropriate professional boundaries; using business accounts that cannot be linked back to personal accounts as the connection point for the virtual relationship (e.g., a business page versus a personal profile).

Records – all information or documents, in any medium, that the counselor keeps about the client, excluding personal and psychotherapy notes.

Records of an Artistic Nature – products created by the client as part of the counseling process.

Records Custodian – a professional colleague who agrees to serve as the caretaker of client records for another mental health professional.

Self-Growth – a process of self-examination and challenging of a counselor's assumptions to enhance professional effectiveness.

Serious and Foreseeable – when a reasonable counselor can anticipate significant and harmful possible consequences.

Sexual Harassment – sexual solicitation, physical advances, or verbal/nonverbal conduct that is sexual in nature; occurs in connection with professional activities or roles; is unwelcome, offensive, or creates a hostile workplace or learning environment; and/or is sufficiently severe or intense to be perceived as harassment by a reasonable person.

Social Justice – the promotion of equity for all people and groups for the purpose of ending oppression and injustice affecting clients, students, counselors, families, communities, schools, workplaces, governments, and other social and institutional systems.

Social Media – technology-based forms of communication of ideas, beliefs, personal histories, etc. (e.g., social networking sites, blogs).

Student – an individual engaged in formal graduate-level counselor education.

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

Supervision – a process in which one individual, usually a senior member of a given profession designated as the supervisor, engages in a collaborative relationship with another individual or group, usually a junior member(s) of a given profession designated as the supervisee(s) in order to (a) promote the growth and development of the supervisee(s), (b) protect the welfare of the clients seen by the supervisee(s), and (c) evaluate the performance of the supervisee(s).

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

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

Training – the instruction and practice of skills related to the counseling profession. Training contributes to the ongoing proficiency of students and professional counselors.

Virtual Relationship – a non–face-to-face relationship (e.g., through social media).

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