Ethics for Social Workers

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ETHICS FOR LICENSED CLINICAL SOCIAL WORKERS

*Service

*Social Justice *Dignity and Worth

*Importance of Human Relations *Integrity

*Competence

In all behavioral health professions, the overwhelming expectation is that professionals must protect the well-being of their clients. The purpose of this article is to review ethical standards for licensed clinical social workers and to provide practical examples of ethical dilemmas that LCSWs may face.

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Introduction

As with all behavioral health professionals, licensed clinical social workers (LCSWs) have an ever-present legal and ethical obligation to protect the welfare of their clients. According to the National Association of Social Workers (NASW) Code of Ethics, "the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people." In keeping with this mission, LCSWs help individuals who are struggling with mental health issues and other personal difficulties in order to improve their ability to function and their overall quality of life. When such professionals work with individual clients, they may face concerns related to competence, social diversity, informed consent, conflicts of interest, privacy and confidentiality, as well as other issues. The Code was developed to respond to potential dilemmas, offer standards, principles, and values to guide social workers' conduct, and to serve the following purposes (NASW, 2008):

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

According to the Clinical Social Work Code of Ethics, clinical social workers examine practical situations in terms of the ethical dilemmas they present, with a critical analysis of how the formulation of a solution fulfils the core requirements of ethical practice; nonmalfeasance, beneficence, and autonomy (CSWA, 2006). Furthermore, while codes cannot guarantee ethical behavior or resolve all ethical issues, they must set forth values, ethical principles, and ethical standards to which professionals aspire and by which their actions can be judged (NASW, 2008).

"Ethical codes have been developed by mental health associations for the purpose of setting professional standards for appropriate behavior, defining professional expectations, and preventing harm to people who go to therapy. Mental health professionals have an obligation to be familiar with their professional code of ethics and its application to their professional services."

GoodTherapy.org, 2014

The History of Ethical Standards in the Social Work Profession

According to The Evolution of Social Work Ethics by Frederic Reamer, when social work was initially recognized as a profession, there was a much greater concern with the ethics or morality of the client rather than that of the professional or practitioner (Reamer, 1998). Since the late 20th century, the social work profession has witnessed the evolution of the four stages of ethical standards, including the Morality Period, The Values Period, The Ethical and Decision-Making Period and The Ethical Standards and Risk Management Period which are summarized below:

- The Morality Period-This period focused on the moral issues facing the poor, oppressed, and vulnerable, and how they often succumbed to immoral deeds due their circumstances and needed relief, which continued to be the general consensus until the mid-1950s.
- The Values Period –An evolution of the assumption that a respected social work profession needed an ethical, values-based foundation directed at the profession and practitioners themselves, rather than the clients, began in the late 1940s.
- The Ethical and Decision-Making Period-in the early 1980s, experts began to contemplate the relevance of moral philosophy, principles, concepts, and theory in evaluating and resolving ethical dilemmas, although the ways in which social values emerge and change was seldom addressed.
- The Ethical Standards and Risk Management Period-The most recent period in the history of social work ethics reflects growth and understanding which is demonstrated in the Ethics Codes of Conduct that outlines expected conduct and identifies ethical obligations to clients, the profession, colleagues, professional organizations, and society.

The social work profession has made significant progress in developing specific strategies to grasp and resolve ethical issues and obligations. However, practitioners must be alert to emerging ethical issues that may arise as a result of societal changes and be prepared to challenge attempts to undermine the profession's traditional values (Reamer, 1998).

The Process of Pursuing Ethical Standards

According to Counselor magazine, there are certain assumptions that should be considered in the discussion of ethics for clinical practitioners (Counselor, 2012):

- Ethics is a continuous, active process in which all clinicians must engage.
- Standards (codes of ethics) are not cookbooks. They often tell us what to do but not always how to do it.
- It is the responsibility of the clinician, not the client, to set the boundary. And if a boundary is crossed, we should not blame the client or stigmatize them for the boundary crossing.
- Each clinical situation is unique. We must examine all of the relevant variables and factors that might affect our choices.
- Counseling is done by fallible human beings. We make mistakes. Wouldn't it be wonderful if we could admit our mistakes to one another? Sometimes the answers to what to do under what circumstances are elusive because sitting in front of you in a counseling session is a unique person with individual characteristics, needs and issues.

Furthermore, knowing that each situation and client is unique, therapists must seek "ethically correct" decisions based on the best interest of the client. The New York State Society for Clinical Social Work Code of Ethics states that the professional practice of clinical social workers is shaped by ethical principles which are rooted in the basic values of the social work profession. These core values include a commitment to the dignity, well-being, and self-determination of the individual; a commitment to professional practice characterized by competence and integrity, and a commitment to a society which offers opportunities to all its members in a just and non-discriminatory manner (NYSSCCW, 2003). Consider this example from the American Counseling Association's Counseling Today publication where a practical situation may bring about an ethical dilemma (Counseling Today, 2011):

"Patrice Hinton Oswalt was flattered upon opening her e-mail and finding an E-vite to a client's long-awaited graduation. Choosing whether to accept or decline the invitation was no simple decision."

Oswalt recognized that engaging with the client outside of the office could have ethical consequences, and was especially concerned with maintaining trust. She states, "The counseling relationship is built on trust — clients trusting that they can be vulnerable and that their counselor will not take advantage of that openness. To earn this trust as counselors, we must be trustworthy, to prove our worth and integrity. These are standards of behavior that tie directly into our professional ethics." Since Oswalt had addressed marital issues with her client and knew that she would likely see the husband and other family members at the graduation, she felt it was important to help her client see the big picture. As they discussed the situation further, the client realized that it was probably not a good idea for Oswalt to accept the invitation.

Although the above example may seem like a minor ethical concern, there is no way of knowing to what extent the clinician's handling of the situation may impact the client, which reinforces the notion that such professionals must act with care and concern. Regardless of the professional organization, there is a reoccurring theme regarding the development and maintenance of ethical standards that protect both parties. According to the American Psychological Association, such a standard requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees and colleagues; and to consult with others concerning ethical problems (APA, 2010).

Conflicts of Interests

As therapists strive to protect the welfare of their clients, they must recognize which actions may be perceived as creating a conflict of interest or crossing a professional boundary. Jeffrey Barnett, professor in the Loyola University Maryland Department of Psychology, states, "most recent thinking is that there is a big difference between crossing a boundary and violating a boundary," but one of the keys is maintaining objectivity. He goes on to say, "If it's a conflict-of-interest situation or if I can't remain objective, it's probably not a good idea" (Counseling Today, 2011). Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment (NASW, 2008) and strive to maintain professional boundaries. A boundary crossing is a deviation from classical therapeutic activity that is harmless, non-exploitative, and possibly supportive of the therapy itself. In contrast, a boundary violation is harmful or potentially harmful to the patient and the therapy. It constitutes exploitation of the patient (Aravind, Krishnaram, and Thasneem, 2012).

Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries (NASW, 2008). The New York State Society for Clinical Social Work Code of Ethics goes on to state, clinical social workers do not, under any circumstances, engage in romantic or sexual contact with either current or former clients. Clinical social workers are also mindful of how their relationship with the family and/or friends of their clients might affect their work with the client. Consequently, they also avoid romantic or sexual involvements with members of the client's family, or with others with whom the client has a close, personal relationship (NYSSCCW, 2003).

In the following vignette, an LCSW is faced with a situation that addresses boundary issues:

Marianne is a divorced LCSW who has been in practice for 14 years. One night when she is out with her girlfriends, she runs into a former client, Tommy. She first met Tommy about three years ago when he and his teenaged son came to see her about relationship difficulties they were experiencing. Marianne worked with Tommy and Adam for approximately three months, until the relationship improved and all parties agreed to terminate therapy. Tommy has been divorced for four years. When they see each other at the restaurant, Marianne and Tommy talk briefly. She learns that Adam is away at college, and that he and Tommy have been doing well overall. She does not really think anything about it until he calls her the following week to ask her out to dinner. Marianne tells Tommy that she will have to think about it, and agrees to call him back later in the week. While Marianne feels some attraction toward Tommy and knows that it has been over two years since their last professional encounter, she also wants to think about all the ethical considerations that would come into play if she were to date and pursue an intimate relationship with Tommy.

While professional codes of ethics have specific guidelines for sexual intimacy with former clients, there are also other issues in this scenario that Marianne would want to consider, including:

Unfair advantage-Is Marianne taking unfair advantage of the relationship she had with Adam if she chooses to enter into a personal relationship with his father?

Integrity- It is a good moral decision to enter into a personal relationship with Tommy, even though time has passed? Would she be behaving in a trustworthy manner?

Multiple relationships-Does entering into a personal relationship with Tommy create a situation of exploitation or potential harm, and will the influential position that she had as the clinician carry over and create an unhealthy dependency?

Sexual Relationships- According to the NASW Code of Ethics, social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers, not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship, assume the full burden for setting clear, appropriate, and culturally sensitive boundaries (NASW, 2008). Can

Marianne be assured that establishing a personal relationship with Tommy will not in any way exploit or cause injury to Tommy or Adam?

If, after considering the above factors, Marianne decides to date Tommy, the onus will be on her to demonstrate that there has been no undue harm to Tommy or Adam. Marianne should document the process and the appropriate precautions taken to establish that she has acted thoughtfully and with care.

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NASW Code of Ethics, 2003

Dual Relationships

Roger has been seeing Leo, a popular 15 year old student-athlete for six months. Leo is grieving over the loss of his father, a 48 year old in the late stages of ALS. Leo was referred to therapy when he began to lose interest in school and sports, started experimenting with drugs and alcohol, and was feeling depressed and anxious. One day Leo comes to his session excited and animated because he has been invited to try out for a well-respected traveling basketball team. Roger becomes anxious when he realizes that Leo is trying out for the team that is own son is on. While he is happy for Leo and thinks this could be a very positive experience for him, he is concerned about the possibility of entering into a multiple relationship with Leo if he makes the team, as the team commitment will involve seeing each other outside of the office, traveling out of town for tournaments, and regular interactions because Leo and Roger's son.

In the above scenario, the issue of multiple roles/dual relationships is presented to Roger without any intent on his part to create the situation. As, Dr. Stephen Behnke, APA Ethics Director states, "Finding oneself in a multiple relationship is not necessarily a sign that one has engaged in unethical behavior. It may rather be a sign that one is fully engaged in the life of a community (Behnke, 2008). Although Roger is contemplating what the best course of action is as he is faced with his professional, personal, and community role, he doesn't feel the need to process anything with Leo until he finds out if Leo has made the team. He knows that he and Leo have made positive steps toward dealing with Leo's grief and loss, and has no intention of abandoning Leo in the therapeutic process. He also knows that he must consider confidentiality and boundary issues if he is going to see Leo outside of the office.

In the article, Ethical Decision-Making and Dual Relationships, Jeffrey N. Younggren addresses dual relationships and states, "By answering the following questions in a step by step fashion a professional who is considering entering into a dual relationship will increase the likelihood that he or she will make the correct choice in the matter: a choice that is in the best interest of both the patient and the therapist" (Younggren, 2002).

- Is the dual relationship necessary?

- Is the dual relationship exploitive?
- Who does the dual relationship benefit?
- Is there a risk that the dual relationship could damage the patient?
- Is there a risk that the dual relationship could disrupt the therapeutic relationship?
- Am I being objective in my evaluation of this matter?
- Have I adequately documented the decision making process in the treatment records?
- Did the client give informed consent regarding the risks to engaging in the dual relationship?

If Leo gets selected for the traveling team, Roger will want to look at the above questions to help determine with Leo whether or not to continue therapy. It may be a great opportunity to empower Leo with some of the decision-making, such as how to manage the situation when they see each other away from the office. Roger will also want to consider how his own son may be impacted by the dual relationship. Finally, Roger may initially choose to continue to see Leo if he feels it is in Leo's best interest, or may feel that he needs to adhere to ethical standards which state, "The clinical social worker terminates services and relationships with clients when such services and relationships are no longer in the client's best interest" (NYSSCCW, 2003). When and if they determine that they should terminate therapy, Roger will make an appropriate referral.

"Informed consent is a legal procedure to ensure that a patient, client, and research participants are aware of all the potential risks and costs involved in a treatment or procedure. The elements of informed consent include informing the client of the nature of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment."

About Education, 2014

Informed Consent

Although the term "informed consent" was not formally introduced until 1957 in a medical malpractice case, the concept has been evolving since the early part of the twentieth century. In 1914, Justice Benjamin Cardozo of the New York Court of Appeals stated, "Every human being of adult years and sound mind has the right to determine what shall be done with his own body," and this statement has served as the foundation for the principles of informed consent as we know them today (Legal and Ethical Issues in Health Occupations, 2009). Michael R. Daley, Ph.D. LCSW PIP, ACSW and suggest that the process of informed consent encompasses the role and limitations of the social worker being fully discussed with the client, with clients being fully empowered to make choices about services (Daley, 2011). Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent (LCSW, 2008).

Informed consent will likely be presented to the client in the form of an agreement signed by the client, the parent or guardian if the client is a minor, and the LCSW. Integral parts of the agreement include what to expect from the clinical process, client rights, services offered, confidentiality factors and limits, practices relating to release of information, recordkeeping, fees, payment, and cancellation, and a

summary of the professional credentials. In the article, *Informed Consent*, Nir Eyal reports that the rationale for informed consent revolves around protection of the client or participant's health and welfare, the guarantee of a right to personal autonomy, as a commitment to prevent abusive conduct, a format to promote and enhance trust, a means to assure self-ownership over oneself, a way to guard against arbitrary control by others, and an opportunity to preserve the client's sense of personal integrity (Eyal, 2012). For minors, the general rule is that they are incapable of giving informed consent, so LCSWs will obtain permission from the minor's parent, guardian, or other legal representative before treating the child or adolescent. As part of the informed consent agreement, clinical social workers will often have specific guidelines related to the minor's right to confidentiality, including under what circumstances confidentiality will be broken (See Appendix A for Sample Informed Consent Form).

Privacy and Confidentiality

Licensed clinical social workers have an ethical and professional obligation to safeguard information that was shared during clinical interactions. Confidentiality issues often become complicated when the client is a minor or when the therapist is seeing more than one person in a family or unit and must protect the confidences of each individual. When social workers provide counseling services to families, couples, or groups, they should seek agreement among the parties involved concerning each individual's right to confidentiality and the obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that they cannot guarantee that all participants will honor such agreements (NASW, 2008). According to the Code, the general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. Additionally, social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed. Cindy Shealy, LCSW, includes the following statement in her Informed Consent for Treatment and Client Rights Disclosure Agreement (Shealy, 2014):

Right to Privacy and Confidentiality

I would like you to be aware of your right to confidentiality and my commitment to safeguard that right. The client-therapist relationship is confidential and privileged and is protected by both law and the ethical code of the National Association of Social Workers. As described in the attached Notice of Privacy Practices, confidentiality is limited by law under the following circumstances: court order or other legally mandated requirement for disclosure of information to obtain needed services for you or your child, such as in the case of an emergency need for hospitalization; clear risk of harm to self or others or suspected child or elder abuse. If any of these circumstances occur, the confidentiality agreement will no longer apply. Finally, disclosure of identifying information is permitted in order to obtain payment and as needed for the operation of this practice. This confidentiality agreement means that with the exception of the circumstances outlined above, I will not disclose any identifying information about you or your child to others unless I have your signed consent.

As a therapist I may wish to consult with other health care or educational professionals in order to enhance your child's treatment. I cannot and will not do this without your authorization in writing. I understand there may be reasons you may not wish me to speak to others about your child and I will respect your decision if you wish to decline this request. I am involved in clinical consultation to further my knowledge and skills as a therapist. If I need to consult with other mental health professionals, about your case, I will do my best to protect you identity. If we happen to see each other outside of therapy appointments, I will generally not acknowledge you unless you acknowledge me. This allows you to have control over your confidentiality.

Even with a clear philosophy related to disclosing confidential information, therapists are often faced with dilemmas pertaining to whether or not they are obligated to violate confidentiality. The following case study from *The Family Journal: Counseling and Therapy for Couples and Families* illustrates a counselor's struggle with the client's right to confidentiality versus the obligation to a greater societal concern (Richard Watts, 1999).

A counselor recently began working with a couple having difficulties in their marriage. The husband is a medical doctor and his wife, a certified public accountant (CPA), runs the business aspects of his practice. During the past 5 years, the couple has lived lavishly and, consequently, developed financial problems. They entered counseling stating that the presenting problem was anger and conflict stemming from their financial difficulties. In a recent session with the couple, the wife shared that about a year ago her husband purposely and terminally overmedicated an elderly patient. The elderly patient was the stepmother of the wife, and because of a recent death, the wife is the lone benefactor of a large insurance policy. The counselor believes the fundamental problem in the couple's relationship is guilt over their conspiracy to terminate the life of the elderly stepmother—especially given the fact that the forthcoming insurance policy payment will cover their debts. However, the counselor is wondering whether she has an ethical or legal responsibility to contact the authorities and report the situation.

Questions for the counselor to consider may include:

- According to *Scott Thompson of Demand Media,* courts have established that social workers have a legal obligation to warn the potential victim if they believe their client presents an imminent threat to that individual. This is called the "duty to warn" (Thompson, 2013). However, ethics codes to not specifically address past criminal activity.
- Since this would be considered past criminal activity, is there a duty to report? The NASW code states, "The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person" (NASW, 2008).
- Does the counselor believe that the doctor and/or his wife may be capable of doing something similar in the future to another individual, or was this an isolated incident?
- Is there an exception to reporting past criminal activity since this incident involved elder abuse?
- Should she seek consultation from a supervisor, knowledgeable colleagues, an attorney, or all of the above?
- Should the counselor encourage her clients to turn themselves in to the authorities?

As is often the case for behavioral health clinicians, there is no clear-cut, black or white answer to the conflict that is faced in this scenario. After consulting with others, speaking further with her clients, and making a decision, the counselor should document the action taken and the rationale for doing so.

Confidentiality with Minor Clients

In the March/April 2012 issue of The Therapist, several professionals presented and responded to vignettes illustrating possible ethical/legal issues in clinical practice, including the following (The Therapist, 2012).

Susie (a 16-year-old) and Susie's parents came in to discuss treatment with LMFT Mark. MFT Mark reviewed his standard informed consent with both Susie and her parents, including a section on confidentiality which briefly mentioned reasons for a breach of confidentiality, including "harm to self."

After the third session, Susie admitted to LMFT Mark that she was sexually active with a few different people in her high school, and that she smoked pot on weekends. LMFT Mark determined that this did not rise to the level of "harm to self" worthy of a breach of confidentiality but instead he would work with her clinically. After the fifth session, she told LMFT Mark that she had been cutting, but never near an artery. LMFT Mark again determined not to breach confidentiality. After the seventh session, Susie told LMFT Mark that she had been drinking heavily, and had started blacking out at parties, waking up in strange beds (clearly having had sexual intercourse). LMFT Mark decided to tell Susie's parents about the drinking and blackouts.

The ethical issue that seems to be of greatest concern in this vignette is Susie's level of self-harm and the risk of greater future harm. Although risky sexual behavior is dangerous, the therapist may not be able to justify breaking confidence. One professional pointed out that she would not likely do so, "unless I felt the client was risking consequences such as acquiring the HIV virus through highly risky behavior, and was unwilling to change her behavior." However, the clinician also stated that the cutting behavior definitely met the threshold of self-harm and warranted parental involvement. Another clinician went on to say, "Given the facts stated in this vignette, the nature of Susie's cutting is unclear. However, because there are multiple, serious risk factors described, including heavy use of alcohol by the client with reported blackouts along with high risk sexual behavior, the therapist would have to consider the possible need to disclose confidential information to Susie's parents, as a protective measure" (The Therapist, 2012).

Mark would have to determine if he believes Susie's behavior rises to the level of making an exception to the responsibility to confidentiality because he believes there is an overriding professional reason to do so (NYSSCCW, 2003). Common practice would dictate that Mark could have sought consultation from peers and supervisors before making a decision to talk to the parents. It would also be important for Mark to involve Susie in the process of informing her parents, and to determine the best way for the parents to buy into a more intense treatment plan to help Susie, rather than seeing a need to punish her for the behaviors.

"Competence equals professionalism; therefore, incompetence cannot be tolerated. It is the responsibility of all professionals to maintain standards and to report any deviation in those standards. Loyalty and beneficence cannot be allowed to blur reality."

Legal and Ethical Issues is Health Occupations, 2009

Competence and Integrity of the Profession

Physicians Ronald Epstein and Edward Hundert (2002) define professional competence as, "The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (AMA Review, 2002). The *National Association of Social Workers Code of Ethics* requires its professionals "to provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience." Furthermore, Daley and Hickman point out that although poor social work practice is not an ethical violation per se, when methods are used that violate generally accepted standards of practice, that do not conform to methods used by the profession, and where social workers lack appropriate training in the method or do not use supervision when needed, ethical violations may result (Daley, 2011). The NASW code outlines additional responsibilities in the areas of competence and integrity of the profession in the following principles (NASW, 2008):

- Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.
- When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.
- Social workers should accept responsibility or employment only on the basis of existing competence or the intention to acquire the necessary competence.
- Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.
- Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.
- Social workers should work toward the maintenance and promotion of high standards of practice.
- Social workers should uphold and advance the values, ethics, knowledge, and mission of the profession. Social workers should protect, enhance, and improve the integrity of the profession

through appropriate study and research, active discussion, and responsible criticism of the profession.

- Social workers should contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the social work profession. These activities may include teaching, research, consultation, service, legislative testimony, presentations in the community, and participation in their professional organizations.
- Social workers should contribute to the knowledge base of social work and share with colleagues their knowledge related to practice, research, and ethics. Social workers should seek to contribute to the profession's literature and to share their knowledge at professional meetings and conferences.
- Social workers should act to prevent the unauthorized and unqualified practice of social work.

Ultimately social workers themselves bear the responsibility to maintain expertise and uphold the integrity of the profession. They must never practice outside the area of their competence, engage in dishonesty or fraud, or allow conduct in their personal life to interfere with their professional roles and responsibilities (Thompson, 2013).

Impairment of Colleagues

Margie is an LCSW in a small town who has been practicing for seven years. One night, her husband, who is a police officer, comes from work and tells Margie that their mutual friend Sally, also an LCSW, has been arrested after a DUI accident. Apparently Sally was coming home from a party and lost control of her car, driving into an unoccupied restaurant downtown. Sally suffered only minor injuries, but a breathalyzer test indicated that her blood alcohol content (BAC) was well over the legal limit. In addition, there was enough damage done to the restaurant that it will have to be closed for several days.

Margie is very concerned about her friend and colleague. She immediately begins to think about her responsibility to the profession as well as her desire to help Sally. According to her professional code of ethics, if she has direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness, she should consult with that colleague when feasible and assist the colleague in taking remedial action (NASW, 2008). Although she does not have any direct knowledge that Margie's actions are interfering with her professional competence, she is concerned about the severity of the incident. Margie decides that she will give Sally some time and then speak to her about her concerns. If, down the road, Margie believes that Sally is continuing to have an impairment that is interfering with her effectiveness and that she has not taken adequate steps to address the issue, ethical requirements state that she should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations (NASW, 2008).

Social Workers' Ethical Responsibilities in Practice Settings-Supervision and Consultation

When LCSWs serve as supervisors to other professionals or students, they are expected to maintain the same standard of professionalism that they exhibit as clinicians. Most codes of conduct address the need to establish clear boundaries in the supervisorial role and to act in a way to establish and preserve

fairness and respect. They also discuss maintaining confidentiality, ensuring that supervisees provide professional services, being aware of cultural diversity issues that may impact the relationship, and enhancing their own supervisorial skills to remain effective. Although a supervisor's role does not include providing therapy to supervisees, supervisors do have a responsibility to monitor worker issues that may affect practice with clients, and ideally, the worker has a trusting relationship with the supervisor, making it easier for the supervisor to address possible impairment concerns with supervisees (Barsky, 2015). The following vignette from SAMSHA's *Treatment Improvement Protocol (TIP) Series* illustrates the role of the supervisor as a monitor of ethical and professional standards for clinicians, with the goal of protecting the welfare of the client (SAMSHA, 2009).

Stan has provided clinical supervision for Eloise for 2 years. He's watched her grow professionally in her skills and in her professional identity. Lately, Stan's been concerned about Eloise's relationship with a younger female client, Alicia, who completed the 10-week IOP 2 months ago and participates weekly in a continuing care group. Alicia comes to the agency weekly to visit with her continuing care counselor. She also stops by Eloise's office to chat. Stan became aware of her visits after noticing her in the waiting room on numerous occasions. Earlier in the day, Stan saw Eloise greet Alicia with a hug in the hall and commented that she will see Alicia "at the barbecue." Stan is aware that Alicia and Eloise see each other at 12-Step meetings, as both are in recovery. Eloise feels she is offering a role model to Alicia who never had a mother figure in her life. Eloise expresses no reservations about the relationship. Stan sees the relationship between Eloise and Alicia as a potential boundary violation.

As Stan addresses Eloise's relationship with Alicia, he will be focusing on helping her address boundary issues, transference and countertransference, and integrating a process of ethical decision making into her clinical skills. When he initially discusses the dual relationship that Eloise may be entering in with Alicia, she replies that she knows better than to sleep with her clients, borrow money from them, hire them for odd jobs, or take them on trips, but she doesn't feel that attending a barbeque where a client will be is inappropriate. Stan then reminds Eloise how a dual relationship can create an abuse of power in a relationship and that an important goal for Alicia in recovery and to achieve a sense of autonomy and make decisions on her own. Stan also acknowledges Eliose's questions and observations and focuses on how, in general, to make ethical decisions about the nature of a relationship with a client or a former client, and what's not professionally appropriate.

Stan remembers to be sensitive to the power differential between supervisor and supervisee while speaking with Eloise, but also wants to help her realize how her actions impact her professional integrity, Alicia's treatment and recovery, Stan as the supervisor, and the reputation of the agency. Eloise appears to be open to the feedback, and in the end agrees to rethink the relationship with Alicia and to develop strategies for making ethical decisions in the future.

Evaluation and Research

Clinical social workers and other professionals who work with research participants must adhere to the same ethical principles that they practice with clients, supervisees, students, and in other capacities. Ethical codes call for carefully considering possible consequences and following guidelines developed for the protection of evaluation and research participants as well as informing participants of their right to withdraw from evaluation and research anytime without penalty (NASW, 2008). In addition, ethically acceptable research begins with the establishment of a clear and fair agreement between the

investigator and the research participant that clarifies the responsibilities of each, and the investigator has the obligation to honor all commitments included in that agreement (NYSSCCW, 2003). Please see the NASW Code of Ethics or other professional codes for more guidance in this area.

Social and Political Action

Social workers have an obligation to their communities and to society as a whole to promote social justice and public welfare, and to maintain ethical and legal expectations. They do not participate in any activities that promote discrimination or inequality, or that may reduce public trust in the profession (CSWA, 2006). Instead, social workers should engage in political and social action that ultimately results in reducing barriers and promotes the betterment of society and social inclusion (Miller, 2014).

Financial Arrangements

Professional standards dictate that LCSWs make financial arrangements with clients that are fair, reasonable and that, according to the NASW Code, "commensurate with the services performed" and give consideration to the client's ability to pay (NASW, 2008). Clinicians should have a clear statement about financial responsibility in their informed consent agreement or their disclosure statement, which may include session fees, charges for telephone conversations or other services if applicable, acceptable forms of payments including policy on acceptance of insurance, fees charged for missed appointments, and the use of collection agencies or legal means to obtain missed payments. A statement about bartering for services should also be included, as this practice is generally not recommended because it has the potential to be exploitative and to distort the relationship. Finally, clinical social workers employed by an agency or clinic, and also engaged in private practice, conform to contractual agreements with the employing facility. They do not solicit or accept a private fee or consideration of any kind for providing a service to which the client is entitled through the employing facility (NYSSCCW, 2003).

More comprehensive information regarding research and evaluation, social and political action, financial responsibilities, as well as administrative considerations, commitments to employers, and interdisciplinary collaboration can be found in the NASW Code of Ethics or within other professional codes.

Cultural competence is defined as "a developmental process that evolves over an extended period of time for which both individuals and organizations are at various levels of awareness, knowledge, and skills along the cultural competence continuum."

National Center for Cultural Competence, 2009

Cultural Competence and Social Diversity

The United States is in the midst of a paradigm shift in service delivery that is heading toward true cultural competency, sensitivity, and diversity, where mental health professionals not only need to

become culturally and linguistically competent, but may also have to take on new roles in serving those at-risk and hard to reach underrepresented populations (Zagelbaum and Carlson, 2011). Clinically, cultural competence means having the self-awareness, knowledge, skills, and framework to make sound, ethical, and culturally appropriate decisions. In certain instances,Western principles and concepts may be in opposition to values and beliefs of other cultures, which in turn creates ethical conflicts and dilemmas. Social workers are responsible for understanding culture and its function in human behavior and society and recognizing the strengths that exist in all cultures (NASW, 2008). In the following vignette, a therapist faces a situation where she suspects physical abuse, but upon further investigation realizes that what she is seeing is the result of an Asian healing practice (AOTA, 2011).

Janine is a Caucasian MFT who has been working with 13 year old Han, who is of Chinese decent, for several months. Han was referred to Janine because he was experiencing anxiety and symptoms of depression since his parents separated. Han is a quiet young man, and it has taken several sessions for him to begin to open up about his feelings. Janine is pleased with the progress they have made and sees that Han has had some symptom relief over the past few weeks, and appears to be happier than when she first met him. During the most recent session, Janine noticed that Han didn't seem like himself and he had some redness and light bruising on his upper arms. Han said that had been sick for about a week and was just beginning to feel better. When Janine inquired about the red marks, Han explained that his mother had taken him to a healer because his cold and fever would not go away, and the healer had rubbed oil on his back, shoulders, and upper arms with a coin. Janine asked if he was in pain during the procedure or currently, and Han replied that it hurt a little bit while the healer was working on him, put that he no longer had any pain. Janine learned from Han that he had been to the same healer several other times over the past few years when he was sick, and he felt that it usually made him feel better. Janine had not suspected Han was being abused in any way, and when they had discussed his parents' disciplinary practices, she learned that he remembered being spanked a few times as a child, but more recently lost privileges and his phone or computer when he got in trouble.

Janine is immediately concerned with her positon as a mandated reporter of suspected child abuse. Although she believes that Han is telling the truth, she did see obvious marks on his arms. Janine decides to do some research, and discovers that Han is talking about an Asian practice known as gua sha, or "coining" which is used to relieve muscle aches, muscle pains, nausea, abdominal pain, back pain, coughs, colds, fevers, and chills. Janine decides to talk to Han's mother and then to speak to her colleagues about the situation, but does not feel the need to file a suspected child abuse report at this time. She will thoroughly document her actions.

The above scenario illustrates the need for behavioural health clinicians to be culturally aware, but also to maintain what some refer to as "cultural humility", which acknowledges that we may never truly understand the experiences of another cultural group of which we are not members, but we will have a respectful attitude and approach toward different points of view (Zagelbaum and Carlson, 2011).

Conclusion

As it is inevitable that licensed clinical social workers will face ethical dilemmas and predicaments, they have an obligation to themselves, their clients, and the profession to be prepared to make sound, thoughtful decisions. As they gain experience, knowledge, and skills, and are open to learning from

others, they will surely learn to face such challenges with grace, confidence, and a sense that they are acting in a manner that is in the best interest of all concerned.

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APPENDIX A:

SAMPLE ADOLESCENT INFORMED CONSENT FORM

Source: Cindy Shealy, LCSW, 2014, Crossing Point Counseling

Retrieved from:

http://www.centerforethicalpractice.org/Form-AdolescentConsent

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Informed Consent for Treatment and Client Rights

I am pleased that you have selected me as your therapist. As a Licensed Clinical Social Worker, I currently provide individual therapy. I work with individuals to process various issues including, but not limited to, depression, emotional regulation, anxiety, anger, stress, trauma and difficulty in relationships. I am certified in EMDR and earned a certificate Expressive Arts Therapy from Appalachian State University. I have worked as a social worker since 1998 and as a LCSW in the mental health field since 2004. I hold a license in North Carolina (license # C005171). I have a Bachelors degree in Anthropology/Sociology from Appalachian State University and a Master of Social Work from the University of Southern Mississippi. I am a member of the National Association of Social Workers, EMDRIA, and a registered yoga teacher (RYT).

The Process of Therapy

Together we will complete an assessment and identify goals. Some clients will need only a few sessions to achieve their goals, while others may require more sessions. I view your mental health from a holistic combination of emotional, cognitive, physical and spiritual needs. Depending on your particular symptoms, there are many different methods that I may use to deal with issues that need to be addressed. I am committed to doing the very best work I can for you and I expect that you will make progress in the areas of concern during therapy. However, there are no guarantees. Therapy sometimes arouses strong or uncomfortable emotions. If you experience any of these feelings please feel free to talk with me about them. Most people feel better and are able to function better after therapy.

We will be establishing a relationship together. If you are involved in any important incidents or there are any major events that occur in your life while you are in treatment with me, please inform me. Also, please be sure to let me know if you are taking medication, both the type and the dosage, and remember to advise me if there are any changes in medication. If you have concerns about your own comfort with me, please inform me of this so that we can discuss it. If your concerns persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Explanation of Dual Relationships

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns.

Fee and Appointment Policies

My current fee for individual sessions is: $85 per 55 minute, $120 per 90 minute session. I accept insurance payment when applicable but it is your responsibility to determine your insurance benefits and in some situations, to file for reimbursement. I require payment and/or copays at the time of service unless we make an alternate arrangement. Please note however, our contract for therapy is between you and me, not between your insurance company and me. Insurance companies generally do not pay for missed appointments. Please inform me of any changes in your insurance. I accept cash or personal checks. In those extremely rare occasions where I am unable to collect for services provided, I will secure the services of an outside agency to collect the unpaid balance. Additional charges and/or fees necessitated by securing the collection agency will be charged directly to you.
Health insurance companies and managed care organizations often required that I make a diagnosis. If you have any questions about this, please feel free to ask. In order for the process of therapy to be effective, it is important that I meet with you regularly. Please do your best to ensure that you are here for every appointment. Of course, on rare occasions, vacations or other matters may make it necessary for you or for

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me to cancel an appointment. If I need to cancel or reschedule your appointment, I will let you know as far in advance as possible and I would appreciate the same courtesy from you. If you cannot be here, advance notice will give the maximum opportunity to reschedule the appointment. After two missed appointments (not calling or calling after the scheduled time), I may need to refer you to another provider. **If you are unable to keep an appointment, please notify me at least 24 hours in advance. If you do not notify me within 24 hours, you will be responsible for half of my regular fee of the missed appointment.**

To Contact Me

If you wish to reach me, please call my cell phone or email me. I do not answer the phone or email during therapy sessions, after 6:00pm on weekdays, or on weekends. I will make every effort to return your calls and emails as soon as possible. You can leave private information on my voicemail since I am the only one who retrieves my messages. If you have an emergency, please call 911, contact your family physician or go to any hospital emergency room and ask for the on-call mental health worker. If I am away for an extended time, I will provide the name of a colleague to contact, if necessary.

Client Rights

Right to Privacy and Confidentiality
I would like you to be aware of your right to confidentiality and my commitment to safeguard that right. The client-therapist relationship is confidential and privileged, and is protected by both law and the ethical code of the National Association of Social Workers**.** As described in the attached Notice of Privacy Practices, confidentiality is limited by law under the following circumstances: court order or other legally mandated requirement for disclosure of information; to obtain needed services for you or your child, such as in the case of an emergency need for hospitalization; clear risk of harm to self or others or suspected child or elder abuse**.** If any of these circumstances occur, the confidentiality agreement will no longer apply.

Finally, disclosure of identifying information is permitted in order to obtain payment and as needed for the operation of this practice. This confidentiality agreement means that with the exception of the circumstances outlined above, I will not disclose any identifying information about you or your child to others unless I have your signed consent. As a therapist I may wish to consult with other health care or educational professionals in order to enhance your child's treatment. I cannot and will not do this without your authorization in writing. I understand that there may be reasons you may not wish me to speak to others about your child and I will respect your decision if you wish to decline this request. I am involved in clinical consultation to further my knowledge and skills as a therapist. If I need to consult with other mental health professionals about your case, I will do my best to protect your identity.

If we happen to see each other outside of therapy appointments, I will generally not acknowledge you unless you have acknowledged me. This allows you to have control over your confidentiality.

You have:
Right Against Discrimination . . . . .
You have the right not to be discriminated against in the provision of professional services on the basis of race, age, gender, ethnic origin, disability, creed or sexual orientation.
Right to Know My Qualifications . . . . .
You are entitled to ask about my education and training and any other relevant information that may be important to you regarding my provision of services to you.
Right to Be Informed . . . . .
You have the right to be informed of my assessment of your problems in language you understand and to know available treatment options; an estimate of the length of time involved in the therapy process; the cost of the service; the method of treatment; and the expected outcomes of therapy. In addition, you have the right and responsibility to help develop your own treatment plan. No audio or video recording of a treatment

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session can be made without your written permission. If medication is being considered, you have the right to be informed by your physician of available options and possible side effects of the medication.

Right to Your Own Records . . . . .
You have the rights listed in the attached Notice of Privacy Practices.

Right to Refuse Treatment . . . . .
You have the right to consent or refuse recommended treatment. You can be treated without consent only if there is an emergency and in my professional opinion, failure to act would jeopardize your health. In such emergencies, reasonable effort will be made to contact a close relative or friend.

Right to Voice Grievances . . . . .
You have the right to voice grievances and request changes in your treatment without restraint, interference, coercion, discrimination or reprisal.

Right Against Sexual Harassment . . . . .
You have the right not to be subjected to sexual harassment, physical or verbal.

Right for Referral . . . . .
You have the right not to be referred or terminated without explanation and notice. You have the right to receive active assistance in referring you to appropriate services.

Informed Consent for Treatment and Client Rights

I hereby give consent for Cindy Shealy, LCSW to provide treatment for me. I understand that I have the right to revoke this consent at any time by informing Ms. Shealy in writing of my intent to do so. I have read all of the information regarding Notice of Privacy Practices and Informed Consent for Treatment and Client Rights and agree to abide by the terms stated herein during treatment**.**

I understand and agree that I am financially responsible for professional services rendered and for half of my regular appointment fee of a session missed with less than 24 hours notice (ex; $40 for an individual 50 minute session). I have also received a copy of the Emergency Numbers and the Notice of Privacy Practices effective April 14, 2003.

Note: This agreement will expire on termination of treatment and after all claims for payment have been satisfied.

_____ _____
Printed Name of Client Date

_____
Signature of Client

_____ _____
Printed Name of Parent, Legal Guardian Date
or Representative (if client is a minor)

_____
Signature of Parent, Legal Guardian
or Representative (if client is a minor)

_____ _____
Cindy Shealy, LCSW Date