



Mindful
Continuing Education

Ethics and Legal Regulations for Behavioral Health Professionals



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Introduction

Behavioral health professionals are meeting individuals at some of the most vulnerable points in their lives. The average person might seek counseling or behavioral health services because they are struggling with depression or anxiety; experiencing difficulties in relationships; having psychotic symptoms, or have a desire to end their life; among many other possible reasons. You can imagine how vulnerable it would be to show up in a professional's office and not knowing what to expect but understanding how important it is that you are there. The best behavioral health professionals take this vulnerability on the patient's end very seriously.

They take this vulnerability seriously because they understand the bravery that is required to receive services but also how important the way that they as professionals respond to patients who walk through their door. They also take this vulnerability seriously because there are such significant ethics involved in behavioral health care from the end of the practitioner.

It is necessary that anyone who pursues a career in behavioral health understands and can practice within the ethical and legal boundaries as identified in their career path. Different positions in behavioral health care may have different ethics identified, but it is necessary to understand that all work done must be for the greater good of the patient and communities. Services cannot exploit or do damage to the individual who seeks them.

Who are behavioral health professionals?

There are many different types of behavioral health professionals. In this course we will discuss the professionals who are most often considered. Please note, however, that there may be additional professionals practicing who are not mentioned here.

The most common professionals are as follows: psychiatrists; psychologists; mental health counselors; marriage and family therapists; social workers; psychiatric nurses; and substance use therapists. These providers are practicing in various settings such as private practice, community mental health, inpatient therapy programs, intensive outpatient programs, hospitals, and other facilities.

Regardless of where the professional works, they will always be responsible to practice within the ethical limits of their scope. For example, a Social Worker is

responsible for practicing within the Code of Ethics identified by the National Association of Social Workers.

Let's look at the professional ethics for each of the above-identified positions.

Professional Ethics

Psychiatrists

Psychiatrists are responsible for meeting the ethics identified by the American Psychiatric Association's Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry ("Principles") (American Psychiatric Association, 2020). The current ethics document for psychiatrists identifies nine sections that the professional must adhere to. This states the following:

Section 1

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

This section speaks to the psychiatrist's responsibility to put their patient before anything else and to really understand the impact that their work has on the patient. They are also responsible for treating all patients equally regardless of any identity such as race, citizenship status, wealth, sexuality, religion, etc.

Section 2

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

This section explains that the relationship between the psychiatrist and patient must be purely professional and medical in nature. The psychiatrist should not have anything to gain from the patient and they must work within their knowledge scope.

Section 3

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

It should be obvious that section three speaks directly to the legal practice of psychiatry. The professional cannot operate outside of the law in their practice.

Section 4

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

The psychiatrist should ensure all necessary and legal safeguarding of the private and protected health information of their patients.

Section 5

“A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.”

Section five highlights the importance of the lifelong learning process that a psychiatrist should undertake when committing to their professional path. They are responsible for working across systems with other professionals as needed depending on the patient case and the provider should always work tot partner with others and not lead or delegate.

Section 6

“A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.”

This section states that the psychiatrist can identify who their preferred network of patients and peers are and operate within them, however, they must work with all patients who require care in the event of an emergency.

Section 7

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

This section speaks to the psychiatrist’s responsibility to their communities of practice. They should take any opportunity to raise awareness and educate others on a micro, mezzo, and macro level. They should only put accurate and helpful information out into the world and always do no harm.

Section 8

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

This section discusses the importance of always putting the patient first. The psychiatrist should not identify or define treatment by any relationship other than that of the patient's. For example, prescribing medication to a patient that may not be the best fit but feels right because the provider has a relationship to the pharmaceutical company is unethical and directly undermines section 8.

Section 9

“A physician shall support access to medical care for all people.”

Finally, this section states that the provider must serve all people (American Psychiatric Association, 2020).

Mental Health Counselor

Professional Mental Health Counselors are responsible for adhering to the American Mental Health Counselor's Association (American Mental Health Counselors Association, 2020). This association has an identified Code of Ethics that the providers are responsible for adhering to. There are six domains the providers must adhere to. They are as follows:

1. Commitment to Clients

Under the commitment to the client's section, the code of ethics states that mental health therapists are responsible for maintaining a professional relationship with any clients they have. They do this through promoting autonomy and self-determination; by being clear about the boundaries and parameters; by maintaining confidentiality; by not exploiting the relationship with clients; by using evidence-based assessment and counseling practices; and by promoting a counseling environment that is free for all people to utilize.

2. Commitment to Other Professionals

Within this commitment, mental health therapists have agreed to consult other professionals as needed when working with clients. They also agree to treat all colleagues with dignity and respect and appreciation for all cultural considerations. They will not accept referral fees or offers.

3. Commitment to Students, Supervisees, and Employee Relationships

Because it is very common in behavioral health to support students in practicum settings and to provide supervision, this is an important piece of the code of ethics for mental health counselors. This commitment ensures that counselors who offer supervision and training to students do not exploit their learning process, have appropriate boundaries, and ensure that their students are practicing in a way that promotes good and does no harm for their patients.

4. Commitment to the Profession

Mental Health Counselors should be deeply committed to the profession of counseling. Whenever possible they should engage in research to promote continuing education, teach, and serve on professional boards. They should also conduct research in an ethical way that does not exploit or harm others. All researchers who interact with others should fully explain to them the processes to ensure they consent to the research being conducted.

5. Commitment to the Public

Mental Health Counselors should be deeply committed to the public. They interact with the public in a way that has a positive impact and is culturally competent. Any information that they use for marketing must be completely factual and true.

6. Resolution of Ethical Problems

Finally, Mental Health Counselors are responsible for always working to resolve any ethical dilemmas that come up during their practice. They should lean on the ethics committee of the American Mental Health Counselors Association for support and consultation as needed (American Mental Health Counselors Association, 2020).

Marriage and Family Therapists

Marriage and Family Therapists, who work specifically with couples and families, are responsible for adhering to the ethics identified by the American Association for Marriage and Family Therapy (American Association for Marriage and Family Therapy, 2019). The standards identified are as follows:

1. Responsibility to clients

Under this standard, Marriage and Family Therapists are required to not discriminate, to ensure they have full consent for treatment from patients, to

understand their influence and not exploit it, always give the client autonomy and respect in their decision making, never to have sexual relationships with patients, and ensure the relationship is always beneficial to the patient.

2. Confidentiality

Standard two identifies the importance for therapists to always practice confidentiality and to disclose the limits of that confidentiality (in the event someone has plans to harm themselves or another person). They must ensure that the patient provides written consent, understands how to access their records, and that any consultation the therapist receives on the case is protected.

3. Professional competence and integrity

Therapists must ensure that they are skilled in what the patient needs before deciding if a patient is the right fit for their practice. They must ensure there are no conflicts of interest and that they can maintain competency for the work required. They must also always seek the appropriate consultation and learning opportunities for their cases. They cannot accept gifts or bribes and they must always be practicing and participating in lawful behavior.

4. Responsibility to students and supervisees

Marriage and Family Therapists understand the role that they play when providing supervision or learning opportunities to students. They do not exploit this role. They do not provide therapy to these students or supervisees. They are responsible for ensuring that the student/supervisee conducts themselves in compliance with these ethics and practices therapy in an evidence-based and confidential way.

5. Research and publication

This standard identifies the practices within conducting research and publishing research that therapists must adhere to. They include ensuring appropriate approval for research prior to starting, having informed consent from participants, offering the ability to withdraw from the research at any time, and ensuring that no plagiarism occurs.

6. Technology-assisted professional services

All technology used in this work must be confidential and compliant. The therapist is responsible for ensuring this prior to starting. They must be trained on how to use the technology and teach the patients how to use it as well. They must document all services and clearly identify that the service was provided by technology.

7. Professional evaluations

Marriage and Family Therapists must avoid all conflict when evaluating or consulting. They can evaluate for forensic evidence but must do so within their competencies and the law. They should avoid dual roles and ensure all clients are informed and consent to services.

8. Financial arrangements

Therapists must be reasonable in their charging for services. They should disclose all financial policies to clients, be truthful in the way they represent services, not barter, and document all financial exchanges for services.

9. Advertising

Therapists must provide accurate marketing and advertisement for their professional selves. They are responsible for ensuring that all promotional materials are true and consistent with their education and specialties. If they identify any misinformation, it must be corrected immediately (American Association for Marriage and Family Therapy, 2019).

Social Workers

Social Workers are responsible for adhering to the National Association of Social Workers Code of Ethics (National Association of Social Workers, 2020). This document states the following ethics:

1. Ethical responsibility to clients

This standard is a very important standard. It identifies the following ethical responsibilities that social workers have to their clients: that the clients must be informed before beginning practice; that the social worker believes in their self-determination and are deeply committed to that; that they practice culturally competent services and services that are within their practice competency; they have no conflicts of interest; adhere to all confidentiality practices; maintain boundaries, which includes no sexual relationships with clients, touching, etc.; and finally, that their fees are fair and reasonable.

2. Ethical responsibility to colleagues

Social workers are required to treat all of their colleagues and peers with respect and without discrimination. This includes maintaining their confidentiality,

collaborating within disciplines as needed, consulting appropriately, reporting unethical behavior of colleagues, etc.

3. Ethical responsibility in practice settings

Social Workers are knowledgeable and supportive in any setting that they provide supervision to others. They act as educators and field trainers whenever possible. They are fair and considerate when reviewing and assessing their peers and those who practice under them. They adopt billing practices that are accurate and reflect the services they provide. They transfer clients to other clinicians as needed when appropriate.

4. Ethical responsibility as professionals

Social workers are competent and only accept responsibility for completing work consistent with their knowledge base. They do not discriminate against anyone on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical ability. They do not allow their own circumstances to interrupt their work or any client progress. They take credit only for work they have performed.

5. Ethical responsibility to the social work profession

Social workers promote high standards of practice within the field of social work. They evaluate and research practices to always provide the highest quality services. They monitor and evaluate policies to ensure they are equitable and work towards the common good. They ensure that any research participants are informed, consent, and understand they can remove themselves at any time. They publish work to move the profession forward and not for any fame, etc.

6. Ethical responsibility to the broader society

Social workers are deeply committed to the general health and wellbeing of communities and society. They work to inform the public about policies and services that can provide support. They always provide assistance during a time of emergency. They engage in political action to ensure that all people are represented (National Association of Social Workers, 2020).

Registered Psychiatric Nurses

Psychiatric nurses adhere to four main principles for code of ethics:

1. Professional accountability (Registered Psychiatric Nurses Association, 2016)

Under professional accountability, nurses have the responsibility of differentiating between personal and professional relationships. They work to always establish therapeutic relationships, recognize the value and vulnerability of all people, practice within their competency, use evidence-based practices, always maintain their own personal level of health, provide safe and ethical care, maintain the confidentiality of all patients, promote the nursing profession, and uphold the values of the profession.

2. Unconditional respect

Under the unconditional respect ethical code, nurses must always promote the autonomy, rights, and choices of all people. They practice advocacy at all times. They understand that each patient and person has a unique set of life experiences and beliefs. And they always apply and maintain the informed consent of their patients.

3. Holistic health

Psychiatric nurses must respect the rights and values of everyone. They understand that health and mental health are a connected and dynamic process and they understand that different lifestyles impact health differently. They believe in collaborative and holistic approaches to health, prevention, intervention, and rehabilitation for recovery. They promote research and evidence-based practices in nursing and they collaborate with other providers as needed.

4. Quality practice milieu

Finally, they believe that the environment that individuals reside in impacts their health greatly. Because of this, they work to always maintain quality practice settings. They do this by modeling appropriate and healthy behavior. They advocate for resources to provide safe and competent treatment. They advocate for equitable access for all individuals (Registered Psychiatric Nurses Association, 2016).

Substance Use Therapists

Certified Alcohol and Drug Counselors are responsible for adhering to a Code of Ethical Standards. Within this code are twelve standards of ethics (National Association for Addiction Professionals, 2020).

1. The counseling relationship

Substance use professionals understand and accept responsibility for practicing in a way that ensures the safety of their clients and the community. They always receive informed consent, practice confidentiality while also understanding the necessary limits of confidentiality, respect the diversity of all individuals they are working with and around, and will not discriminate based on race, ethnicity, color, religious or spiritual beliefs, age, gender identification, national origin, sexual orientation or expression, marital status, political affiliations, physical or mental handicap, health condition, housing status, military status, or economic status. They understand recognize boundaries, will not have dual relationships, and adhere to evidence-based practices for diagnosis, treatment planning, and any other service delivery. They will advocate, refer as necessary, and only bill for an accurate representation of services.

2. Confidentiality and privileged communication

Substance use professionals understand that anonymity is often essential to the recovery process for people with addiction. They work to protect this whenever possible. They accurately document and adhere to privacy laws, ensure that patients have access to their records as needed, and receive informed consent. They follow laws regarding record retention and archiving as well as storage and disposal. Substance use professionals can consult with other professionals as needed.

3. Professional responsibilities and workplace standards

Substance use professionals are responsible for knowing and adhering to the code of ethical standards as well as local and national laws and regulations. They will always act with integrity, respect, honesty, and represent themselves accurately. They will practice nonjudgmentally and without discrimination. They will not harass others and will only practice within their credentials. They will collaborate with other professionals as needed and appropriately serve their clients. They will advocate and promote appropriate policy development in the profession. When acting as supervisors and educators, they will ensure access to appropriate resources to best support students and professionals who are learning. They will give and take credit as appropriate and engage in research to further develop the profession.

4. Working in a culturally diverse world

Addiction professionals will be knowledgeable, aware of, and practice culturally relevant services for all people. They will see every person's dignity and worth. They will respect culture while also maintaining the privacy and confidentiality of

each person. They will develop their own personal values and identify which are and which are not in alignment with the values of the profession and any organization that they work for. In doing so, they will understand that if there are values that are not aligned, they will not use this as a reason to discriminate or not work with another individual in need. They will advocate for diverse populations and especially those who may be marginalized.

5. Assessment, evaluation, and interpretation

Professionals will appropriately use assessments during the counseling and recovery process. They will apply all cultural contexts when evaluating and developing plans with clients. They will apply the tools and processes that are valid and evidence-based. They will not misuse results.

6. E-therapy, supervision, and social media

Substance use professionals can utilize teletherapy processes but they must be aware of the unique difficulties that may arise as related and be prepared to address them. They shall continue to only practice within their competencies and knowledge base and receive electronic informed consent. They will adhere to all licensing laws and federal laws with telehealth. They will continue to use multidisciplinary teams as necessary for the clients they are working with. They will continue to follow all records laws. Providers will respect the client's social media and will not investigate the client without prior consent.

7. Supervision and consultation

Professionals who provide supervision will accept the responsibility of ensuring the students and learners are developing professionally with regards to all ethics. They will only teach appropriate and evidence-based methods. They will provide fair and respectful feedback in a timely manner. They will receive informed consent from all learners and maintain professional boundaries. They will not disclose any client information without the informed consent of the client to the learner. They will monitor all services being provided by the supervisee to ensure validity and relevance.

8. Resolving ethical concerns

Addiction professionals will adhere to the code of ethics and reach out to the national organization for support in the event of a concern regarding ethics. They will strive to resolve all ethical dilemmas and will document an ethical decision-making process. They will utilize supervision as needed where ethical dilemmas are concerned. They will assist in enforcing the code of ethics and be subjected to disciplinary action in the event they do not apply the code of ethics in their work.

9. Research and publication

Professionals are encouraged to build to the professional knowledge base. They will support researchers by participating in research whenever possible or conducting research whenever possible. All research conducted will ensure the safety and welfare of all participants is respected and all participants give informed consent to participate. Professionals who publish research will not plagiarize or publish anything that is not consistent with their research practices and outcomes. They will not copyright or use materials from another professional without their consent (National Association for Addiction Professionals, 2020).

Boundaries

When we looked at the above code of ethics for various professions in behavioral health it is clear to see that there is much overlap between professions. For example, all of the identified professions required informed consent, confidentiality, and boundary setting. While each specific position and educational path may identify what those boundaries look in various ways, all professional boundaries within behavioral health will follow the same main requirements.

It is important that anyone who is entering behavioral health or is practicing in behavioral health maintain ethical boundaries. Without boundaries, the patients and the providers are at risk for a variety of issues. The patients may not be able to receive the full benefit of therapy and mental health care. They could also be at risk of being harmed in services if boundaries are not maintained. Providers are at risk of doing harm to others and putting their careers at risk if they do not adhere to boundaries and norms. They can also put their own wellness and health at risk if not adhering to boundaries. Because of these reasons, and many more, it is essential that any behavioral health professionals are respecting boundaries. Let's explore what these boundaries look like.

To first identify boundaries, it is essential to identify the difference between paid relationships and unpaid relationships. This is what differentiates the behavioral health professional from a friend or peer who simply wants to help.

The paid professional is someone who provides service-oriented care for a limited time and receives payment for that service provided (Belmont University, 2017). In this relationship there is a power differential whereas the professional holds more power than the patient because they receive the payment, can terminate, and can refer for higher levels of services as needed (for example, inpatient

hospitalization). The professional also is focusing only on the needs of the patient and develops and writes goals for the patient.

The unpaid or non-professional relationship is one that is social and unpaid in nature. It is often spontaneous and not consistent. The power is shared between the two parties and there is a focus on casual and shared interests. In this relationship there will be fewer boundaries than in the professional, paid relationship between a behavioral health provider and an individual who is seeking behavioral health services (Belmont University, 2017).

The following boundaries are examples that all behavioral health providers should follow:

- Providing services at regular times (Psychology Today, 2020). For example, during business hours unless services are being provided in an intensive inpatient therapy program or on a crisis basis
- Providing services from the therapist's office or if completed by telehealth where the therapist is obviously not in their immediate living space
- Billing for services and ensuring that clients pay for services on a regular basis
- Answering questions honestly about professional beliefs and practices when clients ask
- Discussing client progress and revisiting their goals as needed during service relationship
- Consulting with other providers as needed if consent is given from the client
- Maintaining strict confidentiality
- Focusing therapy only on the client and not the behavioral health provider

The following boundaries are examples of what all behavioral health providers could consider or not consider depending on the professional relationship with the patient and the benefit it would or would not have:

- Attending an event that your client may or may not be at
- Attending a major life event for the client
- A client attending a lecture given by the provider
- Seeing the client's family members for other individual therapy

- Having tea or coffee with the client during sessions
- Visiting a client while they are in the hospital
- Extending a session when a client is struggling
- Conducting a session by phone in the event the client is out of town
- Lending a book to the client to read

The following would be examples of crossed boundaries that should not occur for all behavioral health providers:

- Going into business with a client
- Asking your client to perform another service for you such as dog walking or babysitting
- Having a client invest in your business
- Accepting keys to the client's vacation house or any other monetary benefit
- Setting clients up on dates
- Accepting a student from your class into your private practice (Psychology Today, 2020)

Providing therapy and mental health services is a very unique experience and often because of the nature of the work, very intimate. For example, you are meeting patients at the most vulnerable moments in their lives very often. Regardless, there will always be warning signs for if you as a professional are beginning to have unhealthy boundaries or poor boundaries with a patient. The following are warning signs that you should look out for:

- Sharing your own personal experience or intimate details of your life with your patients (Belmont University, 2017)
- Keeping secrets with patients, outside of confidentiality laws and regulations
- Receiving a gift from a patient
- Speaking poorly about a professional peer to a patient or another patient to a patient (this is especially important to notice in inpatient treatment facilities)
- Giving your patient your personal contact information

- Frequently thinking of the patient when you are not at work
- Selectively reporting only on positive behavior or negative behavior that the patient has and not the opposite behavior
- Swapping assignments with another peer professional to work with that patient (this is also more common in inpatient treatment settings)

If a professional notices any of the above behavior occurring, it is essential that you discuss with a supervisor in order to identify a clear and ethical path forward. This may involve a conversation with the patient to make adjustments ensuring professional boundaries are adhered to or it may involve going as far as to refer the patient to another provider. The decision a professional makes will depend on the nature of the warning signs of boundaries that are beginning to feel muddy or even be crossed.

It is important that all behavioral health professionals understand what a boundary violation is. A boundary violation is behavior that specifically exploits the relationship between the provider and the patient. Often the provider will struggle to put the needs of the patient before their own in a boundary violation. Examples identified above that providers should not do in therapy are boundary violations. However, there are additional and more harmful boundary violations. These include: abusing a patient, engaging in a sexual relationship with a patient, and being exploitive in a business relationship with a patient. These are unethical and can result in a professional's license being revoked. This would mean that they would not be able to practice in the future. Additionally, depending on the level of the violation, a person could be charged criminally. For example, if a provider bills for services they did not provide, they could be fined or face jail for fraud.

To avoid any boundary violations, the following recommendations are made across all disciplines:

- Avoid caring for family or friends in your work
- Do not use language that could be offensive or sexual in nature
- Do not touch unless appropriate
- Do not give gifts, loans, etc.
- Do not visit or spend additional time with someone outside of work responsibilities
- Do not share personal or financial information with the individual
- Maintain a respectful attitude with all patients equally

Professionals in behavioral health will likely need to clarify and reset boundaries in their work with patients. There are various ways to do this but the most common include the following:

- Explaining the professional relationship multiple times as needed
- Setting verbal boundaries as needed
 - For example: “I understand that you are frustrated but I am not going to allow you to yell at me or swear at me. We can revisit this conversation later when you are calm”
- Setting physical boundaries by moving away from patients if they get too close
- Documenting interactions with the patient (Belmont University, 2017)

If multiple attempts to set boundaries are ignored by the patient, it is important to end the therapeutic relationship if it cannot be maintained. To do this the professional would calmly explain to the patient why they are ending the relationship and provide referrals for ensuring the continuity of their care is maintained with another professional who can serve them more appropriately.

The best action for any professional in an ethical dilemma is to work with their supervisor or the code of ethics from their professional network or credentialing organization to navigate how to move forward.

Successful boundary-setting case study

Jamie is a Social Work student in her final practicum. She is working under a licensed supervisor and is seeing patients in an inpatient residential treatment facility for individual and group therapy. She has been doing this work for almost six months and really enjoys it. She has found that the difficulty in her work is having to frequently set boundaries with older male patients as she is a young female. She feels as though sometimes they underestimate her professional identity and attempt to cross boundaries with her by making sexual or flirtatious comments.

Jamie recently began seeing a new patient in the facility. She has felt that the few sessions they have had have gone well. The work has been focused on his experience with depression and a recent suicide attempt that prompted his hospitalization. On this particular day, the patient came into session and acted differently toward Jamie. He asked her at the end of the session: “I am not sure that I feel I can continue to work with you as I’m having sexual desires towards you”. Jamie was shocked and taken aback. She stated: “I am glad you told me that

this is how you are feeling and want to assure you that my role is to only support you as a therapist and in no other way. If you feel that this is preventing you from engaging in therapeutic work with me, I would be happy to connect you with another therapist here at the facility who can help”.

The patient was relieved to hear her say this and responded by saying: “I’m really glad you said this because I didn’t want to hurt your feelings but I feel at this time I would prefer to work with a male therapist”.

Jamie assured the patient that this was a good plan and she connected the patient to another experienced, male therapist who was working at the facility. Jamie documented this interaction and communicated to her supervisor at the facility what happened. Her supervisor praised her for this conclusion and Jamie felt she did the ethically right thing by offering to the patient for him to end the relationship.

Unsuccessful boundary-setting case study

Tony is a licensed mental health therapist. He works primarily with teenagers who struggle with mood disorders. Tony enjoys this work and feels strongly that his own personal experience with trauma and depression as a young person prompted his career.

Tony has been working with a teenage boy named Julian. Julian is 15 years old and is in foster care. He’s been in the system for several years and has no contact at this time with his bio parents. It is clear to Tony that Julian is seeking a secure relationship.

Julian has lately begun asking Tony to extend their sessions so that they can play basketball outside of the mental health clinic until his foster parents are able to pick him up from therapy. Tony has on one or two occasions played basketball with Julian while waiting for his ride, however, Julian has begun refusing to start therapy and engage in beneficial work until Tony promises him that he will play basketball with him. Tony really enjoys his work with Julian and feels he is making progress so he agrees to play basketball after every session with Julian so that Julian is willing to continue to work with Tony.

Tony is finding himself running late for his next sessions and unable to complete his chart noting because the basketball games are taking too much of his time.

In this example, Tony has failed to successfully set a boundary with Tony. What appeared helpful when used occasionally (basketball playing) became a tool for Julian to gain power and manipulate his therapeutic relationship (regardless of if Julian recognizes it this way).

Tony should have explained to Julian that while on occasion he might be able to play basketball, he will not be able to after every appointment and it is not appropriate for Julian to use this as a way of deciding to participate in therapy or not. There should have been one or more conversations around this until a boundary was successfully set. It will be much more difficult for Tony to set a boundary now that a pattern with Julian is established. He should seek support from his supervisor to identify how to navigate this boundary issue.

Dual relationships

Dual relationships are important to understand when working in behavioral healthcare. This is because it can change the course of treatment and impact boundary setting.

A dual relationship in behavioral health is when the therapist/provider and the client have another relationship outside of the therapeutic relationship that they have established. Often the dual relationship comes before the therapeutic relationship, but that isn't always the case. There are many different types of dual relationships (Zur, 2020). They are as follows:

- **Social dual relationship:** In this relationship the behavioral health provider and client are also friends or engage in a similar social network or circle. For example, they might be friends on social media, attend similar activities and gathering, or operate in the same professional network.
- **Professional dual relationship:** In this relationship the provider and client are professional colleagues. They might work together on a team, teach together, conduct research together, or engage in a work-related activity that creates this dual relationship.
- **Treatment professional dual relationship:** In this relationship the provider offers another service to the client outside of the behavioral health service. For example, they might be the therapist and the massage therapist or personal trainer, etc.
- **Business dual relationship:** In this relationship the provider also has a business deal or relationship with the client.
- **Communal dual relationships:** In this relationship the provider and the client live in the same area and might run into each other or attend the same church, etc. This is especially common in small communities and can be difficult to avoid.

- ***Institutional dual relationship:*** In this relationship the therapist or provider holds another role simultaneously. For example, in an inpatient facility the therapist might provide therapy and be responsible for milieu management. This can be difficult because in the event of a mental health emergency or crisis the therapist could be required to go hands-on with the client that they have a therapeutic relationship with. Having to apply a protected physical intervention for safety on a patient can damage the therapeutic relationship and becomes difficult to navigate. Whenever possible, these dual relationships should be avoided.
- ***Supervisor dual relationship:*** In a supervisor dual relationship the therapist offers supervision to the supervisee and to the supervisee's clients.
- ***Sexual dual relationship:*** In this relationship the therapist and the client are engaging in sexual contact/intimate relationship. This relationship is always unethical and often illegal. It needs to be avoided at all times and if witnessed, needs to be reported immediately.
- ***Online dual relationships:*** In this relationship the provider interacts in online communities that the client does as well. For example, Facebook groups or Reddit threads.
- ***Referral relationships:*** In this relationship a therapist might be treating several friends from a social network who have referred one another to the same therapist.

When identifying if a dual relationship is appropriate or unethical versus inappropriate and unethical, it is important to consider the level of involvement in the dual relationship. Zur suggests there are three levels of involvement:

- ***Low involvement*** might be when a therapist and patient live in the same community and could run into each other at the grocery store. In this example they can easily ignore seeing one another or simply wave and move on. Most often the therapist will ignore unless the patient prompts interaction. Seeing one another like this will most likely not impact the therapeutic relationship and therefore is most often not unethical. In this scenario as long as both parties identify that it could happen and set up a plan for how to address it if they do run into each other, this will not impact services or become an ethical concern.
- ***Medium involvement*** might be when a therapist and patient have occasional encounters that are generally not risky. For example, if they have children who attend the same school they might see each other at a school function or PTA meeting a few times a year. Most often they will also

discuss this beforehand to identify if they feel they can appropriately engage in therapeutic services together. Some people might prefer not to see their therapist at PTA meetings and decide to find another provider. If this is the case, that is absolutely okay. Others might have little issue with it and feel they can move forward with therapy. It is necessary that the therapist and the provider engage in these conversations prior to starting, however, to ensure that they have agreed on the ethics involved in their specific situation.

- ***Intense involvement*** might be when a therapist and patient regularly attend the same social settings or might have to serve together/work together more closely and intimately outside of the therapeutic relationship. In this level of involvement the therapist and patient risk learning so much about one another that it impacts the therapeutic relationship. This is dangerous and generally needs to be avoided to ensure the therapeutic relationship is secure. The patient should not consider their provider a friend because it can turn the focus to the provider or even cause resentment in therapy. For example, if a patient who is accessing substance use services knows that their provider occasionally uses substances because they are friends, this can cause severe resentment and completely undermine the therapeutic relationship. Intensive involvement should be avoided whenever possible as it is generally unethical.

It is important to note that regardless of the level of involvement in a dual relationship, it is recommended to avoid any involvement, even low involvement, at all times. This prevents any exploitation or interruption in the behavioral health services. If a provider finds themselves in a dual relationship, they should if possible exit the dual relationship. They should do this in a way that protects the integrity of the patient and ensures their safety and continuity of care (Zur, 2020).

Dual relationships are often inevitable in small and rural communities (Barsky, 2020). This is because social overlap simply happens. In a town where there might be only one school, one family doctor, and one private therapy practice, it is simply inevitable that a therapist might more closely coexist with their patients than your average therapist in a large city. Additionally, minority or disabled communities might be limited in options for providers as related to accommodations. For example, a deaf person might prefer to use a therapist who uses sign language. That therapist might be integrated into the deaf community and therefore there may be more overlap or likelihood of a dual relationship.

In small communities it is especially important that behavioral health providers avoid the main ways that dual relationships can cause harm. The most common harm that results from dual relationships is when a provider becomes less professional with their client as a result of social overlap as well as exploitation of

the client. The first issue can often cause a loss of judgment and poor clinical decision making. The second becomes a power differential that can result in very damaging outcomes, especially if the exploitation is sexual in nature.

Referral dual relationships and treatment dual relationships are more common in smaller, rural areas. This is because the provider pool may be so limited. The therapist may in fact have to play more roles in smaller areas and may be working with various community members who have all referred their peers and friends to the provider. This becomes a delicate balancing act for the therapist.

It is important for providers in smaller communities to connect with whatever other providers are near them so that as they need to refer to others to avoid dual relationships, they have a strong network to do so. If there are no local options for referral, these providers are forced to address the dual relationships. This could mean setting boundaries over and over in services as necessary. This indicates, however, that boundaries can be set. Not all dual relationships will allow for boundary setting and continued work, but if there is an ethical opportunity to continue working with the patient and set boundaries, then it is suggested to do so (Barsky, 2020).

If a provider is unable to continue working with a patient in a rural community as related to a dual relationship and there are no other local providers, it is suggested to help the patient identify an in-state provider who can offer telehealth services or identify if a different type of provider locally can support the patient well. Each state has laws that indicate how telehealth can be administered and each insurance provider will have policies regarding telehealth as well, but this is a great option for smaller, rural communities.

Successful dual relationship case study

Tyler is a substance use counselor in a large city. He works with inner-city youth who struggle with substance use and various mental health conditions. He loves his work, but knows that one of the struggles of his work is running into the youth he serves in the day program outside of work hours because he also lives in the city he works in. Tyler witnessed one of his youth buying drugs while riding his bike through the park on a Saturday when he was not working.

Tyler continued his bike ride and the young person did not notice him bike by. During their next session together at the day program, Tyler notified the young person that he saw him in the community over the weekend. He made it clear to the young person that he was being transparent about seeing him in what appeared to be an exchange of money for drugs but that he was not sure because he did not stay to watch. He simply continued riding his bike and did not watch or stare.

Tyler let the young person know he lives in the area and that he does not ever plan to stop to say hello to the youth unless the youth prompts him to do so. The young person agreed and they continued their work together.

Tyler did the right thing by disclosing what he felt he witnessed and they had a discussion about it. Tyler made sure to explain that his intention was not to “catch” the teen in the act and that he accidentally came across him in the park and immediately left the area. The teen reported that he understands that if he is buying drugs in public that people might see. He was not upset and thanked Tyler for letting him know. Tyler did not use this as a reason to judge the teen nor change his course of action for treatment. They continued their work together with no further issues.

This is an example of a social dual relationship with love involvement. Both Tyler and the teen felt safe and comfortable moving forward.

Unsuccessful dual relationship case study

Bethany is a Marriage and Family Therapist who also hosts a group for married couples at her local church. A new couple recently joined the church group and have been open with their struggles in their marriage regarding connecting and parenting. Bethany generally has made it a rule that she does not accept any couples from church into her private practice for marriage therapy but when this couple approached her she accepted them into her practice because she really likes them and wants to see them succeed.

As their sessions continue and Bethany continues to run the group the couple attends, the church group becomes closer and closer. By the holiday season, Bethany and this couple are attending the same holiday parties and their families are getting together and becoming friends.

Bethany notices that she is having a hard time being professional in her sessions. She brings up her own marriage and compares it to the couple in a way she hopes to use for teaching but she is realizing that she is not able to adhere to professional boundaries any longer.

Bethany is afraid of losing her friendship with the couple and disrupting the church group so she continues to see them in her private practice, despite feeling as though it is not right.

This is an example of a communal dual relationship with intense involvement. Bethany should never have accepted this couple into her practice if there was a risk for them getting to know each other so well. However, because she did, she

should have terminated services once she identified her own relationship with them was affecting her judgment in the services she was administering the couple.

Confidentiality

The code of ethics for each of the professional positions in behavioral health discussed earlier had many similarities. Each of the professions required a confidentiality agreement between the therapist and the patients. Any provider in behavioral health will be required to follow confidentiality laws as identified by the Health Insurance Portability and Accountability Act of 1996, also known more commonly as HIPAA.

HIPAA states that any information related to the patients past, present, or future mental health or physical health conditions; the provision of their health care; and the past, present, or future payment for that health care service is to be legally protected and not communicated to anyone else outside of the patient unless the patient gives written permission to do so or the privacy rule allows for it (HHS.gov, 2020).

The privacy rule does allow for disclosing protected health information in the following cases without the individual's written consent:

1. If the individual asks for their own files/documents with their own personal health information
2. For treatment, payment, and health care operations. Examples include:
 1. Consultation
 2. Billing with health insurance
 3. Quality assurance
3. For the opportunity to agree or object. Examples include:
 1. Where the individual is incapacitated
 2. An emergency situation
4. For an incident otherwise permitted use and disclosure
5. For public interest and benefit activities. All 12 allowances include the following:

1. When law allows for the information to be released without consent (mandatory reporting)
 2. To control public health from disease, injury, disability, etc.
 3. To protect victims of abuse or neglect
 4. For health oversight (ex: audits)
 5. For judicial and administrative hearings
 6. For law enforcement purposes
 7. To funeral directors or coroners as needed
 8. For organ donation
 9. For research purposes
 10. For serious health and safety threats
 11. For essential government functions
 12. For workers compensation
6. For limited data sets in research for public health or health care operations

All of the above scenarios (#1-6) require that the provider/organization the provider works under use their professional ethics and ethical decision-making processes.

Behavioral health providers must follow all HIPAA laws. If they do not, they will be subjected to large fines, potential criminal penalties, and the loss of their license to practice.

How to protect confidentiality

Before beginning practice, all behavioral health providers should receive extensive compliance training where confidentiality and federal laws are concerned. This will indicate how the provider will conduct their business to ensure the confidentiality of their patients is maintained. There are various safeguarding practices that need to be applied for all behavioral healthcare. These include the following:

1. **Administration safeguards:** “these are the administrative functions that should be implemented to meet the security standards. These include assignment or delegation of security responsibility to an individual and security training requirements” (HHS.gov, 2020). Included under administration safeguards are:

1. Security management process
2. Assigned security responsibility
3. Workforce security
4. Information access management
5. Security awareness and training
6. Security incident procedures
7. Contingency plan
8. Evaluation
9. Business associate contracts
10. Other arrangements as needed

2. **Technological safeguards:** “these are primarily the automated processes used to protect data and control access to data. They include using authentication controls to verify that the person signing onto a computer is authorized to access that protected health information, or encrypting and decrypting data as it is being stored and/or transmitted. Included under technological safeguards are:

1. Access controls
2. Audit controls
3. Integrity
4. Personal authentication
5. Transmission security

3. **Physical safeguards:** “these are the mechanisms required to protect electronic systems, equipment, and the data they hold, from threats, environmental hazards, and unauthorized intrusion. They include restricting access to EPHI and retaining off-site computer backups.” (HHS.gov, 2020) Included under physical safeguards are:

1. Facility access controls
2. Workstation use and workstation security
3. Device and media controls

Mandated reporting and limitations

Each behavioral health provider is a mandatory reporter as well as teachers, school personnel, physicians, nurses, all other healthcare workers, child care professionals, and law enforcement officers. Depending on the state the provider works in may indicate the specific process and ways to which a person would report as well as timelines, however, generally the mandatory reporter status requires the professional to report for children and vulnerable adults (Child Welfare.gov, 2020).

Holding the status as a mandatory reporter means that a professional is legally required to report any situation that gives them probable cause to believe that abuse, neglect, or exploitation has occurred.

Physical abuse is identified as “injury, such as bruises, lesions and fractures that result from hitting (hand, stick, strap, or other objects), punching, shaking, kicking, beating, choking, burning (with open flame or hot objects - boiling water, cigarettes), throwing, stabbing or otherwise harming the vulnerable person” (One Child International, 2011).

Sexual abuse is defined as “rape, molestation, distribution or production or possession of child pornography” (One Child International, 2011).

Emotional abuse is defined as “any attitude, behavior, or failure to act that interferes with a vulnerable person’s mental health or social development” (One Child International, 2011).

Neglect is defined as a “pattern of failing to provide for a person’s basic needs. It is abuse through omission; of not doing something resulting in significant harm or risk of significant harm” (One Child International, 2011). Examples of neglect include providing a lack of food, weather-appropriate clothing, supervision and a safe and home; failure to provide the necessary medical or dental care; failure to enroll a school-age child in school or to provide necessary special education; and failure to provide emotional support, love, and affection (One Child International, 2011).

These definitions all apply to vulnerable people who are at risk of not being able to report the situations themselves or may not be able to escape the situation themselves. The mandatory reporter is required to report to law enforcement and/or welfare services depending on the state law and the situation. For example, a situation may not require law enforcement but will require a report made to the state welfare office.

It is important to understand how a vulnerable person is defined because this is how a mandatory reporter will know that they have to make a call on behalf of the vulnerable person. Many people think of mandatory reporting as only applying to children, but this is not true. A vulnerable person is defined as any person under the age of 18; an elderly person over the age of 65 who requires support with activities of daily living due to health, disability, or cognitive impairment; any person with a learning disability or developmental disability; any person with a physical disability who requires hands-on assistance for functioning; and any person with severe and persistent mental illness (Western Bay Safeguarding, 2020).

Mandatory reporters are not legally required to have witnessed the abuse, neglect, or exploitation, although if they do then they must objectively report the exact behavior that they were witness to. Mandatory reporters are only required to have suspicious reasons to believe the behavior occurs. This may look like the following:

- Witnessing boundary violations towards the vulnerable person (Darkness to Light, n.d.)
- Receiving information verbally from the vulnerable person or another person who knows them indicating that the behavior occurred
- Seeing physical signs of harm on the vulnerable person (Darkness to Light, n.d.)

For any mandatory reporter, the legal responsibility for reporting never ends. For example, a person doesn't become a mandatory reporter when they get on shift and stop being one when they leave for the day. A mandatory reporter is always responsible to report. This is 24/7/365 and does apply to all people. It is not limited to clients.

This is one of the difficult parts of working in behavioral health for many professionals. They will be legally required to report suspected abuse or neglect when it happens in their families or among their friends. They might witness abuse or neglect in the grocery store and still be legally required to call the incident in.

There are limitations within mandatory reporting. A mandatory reporter is not an investigator. They are not responsible for investigating the potential abuse or neglect. This is the job of the entity who receives the report. For example, the

local child welfare office or agency supporting individuals with aging or disabilities, as well as law enforcement. The mandatory reporter is also not required to stop the suspected abuse. If they physically witness abuse they should call law enforcement immediately, who would then be required to come and stop the abuse.

Benefits and difficulties with mandatory reporting

The benefits of mandatory reporting seem obvious. The goal of mandatory reporting is to prevent any situations of abuse, neglect, or exploitation from occurring towards individuals who would otherwise be unable to prevent them. By legally requiring providers to report suspected abuse and neglect, hopefully this prevents it from happening as well as catches it earlier on in the process (AO Advocates, 2020).

There are difficulties with mandatory reporting just as there are benefits. Unfortunately, the systems that are in place to investigate potential situations that require mandatory reporting are often underfunded and overworked. It can take a great amount of time and advocacy to remove vulnerable people from dangerous situations. This is often because there are more calls coming in than there are staff to investigate them. Therefore, the most at-risk people are seen first based on the severity of the allegation and other situations that are less severe may not get dealt with as quickly. This could put the person waiting in more danger than they were before if their perpetrator is aware that a referral was made.

Secondly, there is unfortunately such trauma associated with the process of investigation for people who are in unfounded situations. For example, a family who might be investigated for potentially abusing or neglecting their child could have their child temporarily removed all to realize that there was never neglect or abuse that occurred in the first place. The fear that the parents could live with may never be easily addressed as well as the fear from the children for potentially being removed from the family home again (AO Advocates, 2020).

Supervision plays a very important role in the mandatory reporting process. Behavioral health professionals should be able to request support from their supervisors in the event of supporting a client in the situation of being abused, neglected, or exploited. Consultation and staffing should occur for every event, but some states do require a consultation prior to calling in a report of suspected abuse, neglect, or exploitation. Each behavioral health professional should be knowledgeable about the laws in their practicing state as well as federal laws.

Mandatory reporting case study of a child

Lillian is a second-grade teacher. She has been teaching a student in her class since the beginning of the year, approximately six months ago. This student has been very happy, kind, and energetic. Lillian knows that the student lives with his single mother but that in the last month or so her mother's boyfriend moved in with him and his mother. Lillian has gradually witnessed a change in this student's behavior. He has become subdued, less energetic, and tearful at times. When asked if he is okay, he reports yes. Lillian has not pressured the student to talk but has let him know she is available to him if he needs anything.

On Friday the student came to school with visible bruises on his arm that appear in the shape of a handprint. Lillian asked the student if he was okay and if anyone was hurting him. He did not answer her yes or no, but he did break into tears when she asked. During a break Lillian consulted the situation with her principal. Together they made a report to the local child welfare agency who also reported the suspected physical abuse to their local law enforcement agency. The child welfare investigator investigated the abuse and found that the mother's boyfriend had begun physically abusing her in the last few weeks. She was not aware that he was also physically abusing her son. He was arrested and a no-contact order was placed. When Lillian spoke with the boy's mother she stated: "I don't think I would have had the courage to tell anyone that this was happening to me. Thank you so much for noticing my boy's pain and reporting it. We are so much safer now".

This is an example of how the boy did not verbally report any abuse was occurring to him to his teacher, but she had reason to believe because of his change in presentation and the physical mark on his arm that he was being abused at home. This report was addressed appropriately and timely and positively impacted not only the child's safety, but his mother's as well.

Mandatory reporting of a person with a disability

Greg is a 36-year-old man with Cerebral Palsy. It impacts his ability to walk, perform his own activities of daily living, and perform instrumental activities of daily living. He has a caregiver with him 24/7. He has several caregivers who work eight-hour shifts.

His morning caregiver, Tina, has noticed lately that every morning when she helps Greg get out of bed that he has been in the same position. He is supposed to be being physically turned every few hours throughout the night on a schedule that would have him being in a different position every few days in the morning when she wakes him up to help him with his morning routine. Tina asked Greg if his night shift caregiver has been turning him and he stated no. Because it is a physician's

order that is written in Greg's care plan to prevent him from getting skin tears and ulcers, he is at great risk if this does not occur. Tina and Greg together called the Adult Protective Services office who supports individuals with disabilities.

An investigator came out to interview both Greg and Tina about what has been going on the last week or so regarding his care. Greg's night shift caregiver was found to be neglecting his care plan by not turning him and was required to pay a fine for neglect. She is also no longer allowed to be a caregiver because the neglect was substantiated by the agency.

This is an example of substantiated neglect for an individual with a disability. Greg required turning to prevent skin ulcers from developing. Had he developed a skin ulcer he could have been at great risk for declining health. Because Tina asked Greg and together they made the report, Greg was able to get a new caregiver for nights to better care for him and his previous caregiver will not put another person at risk.

Mandatory reporting for an aging individual

Audrey is an 82-year-old woman who requires minimal assistance physically to take care of herself. She lives in an Assisted Living Facility so she has someone onsite available to assist her when needed. Audrey recently made her adult child her financial power of attorney to assist with financial matters and long-term planning.

Audrey recently noticed that her social security checks were not being debited into her account as normal. She asked her child about the income missing. Her adult child stated that the money was being used to cover the cost of her assisted living facility. Audrey thought that her facility was being paid by Medicaid but she didn't inquire further with her child.

Audrey recently met with the social worker at the facility she lives at. The social worker told her that she was behind on the payments for the facility. Audrey explained that Medicaid should be covering for the facility. Together Audrey and the social worker realized there was a miscommunication. Audrey learned that her social security should be helping to pay for the remainder of the monthly payment for the facility. When she asked her child about this, her child declined it.

The social worker at the facility became suspicious that Audrey's money was being financially exploited by her child who holds financial power of attorney status. She made the report of suspected exploitation and an investigation occurred. The investigation found that her adult child was transferring her social security money that should have been helping pay for her expenses at the facility, into her own personal bank account, and was using it to pay her own personal bills.

Audrey was devastated and revoked her child's power of attorney status immediately.

This is an example of financial exploitation that the social worker called in because of the discrepancies in information about how to pay her monthly expenses towards the facility. The investigation was substantiated. Audrey decided to pay for a financial advisor to assist her with her money management moving forward.

All three of these case studies are examples of behavior that could have been extremely detrimental to the vulnerable people had the professionals who made reports not made them. Mandatory reporting laws are essential to the wellbeing of all people in communities who may not be able to care for themselves or advocate for themselves. It is necessary that behavioral health professionals are well educated on the federal and state laws and policies for reporting. It is also necessary that they take these laws and policies very seriously. Failure to report could result in their license(s) being removed and even civil/criminal penalties depending on the severity of the case.

Duty to warn and the Tarasoff case

Duty to warn laws were established in 1974 as a result of the Tarasoff vs. Regents of the University of California case (Granich, 2020). Tatiana Tarasoff was a university student who was murdered by stabbing by Prosenjit Poddar, another university student. Poddar had previously reported to a psychologist at the university that he had intended to kill the woman. The psychologist reported this information to police who warned Poddar to stay away from Tarasoff. The psychologist did not warn Tarasoff or her family of the potential harm she could be in as a result of this man's violent desire to harm her. Tarasoff's family sued the police and campus health program for failing to protect their daughter after the murder occurred. Of the Tarasoff case, the duty to warn law was enacted. The case documents state:

“When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of the duty may require the therapist to take one or more various steps, depending on the nature of the case. Thus, it may call for him to warn the intended victim or others likely to appraise the victims of that danger, to notify the police or take whatever steps are reasonably necessary under the circumstances” (Granich, 2020)

While the client to therapist relationship may be violated because the therapist will break confidentiality to warn an intended victim, the law dictates now that the provider should do just that. They have a legal and ethical duty to warn the victim if there is reasonable cause to believe that their client could harm the victim.

An additional law that behavioral health providers are responsible to report for under duty to protect is the situation where an individual is at risk for suicide. Each state may have a different interpretation or policy around protecting individuals who are at risk for suicide attempts and therefore the provider should be trained and familiar with their state law (American Psychological Association, 2009). Generally, however, a behavioral health provider is legally required to call 911 or help an individual be transported to a hospital for immediate care if they have thoughts, a plan, and a reasonable ability to complete their plan for suicide (American Psychological Association, 2009).

It is important to understand what reasonable ability means. This means that the person could in fact obtain whatever items needed or access whatever opportunity to attempt suicide. For example a plan that involves using a firearm by a male hunter is reasonable and could likely occur. A plan that involves a young person attempting to swallow a lit firecracker who has no firecracker or ability to access one, may not be reasonable. In the case that the person does not have a reasonable plan or appears to have real intent, the professional should develop a safety plan with the individual and ensure they have the appropriate contact information for crisis services. For the man who has a reasonable plan and ability to carry out his plan, the provider should stay with the individual while they contact 911 together or develop a plan to transport the individual to a hospital for psychiatric evaluation and treatment.

Duty to warn case study that is necessary

A substance use therapist has been working with Bill for many months. Bill is homeless and stays sometimes sheltered and sometimes unsheltered with his wife, Samantha. Samantha and Bill have been married but often separated over the years. Their relationship is tumultuous when they are both using drugs and seems to level off when they are sober.

Bill and Samantha are currently using large amounts of methamphetamine. They have been arguing more and more. Bill has become increasingly frustrated with Samantha lately and reports that he has been fantasizing about injecting Samantha with enough amounts of methamphetamine to intentionally kill her.

The substance use therapist staffs the case with his supervisor. Together they decide that Bill's threats seem serious and plausible enough to occur based on the

history of the couple. They make a report to the police and they find Samantha and warn her. Together with Samantha they find a woman's shelter and help her file a no-contact order against Bill. This was an appropriate and correct application of the duty to warn laws by this substance use therapist.

Duty to warn case study that does not apply

Samantha is a marriage and family therapist. She has been working with a family unit who has recently undergone great stress because a woman and her twin sons recently lose their father in a car accident. The boys have been arguing more recently and fighting over toys.

Samantha has been seeing the boys together and independently for months and feels she knows them well and knows their mother well. During one of the independent sessions, one of the twin reports he "wants to kill" his brother. When Samantha asks him more about this she realizes that it is a language he seems to have picked up at school and he does not appear to have a plan, intent, or really even mean that he wants to harm his brother. They continue their services as planned and unless Samantha has greater concerns, she does not plan to report this to the mother or his twin sibling at this time.

This is an appropriate decision. This case does not require the duty to warn.

Supervision is equally as important with the duty to warn as with mandatory reporting. Behavioral health providers should always seek appropriate clinical supervision as needed with decision making, however, this should only happen if there is time and safety allowed to do so. If a person is at imminent risk of harming themselves or someone else, the professional should contact 911, the authorities, and the individual to notify them of the risk immediately. Consultation and supervision can be provided after this occurs if the situation calls for it.

It is important always for behavioral health providers to understand the laws and policies in their states. For example, some states may require online written reports, and others may only require verbal reports by phone. These may also change depending on the severity of the case.

Before going into private practice or any employment setting in behavioral health, the provider needs to understand the ethical obligations they must adhere to, the boundaries they must set and hold through service delivery, the kinds of relationships that are and are not appropriate (dual relationships, for example), the confidentiality laws, mandatory reporting, and duty to warn and protect laws. These should always be at the forefront of the work being done in behavioral health. It protects the clients, the providers, and communities at large.

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Mindful

Continuing Education

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