

ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10570 SENATE HEALTH EDUCATION & SOCIAL SERVICES

MEDICAID

THE LAW

SEC. 121. STATE OPTION OF MEDICAID COVERAGE FOR ADOLESCENTS LEAVING FOSTER CARE.

(a) In General. – Subject to subsection (c), title XIX of the Social Security Act, is amended –

(1) ii. section 1902 (a)(10)(A)(ii)(42 U.S.C. 1396a(a)(10)(A)(ii)), –

(C) by adding at the end the following new subclause:

(XV) who are independent foster care adolescents (as defined in section 1905 (v)(1)), or who are within any reasonable categories of such adolescents specified by the State;” and (2) by adding at the end of section 1905 (42 U.S.C. 1396d) the following new subsection:

(v)(1) For purposes of this title, the term, “independent foster care adolescent” means an individual –

(A) who is under 21 years of age;

(B) who, on the individual’s 18th birthday, was in foster care under the responsibility of a State; and

(C) whose assets, resources and income do not exceed such levels (if any) as the State may establish consistent with paragraph (2).

(2) The levels established by a State under paragraph (1)(C) may not be less than the corresponding levels applied by the State under section 1931 (b).

(3) A State may limit the eligibility of independent foster care adolescents under section 1902(a)(10)(A)(ii)(XV) to those individuals with respect to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of title IV before the date the individuals attained 18 years of age.

Many issues related to state implementation of the FCIA Medicaid option are addressed in the first *Frequently Asked Questions (FAQ I)*. As states have begun to develop their state plans and work with their Medicaid and child welfare agencies, new questions have emerged.

1. How can a state estimate the number of former foster youth ages 18–21 likely to be eligible for Medicaid and the number of those who will actually enroll?

While many young people in foster care lose their Medicaid eligibility upon their 18th birthday, even before the FCIA there were several ways in which some young people could retain their eligibility or qualify for another health care program past their 18th birthday. In each state young people eligible for continued coverage may include:

- Pregnant or parenting youth who also meet Medicaid income eligibility requirements
- Youth with disabilities who receive Medicaid based upon their Supplemental Security Income (SSI) eligibility

- Youth up to age 21 who would have qualified, under welfare rules, for Aid to Families with Dependent Children (AFDC) prior to TANF, if they were dependent children (often referred to as the "Ribicoff option")
- Youth up to age 19 who meet the eligibility requirements for their State Children's Health Insurance Program (SCHIP), which may be either a Medicaid expansion or a separate state program
- Youth transitioning from foster care in states that fund this medical coverage with state dollars exclusively

Prior to the enactment of the FCIA, the Congressional Budget Office (CBO) had to estimate the cost of the new Medicaid option. It estimated that about 60% of former foster youth between ages 18 and 21 were already eligible for Medicaid under one of the arrangements listed above and that approximately one half of these young people were already enrolled. It meant that about 30% of former foster youth nationally were already covered by Medicaid.

When a state decides to extend Medicaid coverage to young people ages 18–21 under the FCIA, CBO further estimated that 85% of all former foster youth will be eligible for Medicaid coverage and 75% of those youth will be enrolled in a Medicaid program, either as a result of one of the above arrangements or the newer FCIA Medicaid option. This would result in Medicaid coverage for a total of 64% of former foster youth nationally.

The CBO approach to determining the number of youth likely to enroll is designed to provide a national cost estimate, and is based upon the highest potential number of new youth who will enroll in Medicaid. While it is a place to begin to develop rough state estimates, each state can develop a more tailored estimate by considering a number of additional variables. The number of young people in foster care can be found in data provided by the state Adoption and Foster Care Analysis and Reporting System (AFCARS).

Consider the following example:

State A has one thousand 18 year-old youth in foster care in the year 2000. If we assume that this state had a similar number of foster youth in the 3 previous years, we can expect that there are currently 3,000 former foster youth ages 18, 19 and 20. Prior to the FCIA, 60% of these young people (1,800) would have been eligible for Medicaid and at our half of them (900) would have been receiving Medicaid under existing arrangements.

If a state elects to implement the FCIA Medicaid option, 85% of these youth will now be Medicaid eligible (2,550) and 75% of these youth will actually enroll (1,912). Thus, the potential increased Medicaid enrollment in the state, as a result of the Medicaid option, could be up to 1,012 youth.

A state should begin by determining how it will achieve the goal of meeting the health care needs of all young people in transition, and whether the FCIA Medicaid option will be offered to all youth transitioning from foster care who are between the ages of 18 and 21. This is the recommended option. However, the FCIA also provides for state flexibility in covering "reasonable categories" of transitioning young people. With a clear goal of meeting the health care needs of all young people in transition, a state can plan an appropriate and effective outreach strategy.³ During this process, if a state's initial cost estimate for covering all youth is too high for immediate implementation, an incremental approach could be considered. For example, coverage could be extended to one sub-group each year until all youth are covered. Such reasonable categories could include only young people whose foster care was paid for under Title IV-E of the Social Security Act, or only young people who meet an income eligibility test. Limiting coverage to one or more sub-groups could pose an administrative challenge related to eligibility determination, a challenge which could be avoided by offering this Medicaid coverage to all young people in transition.

³ A. English and K. Grasso, *The Foster Care Independence Act of 1999: Enhancing Youth Access to Health Care*. Clearinghouse Review/ Journal of Poverty Law and Policy, Vol. 34, Nos. 3-4, pp. 217-232 (July-August 2000).

Other factors for a state to consider in estimating the number of children eligible for the new option include:

- The number of youth ages 18–21 in a state who already receive Medicaid benefits as a result of one of the arrangements described above (pregnant or parenting, Ribicoff, SSI, S-CHIP, or a state-funded transition program) may be higher than 60%. If that is the case, the increase that will result from exercising the FCIA Medicaid option may be lower than the CBO estimates.
- The number of eligible youth who actually enroll in Medicaid may initially be lower than projected by CBO based on a state's history in reaching out to and maintaining contact with young people as they leave foster care. To determine this, consider several key questions, such as: How good is the state at maintaining contact with youth as they age out of foster care; what does experience indicate regarding the likelihood that these youth will stay connected to systems; and do many of those who age out disappear for a time and then reappear seeking services at a later date? Effective outreach can help a state improve upon these outcomes.
- The number of youth who enroll in Medicaid will also vary based on the decision each state makes about which subgroups of young people to cover.

Factors like these are likely to alter the number of youth who will become newly enrolled in Medicaid as a result of the FCIA option and result in differences from the application of the CBO estimate.

2. How can a state determine the cost of exercising the FCIA Medicaid option?

To arrive at a realistic cost estimate for implementing the FCIA Medicaid option, each state must first determine which young people will be covered and how many of these youth are likely to enroll, as discussed above.

Next, identify a state's share of Medicaid costs. The Federal share of the Medicaid cost (guaranteed for states electing to implement the FCIA Medicaid option) ranges from 50% for many states to 76.8% in the lowest income states. A chart of this federal/state

match rate (referred to as the FMAP) for all states and jurisdictions is available online at <http://www.aspe.hhs.gov/health/fmap.htm>.

Then determine the typical medical costs associated with the youth who will be covered under this option. CBO estimates that medical costs for foster children are two to five times higher than costs for other children who receive Medicaid, and attributes this higher rate, in large part, to the higher utilization of mental health (including substance abuse) services among these young people. CBO also recognizes that former foster youth with the highest needs may be among those who do not enroll in Medicaid or seek out services. Thus, CBO estimates that it will cost a state \$2,700 per year (approximately twice what it costs to serve all children, ages birth to 18, receiving Medicaid, and about \$1000 per year more than the typical costs of serving non-foster-care teens) to provide medical care under Medicaid for these youth.

A new study, *Health Conditions, Utilization and Expenditures of Children in Foster Care*,⁴ is now available on the Children's Bureau website (<http://www.acf.dhhs.gov/programs/cb/>). It found that average monthly expenditures for foster care youth ages 15–18 vary widely by state. For example, \$173 in California, \$400 in Florida, and \$243 in Pennsylvania. The biggest variable is often the number of young people receiving institutional care. For this age group, institutional services made up 44% of expenditures in California, 20% of expenditures in Florida and 53% of expenditures in Pennsylvania.

The study, consistent with CBO projections, shows that mean monthly Medicaid expenditures for children in foster care (ages 0–18) were between 2.0 and 2.4 times the average expenditures of all children covered by Medicaid, depending on the state. California was 2.0, Pennsylvania was 2.2 and Florida was 2.4. It is reasonable to expect that costs per youth will decrease after age 18, particularly as rates of institutional care significantly decrease for this age group.

If a state has its own state-specific data reflecting the actual utilization and costs of providing medical care under Medicaid to foster youth, then the state is ahead of the game. By looking at the costs of care

⁴ U. S. Department of Health and Human Services, Office for Planning and Evaluation (ASPE) conducted this study which provides a more current and accurate picture of medical costs incurred by foster children. Data are for 1994 and include both state and federal expenditures combined.

for foster children ages 16 and 17, as well as the cost of providing Medicaid to any 18, 19 and 20 year olds who are already covered in a state under other arrangements (pregnant and parenting, Ribicoff, SSI, etc.), it will be possible to generate reasonably accurate cost estimates.

3. Who can supply the state's share of the Medicaid match?

The state share of the Medicaid costs can be provided by the state Medicaid agency, or the child welfare agency, or a combination of both. See Appendix G, December 1, 2000 letter to states from the U.S. Department of Health and Human Services. State legislatures can appropriate new funds for this purpose, or costs can be shifted from other programs. This is an important question that can be best answered for each individual state when all members of the planning team work together to find a solution that reflects both the anticipated costs and the economic realities within that state.

4. What Medicaid services must a state that exercises the FCIA Medicaid option provide to young people ages 18–21?

All Medicaid-eligible young people under age 21 are entitled to receive the services covered by the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. By Federal law⁵, EPSDT provides comprehensive benefits including primary, preventive, developmental and long-term care for children and youth in both the physical (medical, hearing, vision and dental) and mental health arenas. All "medically necessary" services as determined under an EPSDT screening process must be offered even if these services are not covered in the state's Medicaid plan, provided they are allowable under Medicaid.

To learn more about EPSDT, visit the Health Care Financing Administration (HCFA) website at <http://www.hcfa.gov/pubforms/pub45pdf/smm5t.pdf>.

In addition, the National Health Law Program website at <http://www.healthlaw.org/index.shtml> has several useful fact sheets about the EPSDT Program. These websites provide a chart

detailing the scope of Medicaid/EPSTDT services described in 42 U.S.C. 1396d(a). The list is comprehensive and among the many services specified are family planning services, substance abuse treatment, eyeglasses and dental care, mental health and psychiatric care, and community-supported living arrangements such as personal assistance or assistive technology.

As more and more states use managed care plans to provide services to Medicaid beneficiaries, it is important to recognize that these plans, when applied to young people (all children — including those ages 18, 19 and 20), are required to provide the full range of EPSTDT services. Furthermore, children in foster care or other out-of-home placement, as well as children receiving foster care or adoption assistance, are considered to be a special needs population. HCFA has recently released the Draft Interim Review Criteria (DIRC) for Children with Special Health Care Needs which outlines the state's responsibilities in managed care programs enrolling children with special needs.⁶

5. As a state begins to address the health care needs of young people transitioning out of foster care, who could be new community partners?

Electing to implement the FCIA Medicaid option creates new opportunities to establish or enhance linkages with other community partners to best meet the health care needs of young people. In addition to opening communication and working relationships between a state Medicaid agency and a child welfare agency, professionals and advocates familiar with child welfare, youth and independent living services can reach out to community groups that have traditionally focused on health care issues, but may be less familiar with this particular population of young people.

Public agencies to engage could include the Substance Abuse and Mental Health Services Administration (SAMHSA), the Maternal and Child Health Bureau's Division of Services for Children with Special Health Needs (MCHB/DSCSHN), the MCHB's Division of Child, Adolescent and Family Health, the

⁵ EPSDT covers all measures described in 42 U.S.C. 1396d(a) necessary "to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." 42 U.S.C. 1396d(r)(5).

⁶ For more information about the DIRC or other technical assistance tools related to managed care, Medicaid and serving foster youth, contact Clarke Cagey at HCFA, Special Assistant to the Director, Division of Integrated Health Systems, Family and Children's Health Programs Group, (410) 786-7700, ccagey@hcfa.gov, or Lynda Honberg, Director, Division of Services for Children with Special Health Needs at the Maternal and Child Health Bureau, (301) 443-6314, lhonberg@hrsa.gov.

State Child Health Insurance Program (S-CHIP) and the State Department of Public Health.

Other potential community partners with valuable experience and expertise include family planning organizations, grassroots health care advocacy groups, legal advocacy organizations and groups from the substance abuse, mental and behavioral health and disability communities. Professional organizations of medical providers, such as the American Academy of Pediatrics and the National Association of Children's Hospitals, can provide valuable linkages and expertise. Many communities have health care and social service organizations specifically focused on the needs of a particular cultural or ethnic group such as Latinos, African Americans, Asian Americans or Native Americans. Finally, health care related foundations (locally or nationally) could be other strong partners, such as the Robert Wood Johnson Foundation. The local United Way may be a good resource for this information.

All of these potential partners can bring new ideas, fresh energy and valuable expertise to this effort. However, they most likely will have little or no experience working with the child welfare community in general and young people leaving foster care in particular. Creating these linkages now can yield lasting benefits for young people that go beyond the scope of health care services.

6. Once a state has adopted the Medicaid option, what are effective ways to get the word out to young people?

Offering Medicaid to young people ages 18–21 will not be meaningful unless they know about this resource and how to access it. Therefore, the development of a comprehensive outreach plan is a critical component to overall planning efforts. Utilize the input of all the members of the state planning team and the new partners described above. Pay particular attention to the feedback provided by the young people themselves. In addition, look at models of outreach that have been developed by such programs as Covering Kids.⁷

Consider print media (newspapers, magazines, newsletters), radio, television and online communications as well as public relations experts as community resources. Identify the most likely places that young people gather, either "in real life" or through the media. Include recreational facilities, night clubs with an under-21 dance night, radio stations that attract a large youth listening audience, fast-food restaurants, church youth groups, homeless shelters, community centers, laundromats, and other places in your community that attract young people. Refer to websites that have been created specifically for young people in foster care and alumni such as <http://www.fosterclub.com>.

⁷ Covering Kids, a national health access initiative, is a program of the Robert Wood Johnson Foundation to help increase the number of eligible children who benefit from health insurance coverage programs. There are 51 statewide and 173 local coalitions funded under Covering Kids to provide a variety of outreach and enrollment activities. For more information, see their website at <http://www.coveringkids.org>

YOUNG PEOPLE WITH SPECIAL NEEDS

THE LAW

All provisions of the Foster Care Independence Act of 1999 (FCIA or the Act) are equally applicable to young people with disabilities. States are specifically required in their state plans to address the inclusion of youth with special needs.

SEC. 477. JOHN H. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM.

(b) Applications. –

(2) State Plan. –

(C) Ensure that programs serve children of various ages and at various stages of achieving independence.

(3) Certifications. –

(F) A certification by the chief executive officer of the State that the State will make every effort to coordinate the State programs receiving funds from an allotment made to the State under subsection (c) with other Federal and State programs for youth (especially transitional living youth projects funded under part B of title III of the Juvenile Justice and Delinquency Prevention Act of 1974), abstinence education programs, local housing programs, programs for disabled youth (especially sheltered workshops), and school-to-work programs offered by high schools or local workforce agencies.

1. Who are young people with special needs?

The Maternal and Child Health Bureau's Division of Services for Children with Special Health Needs, <http://www.mchb.hrsa.gov/html/dscshn.html>, defines children with special needs as follows:

Children with special health care needs include all children who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required generally.

In developing the Chafee Independence Program, Congress learned about the tremendous challenges that face youth aging out of foster care, and the increased risk they face of undesirable outcomes. These include increased rates of homelessness, non-marital childbearing, poverty and delinquent or criminal behavior, as well as higher risk of being

targets of crime and physical assaults.⁸ Similar research shows that youth with special needs are much less likely than their non-disabled peers to finish high school, pursue post-secondary education, get jobs or live independently.⁹ Numerous studies indicate that significant numbers of youth in foster care (ranging from a third to three quarters) have or are at risk for acute, chronic, or disabling physical or mental health conditions.¹⁰

Thus, youth aging out of foster care who also have special health or mental health needs face nearly overwhelming challenges. They have often been excluded from independent living programs because of a belief that they cannot benefit from such services if they are not likely to obtain "full independence". The collaboration with programs serving young people with disabilities required in the FCIA provides both a challenge and an opportunity to create and deliver a more comprehensive,

⁸ P.L. 106-169, Findings, paragraph (4)

⁹ John Reiss, Ph.D., Director, Policy and Program Affairs, Institute for Child Health Policy, *Healthy and Ready to Work: Transition Activities of State Title V CSHCN Program*, September, 2000

¹⁰ Ronna Cook, et al, *A National Evaluation of Title IV-E Foster Care Independent Living Programs for Youth, Phase I, Final Report*, Volume One 4-1, (1990), Westat Inc., Rockville, MD, and Chernoff et al, *Assessing the Health Status of Children Entering Foster Care*, 93 *Pediatrics* 594 (April 1994)

integrated and appropriate array of services to this group of young people so that they too can achieve their highest level of independence.

2. How can the Chafee Foster Care Independence Program help coordinate services for young people in foster care with special needs?

Young people served by the Chafee Independence Program should have a personalized independent living plan. The law requires young people themselves to participate in designing and carrying out their own plan. Youth with special needs are also likely to have—or be entitled to—an individual Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA). They may also have—or be entitled to—an Individual Written Rehabilitation Plan (IWRP) through the Department of Vocational Rehabilitation. Finally, they are likely to have—or be entitled to—a plan of service care and coordination through Title V (Maternal and Child Health Bureau's Division of Services for Children with Special Health Needs (DSCSHN)).

The multi-agency collaboration required under the Chafee Independence Program helps to coordinate these plans and ensure that they do not conflict. Planning teams can create a seamless plan of services with designated areas of responsibility provided by the schools, the child welfare agency, health care providers and the state vocational rehabilitation agency.

Under IDEA, beginning at age 14, a student's IEP must include "a statement of transition service needs" which must be updated annually. Beginning at age 16, this statement must include a description of transition services¹¹ that are a "coordinated set of activities that promote movement from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living or community participation."¹²

This focus on three outcome areas—post-secondary education and employment, adult living and community participation—are the same three outcome areas that an Independent Living Plan

under the Chafee Independence Program should address. While significant numbers of youth in foster care have special educational needs and should have IEPs, their rights and opportunities under IDEA can often fall to the wayside. This happens as a result of multiple moves, involving multiple school changes, and the fact that there is often no consistent parent or other adult to monitor and advocate for a comprehensive and appropriate IEP. Similarly, although many foster youth are likely to be eligible for services provided through their state Department of Vocational Rehabilitation and/or Title V (DSCSHN), the same obstacles may result in spotty or negligible access to these services. As each state develops its multi-year plan for implementation of independent living services under the Chafee Independence Program, inclusion of representatives from special education, vocational rehabilitation and DSCSHN is essential. Not only will young people be better served by the creation of these linkages, but the child welfare agency can benefit from the expertise and experience these other agencies collectively provide.

3. Why is it important to pay special attention to foster youth with special needs?

While transitioning youth with special needs face the same challenges as their non-special-needs peers, they are at higher-risk for several of the least desirable outcomes such as poverty, early or unintended pregnancy and becoming a victim of sexual assaults. Many of the young people with special needs in foster care may have "invisible special needs" such as learning disabilities or emotional and behavioral challenges. These may have gone undiagnosed and/or untreated and therefore further increase the risk these particular teens have for problematic outcomes.

The National Longitudinal Transition Study (NLT), a 1987 and 1990 survey of 8000 youth with disabilities in 300 school districts found, for example, that 50% of young women with learning disabilities became pregnant within five years of leaving high school—and many of these young women had dropped out of school.

¹¹ Beginning at age 16 or younger, if determined appropriate by the IEP team, the IEP should have a "statement of needed transition services for the child, including, when appropriate, a statement of the interagency responsibilities or any needed linkages." 42 U.S.C. 1414(d)(1)(A)(vii) & (II).

¹² P.L. 105-17, Section 614

Teenagers with special needs were found, in the same study, to be 68% more likely to live in poverty than their non-disabled peers, and experience a greater degree of social isolation. They often are unable to pick up on the often subtle cues needed to learn social and independent living skills. Many young people leaving foster care read at below grade level, and may also have auditory processing problems, as well as difficulty attending to information. This makes it more challenging for them to benefit from materials and instructional programs designed for typically-developing adolescents or young adults.

A startling finding from the NLT reveals that young people with disabilities are four times more likely to be sexually abused than their non-disabled peers. Sexual education and pregnancy prevention strategies that are designed to meet the needs of young people with special needs are nearly non-existent.

Schools and service providers are not well equipped to help young people with special needs.

Lack of training, knowledge and sensitivity to transition issues of youth with special needs on the part of service providers across the spectrum were cited as the most significant barriers to successful transition of youth with special needs in a Spring 2000 survey of providers, parents and youth in 44 states conducted by the Institute for Child Health Policy. California's School-To-Work Interagency Transition Partnership (SWITP—<http://www.sna.com/switp>) finds that very few school-to-work programs nationwide understand or focus on the unique issues faced by young people with special needs, and some school-to-work programs are not even offered to youth in special education programs. Service providers are often unable to translate factual information about a young person's disability into terms that will assist with other planning efforts.

There is a failure to focus on their overall needs.

Young people with special needs often report that they are not treated in a holistic manner. They only receive treatment and follow-up care based on their diagnosed condition. Concerns they have about continuing education, employment, housing or recreation are typically overlooked. Young people with special health care needs often find that their mental health needs are not addressed, yet these youth are at higher-than-average risk of depression and other mental health challenges.

There is a lack of family networks and service coordination.

The Center for Promoting Employment in Boston has identified the importance of a family network in the creation and maintenance of job opportunities for youth with disabilities. Yet, young people leaving the foster care system are less likely to have such a network available to them. Additional challenges faced by young people with special needs during the transition process include lack of coordination among multiple agencies that serve them. A young person in Maine's Adolescent Transition Partnership (<http://www.ume.maine.edu/cci/matp/matp.html>) described it well, "Sometimes it seems like people from the different agencies do not know what each other does very well—I think that makes it hard for them to help me get what I need." Expectations for these youth are often lowered, and challenges faced by all young people, such as transportation, are even more complex when special needs are involved.

4. How can independent living programs ensure inclusion of and appropriate services to young people with special needs?

Services must be developed and provided in ways that address the multiple needs and learning styles of participants. Suggestions include:

- Information and materials should be tailored to the needs of the audience. Young people with cognitive disabilities, for example, will need materials that are very concrete. Further, many young people have college potential and neither expectations nor materials should be too low to meet their needs.
- Repeated opportunities to practice new skills should be available. Young people with learning disabilities or attention deficits may need information in a multi-modal format. They may be challenged by impulsivity and poor organizational skills, making it difficult for them to process and utilize information presented in traditional ways.
- Use a holistic approach to assess and meet all of the needs of young people. Do not focus solely on a disability or assume that a person with a disability cannot benefit from independent living services.
- Do not neglect the mental health needs of youth in transition. Independent living services should

include strategies to assist youth in obtaining therapy and other mental health services as needed.

The Chafee Independence Program provides an important vehicle for child welfare agencies serving youth in transition to reach out to and coordinate efforts with other agencies and organizations that serve young people with disabilities. These can include special educators, health and mental health care providers, substance abuse treatment facilities, children's hospitals and vocational rehabilitation services.

For some young people with special needs, the challenge is to provide ongoing support related to their disabilities as well as continued assistance towards achieving self-sufficiency. It may mean making sure they receive SSI or other benefits for which they may be entitled. It may mean connecting them to services through the adult Mental Retardation or Developmental Disabilities agencies. The most effective support will be individualized for each young person.

5. Who are potential partners in the community and what resources exist?

As states plan for the transition issues of young people with special needs leaving foster care, consider national, state and community level partners for information and resources.

- On October 25, 2000, President Clinton signed an Executive Order amending the Presidential Task Force on Employment of Adults with Disabilities to include a focus on youth. Among the goals are to "improve employment outcomes by addressing, among other things, ... transition ...and independent living issues affecting young people with disabilities." The Executive Order creates a nationally representative Youth Advisory Council to the Presidential Task Force. To learn more about the Task Force, visit the website at http://www.dol.gov/dol/_sec/public/programs/ptfead/main.htm.

- The Healthy and Ready to Work (HRTW) initiative funded by the Division of Services for Children with Special Health Needs of the Maternal and Child Health Bureau (MCHB) provides a wealth of resources to assist communities in meeting the challenges of transition for young people with special needs. In addition to the MCHB website at <http://www.mchbhrtw.org>, most of the nine model sites, located in California, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Ohio and Oregon, also have their own websites. Some particularly useful resources include the needs assessment tools and community collaboration best practice models in California and the "Youthspeak" training materials in Maine. "Youthspeak" provides five youth-written training presentations for employers, teachers, parents, health care providers and policy makers. Oregon's HRTW project includes special resources on providing services to minority youth with special needs, as well as assistance in starting youth organizations.

- The Pacer Program in Minnesota at <http://www.pacer.org>, through the Technical Assistance and Training on the Rehabilitation Act (TATRA) project, has extensive materials and examples of programs throughout the country. Another resource is the National Clearinghouse of Rehabilitation Training Materials in Stillwater, Oklahoma. There are also resource centers specifically focused on providing services to Native American, Hispanic and African American persons with disabilities.

At the state and community level, organizations such as the Parent Training Institutes (PTIs) can be valuable partners. Special education teachers, school-to-work programs, disability advocates and local divisions of federal agencies such as the Maternal and Child Health Bureau's Division of Services for Children with Special Health Needs, Departments of Mental Health and Developmental Disabilities, and the Department of Vocational Rehabilitation should also be included in planning and implementation efforts.

HOUSING

THE LAW

SEC. 477. JOHN H. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM.

(a) Purpose. –

- (5) to provide financial, housing, counseling, employment, education and other appropriate support and services to former foster care recipients between 18 and 21 years of age to complement their own efforts to achieve self-sufficiency and to assure that program participants recognize and accept their personal responsibility for preparing for and then making the transition from adolescence to adulthood.

(b) Applications. –

(3) Certifications. –

- (B) A certification by the chief executive officer of the State that not more than 30 percent of the amounts paid to the State from its allotment under subsection (c) for a fiscal year will be expended for room or board for children who have left foster care because they have attained 18 years of age and who have not attained 21 years of age.
- (C) A certification by the chief executive officer of the State that none of the amounts paid to that State from its allotment under subsection (c) will be expended for room or board for any child who has not attained 18 years of age.

Research shows that youth leaving foster care face a significant risk of homelessness. Young people who provided testimony and feedback to Members of Congress throughout the discussions leading up to the passage of the FCIA highlighted their own experiences with and/or fears of homelessness.

1. Who is eligible for room or board services under the Chafee Foster Care Independence Program?

For the first time, states can use up to 30% of their federal independent living dollars to provide room or board services to young people over the age of 18. Room or board services may be provided, and are currently being provided by many states, to young people older than age 18 through state funded programs. Chafee Independence Program funds must be used to supplement, not to supplant existing programs.

Youth eligible for room or board services under the Chafee Independence Program are those "who have

left foster care because they have attained 18 years of age and who have not attained 21 years of age." This includes young people who have aged out at age 18 or older up to age 21 who move directly from foster care into independent living programs, as well as those who age out, lose touch with the agency, and then return for assistance before reaching the age of 21. Further, this includes young people who leave care voluntarily at age 18, but find themselves in need of supportive services after leaving, but prior to turning age 21.

The law is also very clear that none of the funds states receive under the Act may be used for room or board services for young people under the age of 18.

2. How are states using up to 30% of their Chafee Foster Care Independence Program dollars to provide room or board for young people leaving foster care?

As states have begun to plan for and implement their newly designed independent living programs under the Chafee Independence Program, providing housing to these young people is, in many cases, least developed and most challenging. While many states are pleased that the new law allows them to spend some of these funds on room or board services for young people over the age of 18, they clearly recognize that 30% of an already limited amount of money will not go very far towards providing a comprehensive package of housing services.

States are grappling with the question of whether to provide some very limited housing assistance to a larger number of young people (i.e. money for security deposits on apartments), or a more complete package of room and board services to a much smaller number of youth. Many states are just starting to create priorities and criteria for use of these dollars.

A second challenge some states have noted is how to maintain open cases on young people over the age of 18 for the purpose of providing housing and other assistance. For states which close foster care cases on the young person's 18th birthday, holding these cases open longer appears to create administrative and caseload burdens in a system that is already weighted down to begin with. Other states have raised questions about whether or not they can (or need to) require young people to remain in foster care, under supervision, in order to access the housing dollars and supports that the Chafee Independence Program offers.

Several states, including Arizona, Louisiana and New Mexico, have responded to this second challenge by maintaining voluntary open cases for young people over the age of 18. Other states, such as Maryland and Connecticut, provided housing and other supportive services to young adults through voluntary agreements prior to the passage of the FCIA. Louisiana's program, known as the "Young Adult Program," allows youth between the ages of 18 and 21 to receive a variety of services, including housing supports, which will enable them to complete high school, go to college or enter vocational training. The housing provided to youth in this program can be located in a foster home, college dorm or an apartment (both supervised and non-supervised).

Arizona's Voluntary Foster Care Agreement for Young Adults allows young people to continue to receive all traditional foster care and case management services, including room or board, until age 21. Housing and other assistance are also available through the Transitional Independent Living Program to youth who do not wish to remain in care. This program is a limited service, with approximately \$1,800 available per young person, and is often used to meet the initial costs of securing housing.

Other states are considering contracting out case management services that will be provided to former foster youth over the age of 18. Missouri, for instance, is creating contracts with other agencies to serve as fiscal agents to administer funds related to services for youth who left foster care at age 18. Missouri is clear that these services are intended to be short term and flexible, with a goal of helping young people stabilize themselves and move towards self-sufficiency. Thus, the funds may be used for housing "start-up costs," but not long-term housing assistance.

A number of states have recently enacted tuition waivers or other post-secondary support programs for young people leaving foster care in order to obtain college educations. Kansas and Arkansas are two of the states that will use some of the Chafee Independence Program housing dollars to provide the room or board a young person needs while furthering their education at the college level. Kansas is currently developing plans to expand housing support to include non-college-bound youth. Up-to-date information on state tuition waivers can be found on the National Resource Center for Youth Services' website at <http://www.nrcys.ou.edu/tuitionwaivers/usmap.htm>

3. How can states maximize the housing dollars allowable under the Chafee Foster Care Independence Program?

While many states are exploring whether to provide limited housing assistance to many youth or more intensive housing assistance to a fewer number of youth, many other states have recognized that the most effective strategy to maximize the housing options for young people is to use both existing dollars and the new focus on housing promoted by the Chafee Independence Program to leverage

other sources of funding for housing, including state dollars.

As has been noted, some states are using Chafee Independence Program dollars to serve college-bound young people. Youth with special educational needs should have a transition IEP developed through the school. Living independently, including the ability to locate, obtain and maintain appropriate housing, is one of the transition services listed in IDEA for inclusion in IEP planning and implementation. Education staff in some communities have developed strategies to assist young people in exploring their housing options, and teachers have even accompanied youth as they investigate these options in their community. Independent living program providers can coordinate efforts with the schools to assist these young people in obtaining appropriate housing. The school can provide many of the case management and support services, freeing the Chafee dollars to go directly toward the actual housing costs.

There are a number of programs available through the U.S. Department of Housing and Urban Development (HUD) that can include young people leaving foster care. Again, the Chafee Independence Program dollars can be supplemented by funds and services from other programs to extend their reach. Three examples are:

- The Supportive Housing Program (SHP), one of the Stewart B. McKinney Act programs, is designed to move homeless persons from streets and shelters to permanent housing and maximum self-sufficiency. A person must be homeless in order to receive assistance under SHP. While young people in foster care are not typically eligible for SHP dollars, youth in foster care may receive needed supportive services which supplement, but do not substitute for, the state's assistance, and youth who have left foster care are more likely to be eligible.
- The Family Unification Program (FUP) is a collaborative program between local housing authorities and child welfare agencies that links vulnerable families with HUD-funded Section 8 housing subsidies and supportive services so that they can stay together and become self-sufficient

families. Recently enacted legislation enables youth aging out of foster care to receive time-limited Section 8 vouchers (up to 18 months) under FUP. With the FUP vouchers for young people, child welfare and housing agencies in local communities will need to collaborate to design programs and services for former foster youth.¹³

- Special housing grants funded under Section 202 are targeted to provide housing for persons with disabilities—which includes many young people leaving foster care, and special programs for supported housing for the elderly. In Los Angeles, an innovative program has utilized Section 202 dollars, in combination with other funding, to provide intergenerational housing for elderly and youth together.

By including local, county and state housing and homeless experts in planning and implementation of the Chafee Independence Program, a state can identify other ways to combine these funds with other funds or programs to maximize housing options for youth. For example, in New York City, when housing and youth workers recognized that a large number of studio and efficiency rental units were remaining vacant (unable to meet the needs of homeless or low-income families), they created a program allowing youth leaving foster care to achieve a priority status for these particular apartments.

4. Who are other potential housing partners at the state and community levels?

Community development organizations are important partners, as are local initiatives which combine public and private, and often faith-based, efforts to combat homelessness. In addition, some communities have voluntary programs such as Home Share or Home Companions which match homeowners or renters who want to share their living space. Some communities have cooperative living associations, where members each have their own private space but share common spaces for dining, laundry and recreational facilities. There may be opportunities for young people leaving foster care to participate in these programs.

¹³ The Child Welfare League of America is developing models, training and technical assistance to assist communities in creating these collaborations and designing programs. Contact: Maria Garin-Jones, Director, Youth Services, Child Welfare League of America, see Appendix A.

YOUTH INVOLVEMENT

THE LAW

Congress heard directly from young people while considering the Foster Care Independence Act of 1999 (FCIA or the Act). The following sections of the Act reflect Congressional intent that young people take an active role in state implementation of programs and services funded under the Act, as well as in individual service planning and delivery:

SEC. 477. JOHN H. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM.

(a) Purpose. —

- (5) to provide financial, housing, counseling, employment, education and other appropriate support and services to former foster care recipients between 18 and 21 years of age to complement their own efforts to achieve self-sufficiency and to assure that program participants recognize and accept their personal responsibility for preparing for and then making the transition from adolescence to adulthood.

(b) Applications. —

(3) Certifications. —

- (H) A certification by the chief executive officer of the State that the State will ensure that adolescents participating in the program under this section participate directly in designing their own program activities that prepare them for independent living and that the adolescents accept personal responsibility for living up to their part of the program.

1. How are states listening to and utilizing the expertise of young people in care and those who have aged out of care?

States have taken a variety of approaches to involve foster youth in the design and implementation of independent living services and programs. These range from states with intensive efforts to support and promote highly active youth advisory boards, to states that presently have minimal youth involvement. In light of the requirements of the Chafee Independence Program, all states are evaluating their approach to youth involvement and many are considering stepping up their efforts to include young people in meaningful ways.

States that embrace youth in significant ways report a range of opportunities for youth voices to be heard, input considered and leadership skills developed. Some of these state activities include:

- Annual conferences for teens in foster care and recent alumni of care, with young people involved in both conference planning and participation
- Youth speakers' bureaus, with young people trained and skilled in public speaking
- Youth or alumni actually delivering independent living services, especially life skills training, to other teens in care
- Youth or alumni assisting in the recruitment and training of foster and adoptive parents
- Training young people as advocates, and engaging their advocacy efforts at legislative and administrative levels
- Young people contributing to, editing or totally managing a newsletter for youth in care and recent alumni
- Peer counseling and mentoring programs— young people serving as mentors for children and youth in foster care
- Handbooks by youth and for youth in foster care

and transitioning to independent living—three excellent examples in Maine, Florida and Kentucky

- Websites targeted to and often created and maintained by foster youth and recent alumni—for example, Maine's website at <http://www.ylat.usm.maine.edu>
- Creating liaisons and partnerships between young people in foster care and community employers

2. How can youth involvement make a difference?

Youth involvement in implementation of the Chafee Independence Program and related initiatives is key to the overall success of these efforts. It takes hard work to get youth involved and keep youth involved, but the benefits are enormous.

Youth involvement produces results. For example, in various states, including Texas, Maryland and Kansas, the youth voice was instrumental in passing state laws that make higher education more available to former foster youth through the creation of tuition waivers and other opportunities.

In Connecticut, services to parenting teens needed to be strengthened. As a direct result of youth feedback, Connecticut now provides monthly stipends, child care assistance and other supportive services to current or former foster youth who are now parents. In Oklahoma, the Youth Speakers' Bureau has provided training about the needs and concerns of youth in care to judges, lawyers, mental health providers and medical school staff.

In New Hampshire, the results of a youth survey have led to an Employment Advocate/Mentor program, which strongly supports youth involvement. Employers are reminded that youth should "establish their own goals" and "form partnerships in their communities." Missouri has involved youth in identifying and reaching out to other young people between the ages of 18 and 21 who could benefit from independent living services.

3. How many states have youth advisory boards?

Half of the states have formal youth advisory boards (YABs) according to the National Independent

Living Association (NILA) at <http://www.nilausa.org>. In the remaining states, two have had youth advisory boards in the past and are currently working to bring them back (Kansas and Hawaii), and two others have formal programs for youth leadership training (Wisconsin and Pennsylvania). Other states are currently reviewing models and approaches to establish YABs. The Child Welfare League of America is creating a National Youth Advisory Board that will represent youth in care and alumni at the national level.

4. How do youth advisory boards function?

Effective youth advisory boards are actively involved in decision making, shaping policy and monitoring implementation of services for young people. Youth advisory boards may be statewide or regional. Several states, such as Louisiana, combine both approaches. Most require that YAB members are current participants in independent living programs. Some YABs include alumni. Nebraska goes further. It ensures representation on their YAB of a youth involved with the juvenile justice system, an adopted teen, a teen in a drug or alcohol rehabilitation program, a parenting teen, a homeless young person and representation from a variety of ethnic communities including Native American and refugee youth.

Youth advisory boards meet anywhere from once a year to monthly. In their capacity as advisors, they provide input and feedback to program administrators, legislators and others involved in providing youth services in their state. Transportation to attend meetings can become a barrier to youth involvement. Consequently, several states have taken steps to address this issue. Nebraska has a partnership with Job Corps to provide transportation. Some states provide per diem stipends to young people who take time from work or school to participate on their YAB. Only a few states have paid staff working with the YAB. Texas, for example, has a foster care alumni in a part-time paid position as an advisor of its Youth Advisory Board. The California Youth Connection (CYC) also maintains paid youth and adult staff to facilitate the activities of their organization.

5. Can states use Chafee Foster Care Independence Program funds to support youth involvement on youth advisory boards?

States can use Chafee Independence Program funds to ensure that states involve youth as an integral part of the broad consultation required by the Act in developing states' multi-year plans. Youth advisory boards can also serve as advisors to the state child welfare administrators in the long-term implementation of the state plans.

6. In addition to youth advisory boards, how can states maximize youth involvement?

States can undertake broad outreach. For example, New Hampshire sent a survey to all young people in foster care, asking them to identify their needs as well as asking if they would be interested in participating on a youth advisory board. Utilizing media outlets that target teens, such as radio stations, to reach out to young people is another approach.

States can also include young people in official capacities on other task forces and advisory boards that set, review or oversee policies and practices affecting young people. These might include health care boards, employment and training boards, and education boards. For example, states should specifically consider placing a youth in care or alumni on local Workforce Development Corporation Youth Advisory Councils, established pursuant to the Workforce Investment Act.

Input from young people not involved directly on YAB or other boards is also essential. Several young people active on their state YAB have expressed concern that only those youth with the desire and skills to serve on such a board are heard from. Input can be obtained through surveys, conferences or service-provider agencies (such as health care clinics).

States should also consider Nebraska's example to ensure representation from a diverse universe of young people whose life experiences and contact with public systems are different. In particular, states should obtain input from young people of all ethnic and religious backgrounds, those with disabilities, those who are college-bound and those who are parenting.

7. How do states involve young people in their own individual case plans?

The Chafee Independence Program requires that states facilitate the development of personal responsibility by ensuring that young people participate in the planning and implementation of services at the individual level. Young people must be involved in the case planning process. They must also have some degree of choice and decision making in identifying their own needs and what services they participate in. In a broader context, this requirement of the Act points toward a need for client-centered social work practice, where the determination of the service delivery rests in the hands of the client, with support from professionals and other service providers. Some providers of services to persons with developmental disabilities or mental health needs have developed expertise in client-centered social work practice and may make appropriate partners in this effort. Organizations such as the National Program Office on Self Determination at <http://www.self-determination.org> provide leadership and models of this approach to client services.

Young people should also have consistent opportunities to give structured feedback regarding the quantity and quality of services and supports provided to them in care and after they have aged out. This consumer feedback provides both quality assurance for independent living projects and critical indicators of youth-identified service needs.

TRIBAL INVOLVEMENT

THE LAW:

The Foster Care Independence Act of 1999 (FCIA or the Act) requires that states do more than simply include Indian children in services provided. States must also actively involve Indian tribes in developing programs.

SEC. 477. JOHN H. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM.

(b) Applications. –

(3) Certifications. –

(G) A certification by the chief executive officer of the State that each Indian tribe in the State has been consulted about the programs to be carried out under the plan; that there have been efforts to coordinate the programs with such tribes; and that benefits and services under the programs will be made available to Indian children in the State on the same basis as to other children in the State.

1. What activities are currently underway in regard to tribal involvement, as required by the Chafee Foster Care Independence Program?

Less than one percent of young people served by federally-funded independent living programs were identified as Native Americans, according to 1996 data from the U.S. Department of Health and Human Services. Therefore, the new requirements for consultation and collaboration under the Chafee Independence Program suggest both new opportunities and new responsibilities for states, tribal organizations and advocates to reach out to, and serve, Indian youth in transition in a more comprehensive way.

Some states have entered into formal state/tribal agreements to provide independent living services to Indian youth. One example is the Sault Ste. Marie Tribe of Chippewa Indians in Michigan, which operates an independent living program for tribal youth under an agreement with the state Family Independence Agency.

States are exploring methods and approaches for ensuring appropriate and meaningful tribal involvement in the development and implementation of their state plan for independent living services under the Chafee Independence Program.¹⁴ While most states have been working towards improved communication and collaboration with tribes around the provision of child welfare services, they also see the requirements under the Chafee Independence Program as adding increased responsibilities. Many see the requirement for state and tribal collaboration for independent living services as an opportunity to expand and improve upon state/tribal relationships that can serve as a model to enhance services to Indian children throughout the child welfare system.

2. What resources exist to enhance and expand tribal involvement?

The National Indian Child Welfare Association (NICWA) has taken a leadership role in ensuring

¹⁴ According to an informal email survey of state independent living coordinators, conducted by the National Indian Child Welfare Association (NICWA) in the summer of 2000.

that Indian tribes throughout the nation are informed about their opportunities and responsibilities under the Chafee Independence Program. They are providing initial technical assistance to states and tribes, through written information, phone calls and conference presentations, as states begin to implement this component of the Act. NICWA, in association with Casey Family Programs, has created a publication to assist both tribes and states in thinking through the issues and challenges involved in providing appropriate, comprehensive and culturally competent independent living services to Indian young people.¹⁵ See NICWA's website at <http://www.nicwa.org>.

The National Resource Center for Youth Services is developing a training package for child welfare practitioners in states to assist them in working effectively with tribal governments and with tribal youth as they transition out of either tribal or state foster care.

3. What issues and challenges are tribal communities raising concerning independent living services for Indian youth?

Both research and practical experience have shown that Indian youth are often at higher risk than non-Indian youth for factors related to negative outcomes upon transitioning from foster care.¹⁶ For example, Indian youth are more likely to suffer from depression, anxiety disorders or substance abuse than their non-Indian peers. Suicide rates among Indian youth are higher, and teen pregnancy rates are nearly double those of young women of all races. Indian youth drop out of school at higher

rates than the general population and often face significant challenges to obtaining and maintaining employment. While the research points to these significant risk factors faced by Indian youth, there is little data that addresses the specific needs and status of Indian youth transitioning from foster care. This makes planning difficult.

The combination of these risk factors with the fact that Indian youth are placed in foster care at higher rates than their non-Indian peers, and the limited experience on the part of both states and tribes in providing independent or transitional living services to Indian youth, creates a very challenging situation. There are also wide variances in cultural norms and approaches to independent living among different Indian tribes, even within one state.

Finally, there are separate challenges related to reaching and serving Indian youth who are not living in tribal communities. Often these young people are in urban settings and their needs may go unnoticed by both state and tribal child welfare agencies. NICWA reports that many tribes are finding that Indian youth who had been in foster care in urban settings are coming back to the reservation upon aging out, and are in need of a variety of services.

For states and tribes to be successful in developing and implementing independent living services for Indian youth which effectively respond to these challenges, they need to make a long-term commitment to on-going communication, collaboration and relationship-building among public, private and tribal agencies and community organizations.

15 Nicole Clemens. (December 2000). *Improving Access to Independent Living Services for Tribes and American Indian Youth*, Portland, OR, National Indian Child Welfare Association and Casey Family Programs.

16 For example, see Terry L. Cross & Seathl Ollgaard (1995). *The Status of Child Abuse and Neglect Prevention in American Indian Communities*, Portland, OR: National Indian Child Welfare Association, U.S. Congress, Office of Technology Assessment (1990), *Indian Adolescent Mental Health*, (OTA-H-446), Washington, DC, US Government Printing Office. Beauvais, F., Oetting, E.R., Wolf, W. and Edwards, R.W. (1989), *American Indian Youth and Drugs, 1976-1987: A Continuing Problem*, *American Journal of Public Health*, 79(5), 634-636.

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Marital and Family Therapy

Sec. 08.63.140. Licensure by credentials. The board shall issue a license to practice marital and family therapy to a person who

- (1) is licensed or certified for the practice of marital and family therapy in another state that has requirements for the license or certificate that are substantially equal to or greater than the requirements of this state; and
- (2) meets the requirements of AS 08.63.100(a)(1), (2), and (3)(A).

ARTICLE 3. GENERAL PROVISIONS

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Section

200. Confidentiality of communication
210. Grounds for imposition of disciplinary sanctions
220. License required if designation used
900. Definitions

Sec. 08.63.200. Confidentiality of communication. (a) A person licensed under this chapter may not reveal to another person a communication made to the licensee by a client about a matter concerning which the client has employed the licensee in a professional capacity. This section does not apply to

- (1) a case conference or case consultation with other mental health professionals at which the patient is not identified;
- (2) the release of information that the client in writing authorized the licensee to reveal;
- (3) information released to the board as part of a disciplinary or other proceeding; or
- (4) situations where the rules of evidence applicable to the psychotherapist-patient privilege allow the release of the information.

(b) Notwithstanding (a) of this section, a person licensed under this chapter shall report incidents of

- (1) child abuse or neglect as required by AS 47.17;
- (2) harm or assaults suffered by an elderly person or disabled adult as required by AS 47.24.

(c) Information obtained by the board under (a)(3) of this section is confidential and is not a public record for purposes of AS 09.25.110 — 09.25.140.

Sec. 08.63.216. Grounds for imposition of disciplinary sanctions. After a hearing, the board may impose a disciplinary sanction under AS 08.01.075 on a person licensed under this chapter when the board finds that the person

- (1) secured a license through deceit, fraud, or intentional misrepresentation;
- (2) engaged in deceit, fraud, or intentional misrepresentation in the course of providing professional services or engaging in professional activities;
- (3) advertised professional services in a false or misleading manner;
- (4) has been convicted of a felony or of another crime that affects the person's ability to practice competently and safely;
- (5) failed to comply with a provision of this chapter or a regulation adopted under this chapter, or an order of the board;
- (6) continued to practice after becoming unfit due to
 - (A) professional incompetence;
 - (B) addiction or severe dependency on alcohol or another drug that impairs the person's ability to practice safely;
- (7) engaged in unethical conduct in connection with the delivery of professional services to clients.

Sec. 08.63.220. License required if designation used. A person who is not licensed under this chapter or whose license is suspended or revoked, or whose license has lapsed, who knowingly uses in connection with the person's name the words or letters "L.M.F.T.," "L.M.F.C.," "Licensed Marital and Family Therapist," "Licensed Marriage and Family Counselor," or other letters, words, or insignia indicating or implying that the person is licensed as a marital and family therapist by this state or who in any way, orally or in writing, directly or by implication, knowingly holds out as being licensed by the state as a marital and family therapist in this state is guilty of a class B misdemeanor.

Sec. 08.63.900. Definitions. In this chapter, unless the context indicates otherwise;

- (1) "advertise" includes issuing or causing to be distributed a card, sign, or device to a person, or causing, permitting, or allowing a sign or marking on or in a building or structure, or in a newspaper, magazine, or directory, or on radio or television, or using other means designed to secure public attention;
- (2) "board" means the Board of Marital and Family Therapy;
- (3) "course" means a class of at least three credit hours in a graduate program at an accredited educational institution or an institution approved by the board;

Marital and family therapy

(8) first-time preparation and presentation of a marital and family therapy course, seminar, or workshop, up to a maximum of 10 contact hours allocated among all marital and family therapists and other professionals involved;

(9) first-time presentation or publication of an article or book chapter related to the practice of marital and family therapy that was presented at a state or national association meeting or published by a publisher recognized by the profession, up to a maximum of 10 contact hours allocated among all marital and family therapists and other professionals involved; and

(10) completion of a formal correspondence program, video tape program, audio cassette program, or other individual study program; the number of hours of continuing education credit awarded will be determined by the board using the contact hour standards described in 12 AAC 19.310(d)(1), not to exceed one-half of the total contact hours of continuing education required for license renewal under 12 AAC 19.310; a program under this paragraph is acceptable only if

(A) the program requires registration and provides evidence of successful completion; or

(B) the licensee submits a signed statement verifying that the licensee has successfully completed the program from a licensee who is a supervisor approved under 12 AAC 19.210 and has supervised the licensee's study program under this paragraph.

(c) Hours spent in job orientation will not be accepted as continuing education contact hours.

12 AAC 19.330. AUDIT OF CONTINUING EDUCATION REQUIREMENTS. (a) After each renewal period the board will, in its discretion, audit renewal applications to monitor compliance with the continuing education requirements of this chapter.

(b) A licensee selected for audit shall, within 30 days from the date of notification, submit documentation to verify completion of the contact hours claimed under 12 AAC 19.300.

(c) An applicant for renewal is responsible for maintaining adequate and detailed records of all continuing education hours claimed and shall make them available to the board upon request under this section. Records must be retained for three years after the date the continuing education hours were earned.

12 AAC 19.340. FAILURE TO MEET CONTINUING EDUCATION REQUIREMENTS AND LICENSE REINSTATEMENT. (a) The board will reinstate a license that was not renewed because of the licensee's failure to meet the continuing education requirements in 12 AAC 19.300 - 12 AAC 19.330 if the licensee submits to the board proof of completion of all required continuing education credit hours and meets all other requirements for license renewal.

(b) A licensee who is unable to obtain the continuing education hours required for license renewal due to reasonable cause or excusable neglect may submit a written request to the board for an exemption. The request for an exemption must include an explanation of the reasonable cause or excusable neglect that resulted in the licensee's failure to meet the continuing education requirements. If the board grants the exemption, the board will, in its discretion, prescribe an alternative method of compliance with the continuing education requirements as the board considers appropriate to the individual situation.

(c) In this section, "reasonable cause or excusable neglect" includes

- (1) chronic illness;
- (2) retirement;
- (3) military service;
- (4) leave of absence from active practice during the concluding licensing period; and
- (5) hardships recognized by the board.

ARTICLE 4. GENERAL PROVISIONS

Section

.900. Code of ethics

990. Definitions

12 AAC 19.900. CODE OF ETHICS. Marital and family therapists licensed in this state shall adhere to the *Model Code of Ethics for Marriage and Family Therapists* of the Association of Marital and Family Therapy Regulatory Boards (October 1993 revision). The *Model Code of Ethics for Marriage and Family Therapists* is incorporated by reference in this section.

Editor's note -- A copy of the *Model Code of Ethics for Marriage and Family Therapists* may be obtained from the Department of Commerce and Economic Development, Division of Occupational Licensing, P.O. Box 110806, Juneau, AK 99811.

12 AAC 19.990. DEFINITIONS. In this chapter and in AS 08.63,

- (1) "board" means the Board of Marital and Family Therapy;

Association of Marital and Family Therapy Regulatory Boards
130-D Brackett Hall, Box 341513
Clemson University
Clemson, South Carolina 29634-1513

DEPARTMENT OF COMMERCE
& ECONOMIC DEVELOPMENT

11 22 1994

DIVISION OF
OCCUPATIONAL LICENSING

MODEL CODE OF ETHICS FOR MARRIAGE AND FAMILY THERAPISTS

Adopted October 7, .993

Scope: This Model Code of Ethics regulates the ethical and professional conduct of: (1) all certified and licensed MFT's, (2) all applicants for licensure or certification, (3) MFT interns and supervisors during their education, practicum and post-graduate training; and expert witnesses. It applies to all MFT's, licensed or unlicensed, in direct contact with clients, as well as during education, training, and research endeavors.

Purpose: The purpose of this Model Code of Ethics is to provide clear guidelines state regulatory boards can use to assess the professional conduct of certificants. Standardization eliminates confusion and misinterpretation of ethical behavior within the profession and by the public.

Violations: A violation of a Code of Ethics is referred to as "unprofessional" or "unethical" conduct. It constitutes sufficient evidence for disciplinary action by state licensing boards.

Integrity: A Marriage and Family Therapist is expected to behave according to the standards of professional integrity and competence as defined by rule or law. A therapist must not condone, associate with, or participate in dishonest, fraudulent, or deceitful behavior. MFT's must not misrepresent themselves, their training, or their services. It is the responsibility of licensees and applicants for licensure to be completely informed about the Professional Code of Ethics by which they are governed.

1. PROFESSIONAL COMPETENCE AND CONDUCT

- A. A therapist must not perform, nor pretend to be able to perform, professional services beyond his or her scope of practice. A therapist must not misrepresent his or her credentials, degrees, professional associations, or competencies either through spoken work or written materials. A therapist must immediately retract or correct any misrepresentation. A therapist must correct misrepresentations by third parties as soon as the therapist is informed of the error.
- B. A therapist must neither permit an intern or trainee under the therapists's supervision to perform, nor allow a trainee or intern to pretend to be competent to perform professional services beyond the trainee's or intern's level of training. Disclosure of the intern's status and the name of the supervisor is required. A waiver of liability signed by the client is required when an MFT intern is treating the client at a reduced fee.
- C. A therapist must recognize the potentially influential position he or she may have with respect to clients, students, employees, and supervisees. A therapist must conduct himself or herself with sensitivity to clients' potential vulnerability. A therapist should avoid exploiting clients' trust and dependency. Therapists must also avoid dual relationships with clients during treatment and following termination of therapy. Examples of dual relationships include, but are not limited to, close personal friendships, business or other relationships that are used to further a therapist's own interests, or the provision of therapy to students, employees, or supervisees. Sexual intimacy between therapist and client, students, or supervisees is prohibited.

- D. A therapist must not engage in sexual or other harassment or exploitation of students, trainees, employees, colleagues, research subjects, or actual or potential witnesses or complainants in legal or clinical proceedings.
- E. A therapist who is convicted of any crime related to his or her qualifications or professional responsibilities may be subject to disciplinary action by the Board. Likewise, a therapist who engages in conduct which could lead to conviction of a crime related to his or her qualifications or professional responsibilities, may be subject to disciplinary action.
- F. A therapist who becomes impaired and unable to function according to the standards of practice, may be subject to disciplinary action if an active practice continues. Causes of impairment may include, but are not limited to, the abuse of mood altering chemicals and physical or mental problems.
- G. A therapist must never accept, offer, or give any type of compensation to a referring party or his or her agents for referrals, as this may impair the therapist's judgement.
- H. It is the responsibility of therapists to seek supervision and/or personal therapy for any problem that is interfering with their ability to perform their professional services according to the minimum standards of competency and the Code of Ethics.

2. RESPONSIBILITY TO CLIENTS

- A. A therapist must not subject a client to discrimination based on race, gender, religion, national origin, political affiliation, social or economic status, choice of lifestyle, sexual or affectional orientation.
- B. A therapist must inform a client of any conflict of interest, values, attitudes, or biases between them that are sufficient to impair their professional relationship. Either the client or the therapist may terminate the relationship. However, it is the therapist's responsibility to terminate the professional relationship when it no longer serves the client's needs or interests. It is the responsibility of the therapist to facilitate termination, and to assist in referring the client to another professional. Termination should be handled with care and sensitivity.
- C. A therapist has the responsibility to be informed of other professional, technical, and administrative resources available to clients. A therapist must utilize those resources and/or refer clients when it is in the best interest of the client.
- D. A therapist must make a referral upon client request regardless of administrative and/or funding mandates.
- E. A therapist must not allow an individual or agency paying for his or her professional services to a client to exert undue influence over the therapist's work performance and clinical judgement.
- F. A therapist must offer all facts regarding services rendered to the client prior to administration of professional services. The purpose of informed consent is to insure client's complete access to information pertaining to professional services. Examples include, but are not limited to, length of treatment and utilization of consultants. The client's signature indicating receipt of pertinent information and the Client's Bill of Rights is strongly encouraged.
- G. A therapist must not provide services to a client when the therapist's objectivity or effectiveness is impaired. The therapist must make this known to the client and assist the client in obtaining a referral to another professional.

- H. A therapist must not conduct a therapy session with a client whose judgement or reason is impaired due to alcohol or drugs. Charging fees for services rendered to an impaired client is unprofessional.

DEPARTMENT OF COMMERCE
& ECONOMIC DEVELOPMENT
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DIVISION OF
OCCUPATIONAL LICENSING

3. CONFIDENTIALITY AND DATA PRIVACY

- A. A therapist must hold in confidence all information pertaining to a client's therapy. It is the responsibility of the therapist to safeguard client confidences as required by law and rule. This includes a therapist's employees and professional associates.
- B. A therapist must inform a client of limitations of confidentiality. These limitations include, but are not limited to:
- (1) Limitations mandated by the law.
 - (2) The prevention of clear and immediate danger to one or more persons.
 - (3) When the therapist is a defendant in a civil, criminal, or disciplinary action arising from the therapy, in which case, client confidences may be disclosed in the course of that action.
 - (4) When a written waiver has been obtained, all information revealed must be in accordance with the terms of the waiver. If there is more than one party involved in the therapy, the waiver must be signed by all members legally competent to execute such a waiver.
 - (5) When release of information pertaining to a minor is requested, it must be signed by a parent or guardian.
- C. A therapist is responsible to insure that all records and written data are stored using security measures that prevent access to records by unauthorized persons.
- D. A therapist is responsible for insuring that the content and disposition of all records is in compliance with the relevant state laws and rules.

4. RESPONSIBILITY TO THE PROFESSION

- A. A therapist must take action when a violation of the Code of Ethics is observed, reported or suspected. Client confidentiality and the impact of filing a complaint on the client is paramount in determining a course of action. When appropriate, discussing the violation with the professional can be a means of acquiring additional information and processing information. If this action is not undertaken, does not result in an acceptable response on the part of the professional, or is not sufficient given the seriousness of the violation, then a complaint must be filed with the licensing board and/or professional association. In states with mandatory reporting laws, the complaint must be submitted in accordance with state laws and rules.
- B. A therapist must not make defamatory remarks about another therapist to the general public or clients.

(B) satisfies the requirements of AS 08.95.120(a)(2) and (4) and provides a photocopy, together with a sworn statement as to the copy's veracity, of the applicant's current license as a baccalaureate social worker in another jurisdiction;

(b) A temporary license provided to an applicant under (a)(1)(A) or (a)(2)(A) of this section is valid for one year and is valid notwithstanding the applicant's failure to satisfactorily complete the examination required under AS 08.95.110(a)(6) during the period that the license is valid.

(c) A temporary license issued under (a)(1)(B) or (a)(2)(B) of this section is valid for one year.

(d) An individual's temporary license becomes invalid, notwithstanding (b) and (c) of this section, if the individual's application for a permanent license under AS 08.95.110 or 08.95.120 is rejected by the board. The temporary license becomes invalid on the date of board action rejecting the license application.

(e) The board

(1) may impose by regulation additional limitations that it determines appropriate on a temporary license issued under this section;

(2) may not, under this section, issue more than one temporary license to an applicant;

(3) may not renew a temporary license.

Sec. 08.95.130 Display of License. A person licensed under this chapter shall display the license in a conspicuous place where the licensee practices.

**ARTICLE 3.
GENERAL PROVISIONS.**

Section

- 900. Confidentiality of communication
- 905. Immunity relating to certain reports
- 910. Exemptions
- 911. Exemptions (Repealed July 1, 2000)
- 920. Unified Occupation
- 950. Definitions

Sec. 08.95.900. Confidentiality of communication. (a) A licensed social worker, and the social worker's employees or other persons who have access to the social worker's records, may not reveal to another person a communication made to the licensee by a client about a matter concerning which the client has employed the licensee in a professional capacity. This section does not apply to

(1) a case conference with other licensed social workers or with other licensed practitioners of the healing arts.

(2) the release of information which the client in writing authorized the licensee to reveal;

(3) information released to the board as part of a disciplinary or other proceeding by the board;

(4) information revealed as part of the discovery of evidence related to a court proceeding or introduced in evidence in a court proceeding;

(5) communications relevant to the physical, mental, or emotional condition of the client in a proceeding in which the condition of the client is an element of the claim or defense of the client, of a party claiming through or under the client, or of a person raising the client's condition as an element of the person's own case, or of a person claiming as a beneficiary of the client through a contract to which the client is or was a party; or, after the client's death, in a proceeding in which a party puts the condition of the client in issue;

(6) a communication to a potential victim or to law enforcement officers where a threat of imminent serious physical harm to an identified victim has been made by a client; or

(7) a communication that indicates that another licensed practitioner of the healing arts has committed an act of unprofessional or unlawful conduct in the provision of health or mental health services if the communication is disclosed by the social worker only to the licensing board with jurisdiction over the type of person who allegedly committed the unprofessional or unlawful conduct and the disclosure is made in good faith.

(b) Notwithstanding (a) of this section, a licensed social worker shall report incidents of child abuse or neglect as required by AS 47.17.020 and incidents of harm to vulnerable adults as required by AS 47.24.010.

(c) Information obtained by the board under (a)(3) and (7) of this section is confidential and is not a public record for the purposes of AS 09.25.110-09.25.140.

Sec. 08.95.905. Immunity relating to certain reports. A person licensed under this chapter who, in good faith and without malice, discloses to the appropriate licensing board that another licensed practitioner of the healing arts has allegedly committed an act of unprofessional or unlawful conduct in the provision of health or mental health services is immune from civil liability arising out of the disclosure.

Sec. 08.95.910. Exemptions. Repealed 9/1/99.

discretion, grant a written request from an applicant for an exception to the limitation on the number of group supervision hours.

(b) The board will, in its discretion, approve the supervision of experience of an applicant for a clinical social work license to satisfy the requirements of AS 08.95.110(a)(2) if the clinical supervisor

- (1) documents the applicant's supervised experience on a form provided by the department; and
- (2) is a clinical social worker, psychologist, or psychiatrist who holds an unrestricted license to practice that profession in this state or other licensing jurisdiction during the period of supervision.

(c) To be accepted by the board,

(1) direct clinical supervision must be provided in face-to-face meetings between the supervisor and the applicant unless the board, for good cause shown, has granted an exception allowing for an alternate form of supervision.

(2) if direct clinical supervision is not provided to the applicant within the applicant's agency of employment, the applicant must provide the board with a written release from the administrator of the applicant's agency for the applicant to be supervised outside the applicant's agency setting; and

(3) the clinical supervisor must be responsible for direct clinical supervision of the applicant within the following content areas:

- (A) clinical skills;
- (B) practice management skills;
- (C) skills required for continuing competence;
- (D) development of professional identity;
- (E) ethical practice;
- (F) legal and regulatory requirements.

12 AAC 18.120. EMPLOYMENT REQUIREMENT. The employment required for licensure under AS 08.95.110 must be employment that requires the use of social work principles and methods, as defined in AS 08.95.990, including intervention directed at interpersonal interactions; intrapsychic dynamics; life-support and management issues; assessment; diagnosis; treatment, including psychotherapy and counseling; client-centered advocacy; consultation; and evaluation.

12 AAC 18.130. PROFESSIONAL REFERENCES. (a) Except for references from current or former employers required under AS 08.95.110 or AS 08.95.120, an applicant for licensure under this chapter must submit references that meet the requirements in (b) of this section.

(b) A letter of professional reference required for licensure under this chapter will be considered by the board only if the person providing the reference is a

- (1) master's or doctorate degree social worker; or
- (2) licensed psychological associate, clinical psychologist, or physician specializing in psychiatry;
- (3) repealed 10/15/99;
- (4) licensed medical or osteopathic physician;
- (5) licensed advanced nurse practitioner with a specialty area of practice in mental health;
- (6) licensed registered nurse with a master's degree in psychiatric nursing;
- (7) licensed marriage and family therapist; or
- (8) licensed professional counselor.

12 AAC 18.140. REASONS FOR APPLICATION DENIAL. (a) The board will, in its discretion, deny an application for a license under AS 08.95.110 if the board finds that the applicant's history of felony or misdemeanor convictions make the applicant unfit for the license. The board will consider the number and recency of any convictions and the relationship those convictions may have to licensure under AS 08.95.110.

(b) Notwithstanding (a) of this section, a person who has been convicted of a felony crime against a person described in AS 11.41 within the ten years before the date of application, is unfit for licensure under AS 08.95.110, and that person's application for licensure under AS 08.95.110 will be denied.

12 AAC 18.150. SOCIAL WORKER CODE OF ETHICS. A social worker licensed in this state shall adhere to the code of ethics adopted by the Board of Social Work Examiners. The board hereby adopts the *Code of Ethics*, National Association of Social Workers, Inc., 1996 edition, as the code of ethics for social workers licensed in this state.

Editor's note: A copy of the *Code of Ethics* described in 12 AAC 18.150 is available for inspection at the Department of Community and Economic Development, Division of Occupational Licensing, Juneau, Alaska, or may be obtained from the National Association of Social Workers, Inc., 750 First Street, NE, Washington, DC 20002-4241 or from the Alaska Chapter of the National Association of Social Workers, 318 4th Street, Juneau, Alaska, 99801, Phone: (907) 586-4438, e-mail: naswak@alaska.net.

12 AAC 18.160. STANDARDS OF PRACTICE. A social worker licensed in this state shall adhere to the standards of practice adopted by the Board of Social Work Examiners. The board hereby adopts the "Standards of

Practice/Code of Conduct", Parts 1 - 10 of the *Model State Social Work Practice Act* published by the American Association of State Social Work Boards, 1990 edition, as the standards of practice for social workers licensed in this state.

Editor's note: A copy of the "Standards of Practice/Code of Conduct" described in 12 AAC 18.160 is available for inspection at the Department of Community and Economic Development, Division of Occupational Licensing, Juneau, Alaska, or may be obtained from the American Association of State Social Work Boards, 400 South Ridge Parkway, Suite E, Culpeper, VA 22701.

**ARTICLE 2.
LICENSE RENEWAL AND CONTINUING
EDUCATION**

Section.

- 200. License renewal requirements
- 210. Continuing education requirement
- 220. Approved continuing education activities
- 230. Audit of continuing education requirements

12 AAC 18.170. LICENSE RENEWAL REQUIREMENTS. An applicant for renewal of a license under this chapter shall

- (1) complete a renewal application on a form provided by the department;
- (2) pay the license renewal fee established in 12 AAC 02.155; and
- (3) submit a sworn statement of the continuing education contact hours completed during the concluding licensing period, which must include the following information, if applicable, for each course, seminar, or workshop:
 - (A) the name of the sponsoring organization;
 - (B) the location of the course, seminar, or workshop;
 - (C) the title or a brief description of the course, seminar, or workshop;
 - (D) the principal instructor;
 - (E) the dates of attendance;
 - (F) the titles, issues, and dates of publications or presentations; and
 - (G) the number of continuing education contact hours claimed.

12 AAC 18.210. CONTINUING EDUCATION REQUIREMENT. (a) For the first biennial renewal of a person's social worker license, an applicant for renewal shall document completion of 45 contact hours of continuing education activities acceptable to the board that were earned during the two years before the expiration date of the person's license that included a minimum of

- (1) six contact hours in substance abuse education;
- (2) six contact hours in cross-cultural education relating to Alaska Natives; and
- (3) three contact hours in professional ethics.

(b) After a person's first biennial renewal of a social worker license, an applicant for renewal shall document completion of 45 contact hours of continuing education activities acceptable to the board that were earned during that licensing period and included a minimum of

- (1) six contact hours in substance abuse education;
- (2) six contact hours in cross-cultural education, of which three hours include issues relating to Alaska Natives; and
- (3) three contact hours in professional ethics.

(c) For the purposes of this section,

- (1) one "contact hour" equals a minimum of 50 minutes of classroom instruction between instructor and participant;
- (2) one academic semester credit equals 15 contact hours; and
- (3) one academic quarter credit equals 10 contact hours.

(d) Only hours of actual attendance during which instruction was given will be accepted as continuing education contact hours earned from an academic course that is audited by the licensee, and the total number of contact hours earned may not exceed the academic credit hours offered for that course.

12 AAC 18.220. APPROVED CONTINUING EDUCATION ACTIVITIES. (a) To be accepted by the board, continuing education must contribute directly to the professional competency of a social worker and must be directly related to the skills and knowledge required to implement social work principles and methods as defined in AS 08.95.990.

(b) The following continuing education activities are acceptable if they are related to social work in accordance with (a) of this section:

Social Work
1996 Edition



Code of Ethics



National Association of Social Workers

NASW Code of Ethics

OVERVIEW

The *NASW Code of Ethics* is intended to serve as a guide to the everyday professional conduct of social workers. This *Code* includes four sections. The first section, "Preamble," summarizes the social work profession's mission and core values. The second section, "Purpose of the *NASW Code of Ethics*," provides an overview of the *Code's* main functions and a brief guide for dealing with ethical issues or dilemmas in social work practice. The third section, "Ethical Principles," presents broad ethical principles, based on social work's core values, that inform social work practice. The final section, "Ethical Standards," includes specific ethical standards to guide social workers' conduct and to provide a basis for adjudication.

The National Association of Social Workers (NASW) is the largest organization of professional social workers in the world. NASW serves nearly 160,000 social workers in 55 chapters throughout the United States, Puerto Rico, the Virgin Islands, and abroad. NASW was formed in 1955 through a merger of seven predecessor social work organizations to carry out three responsibilities:

- *strengthen and unify the profession*
- *promote the development of social work practice*
- *advance sound social policies.*

Promoting high standards of practice and protecting the consumer of services are major association principles.

Approved by the 1996 NASW Delegate Assembly.

Ethics

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Preamble

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation, administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence.

This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience.

Purpose of the NASW Code of Ethics

Professional ethics are at the core of social work. The profession has an obligation to articulate its basic values, ethical principles, and ethical standards. The *NASW Code of Ethics* sets forth these values, principles, and standards to guide social workers' conduct. The *Code* is relevant to all social workers and social work students, regardless of their professional functions, the settings in which they work, or the populations they serve.

The *NASW Code of Ethics* serves six purposes:

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

The *Code* offers a set of values, principles, and standards to guide decision making and conduct when ethical issues arise. It does not provide a set of rules that prescribe how social workers should act in all situations. Specific applications of the *Code* must take into account

¹For information on NASW adjudication procedures, see *NASW Procedures for the Adjudication of Grievances*.

Code of Ethics

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the context in which it is being considered and the possibility of conflicts among the *Code's* values, principles, and standards. Ethical responsibilities flow from all human relationships, from the personal and familial to the social and professional.

Further, the *NASW Code of Ethics* does not specify which values, principles, and standards are most important and ought to outweigh others in instances when they conflict. Reasonable differences of opinion can and do exist among social workers with respect to the ways in which values, ethical principles, and ethical standards should be rank ordered when they conflict. Ethical decision making in a given situation must apply the informed judgment of the individual social worker and should also consider how the issues would be judged in a peer review process where the ethical standards of the profession would be applied.

Ethical decision making is a process. There are many instances in social work where simple answers are not available to resolve complex ethical issues. Social workers should take into consideration all the values, principles, and standards in this *Code* that are relevant to any situation in which ethical judgment is warranted. Social workers' decisions and actions should be consistent with the spirit as well as the letter of this *Code*.

In addition to this *Code*, there are many other sources of information about ethical thinking that may be useful. Social workers should consider ethical theory and principles generally, social work theory and research, laws, regulations, agency policies, and other relevant codes of ethics, recognizing that among codes of ethics social workers should consider the *NASW Code of Ethics* as their primary source. Social workers also should be aware of the impact on ethical decision making of their clients' and their own personal values and cultural and religious beliefs and practices. They should be aware of any conflicts between personal and professional values and deal with them responsibly. For additional guidance social workers should consult the relevant literature on professional ethics and ethical decision making and seek appropriate consultation when faced with ethical dilemmas. This may involve consultation with an agency-based or social work organization's ethics committee, a regulatory body, knowledgeable colleagues, supervisors, or legal counsel.

Instances may arise when social workers' ethical obligations conflict with agency policies or relevant laws or regulations. When such conflicts occur, social workers must make a responsible effort to resolve the conflict in a manner that is consistent with the values, principles, and standards expressed in this *Code*. If a reasonable resolution of the

conflict does not appear possible, social workers should seek proper consultation before making a decision.

The *NASW Code of Ethics* is to be used by NASW and by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, professional liability insurance providers, courts of law, agency boards of directors, government agencies, and other professional groups) that choose to adopt it or use it as a frame of reference. Violation of standards in this *Code* does not automatically imply legal liability or violation of the law. Such determination can only be made in the context of legal and judicial proceedings. Alleged violations of the *Code* would be subject to a peer review process. Such processes are generally separate from legal or administrative procedures and insulated from legal review or proceedings to allow the profession to counsel and discipline its own members.

A code of ethics cannot guarantee ethical behavior. Moreover, a code of ethics cannot resolve all ethical issues or disputes or capture the richness and complexity involved in striving to make responsible choices within a moral community. Rather, a code of ethics sets forth values, ethical principles, and ethical standards to which professionals aspire and by which their actions can be judged. Social workers' ethical behavior should result from their personal commitment to engage in ethical practice. The *NASW Code of Ethics* reflects the commitment of all social workers to uphold the profession's values and to act ethically. Principles and standards must be applied by individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments.

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ed by NASW and by individuals such as licensing and regulatory providers, courts of law, agencies, and other professional associations. These principles are used as a frame of reference. Alleged violations of these principles are not automatically cause for disciplinary action. Disciplinary action can only be made through the grievance and arbitration process. Such processes are designed to ensure a fair and equitable process. Such processes allow the profession to

maintain high ethical standards and professional behavior. Moreover, a code of ethics or standards of practice is developed to address issues or disputes or capture the essence of responsible behavior. A code of ethics sets forth standards to which professionals are held. Social workers' ethical standards are based on a commitment to engage in practice that reflects the commitment of the profession to its values and to act ethically. Social workers, as individuals of good character and high moral faith, seek to make

Ethical Principles

The following broad ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These principles set forth ideals to which all social workers should aspire.

Value: *Service*

Ethical Principle: *Social workers' primary goal is to help people in need and to address social problems.*

Social workers elevate service to others above self-interest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems. Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service).

Value: *Social Justice*

Ethical Principle: *Social workers challenge social injustice.*

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

Value: *Dignity and Worth of the Person*

Ethical Principle: *Social workers respect the inherent dignity and worth of the person.*

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to

change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

Value: Importance of Human Relationships

Ethical Principle: Social workers recognize the central importance of human relationships.

Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

Value: Integrity

Ethical Principle: Social workers behave in a trustworthy manner.

Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.

Value: Competence

Ethical Principle: Social workers practice within their areas of competence and develop and enhance their professional expertise.

Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

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Ethical Standards

The following ethical standards are relevant to the professional activities of all social workers. These standards concern (1) social workers' ethical responsibilities to clients, (2) social workers' ethical responsibilities to colleagues, (3) social workers' ethical responsibilities in practice settings, (4) social workers' ethical responsibilities as professionals, (5) social workers' ethical responsibilities to the social work profession, and (6) social workers' ethical responsibilities to the broader society.

Some of the standards that follow are enforceable guidelines for professional conduct, and some are aspirational. The extent to which each standard is enforceable is a matter of professional judgment to be exercised by those responsible for reviewing alleged violations of ethical standards.

1. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO CLIENTS

1.01 Commitment to Clients

Social workers' primary responsibility is to promote the well-being of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.)

1.02 Self-Determination

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

1.03 Informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and

understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

(b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.

(c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent.

(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service.

(e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.

(f) Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party.

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

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(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

1.05 Cultural Competence and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability.

1.06 Conflicts of Interest

(a) Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client.

(b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.

(c) Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients

in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

(d) When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest.

1.07 Privacy and Confidentiality

(a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person or when laws or regulations require disclosure without a client's consent. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

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(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the course of the relationship.

(f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements.

(g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling.

(h) Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure.

(i) Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants.

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media.

(l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information.

Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.

(m) Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible.

(n) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure.

(o) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.

(p) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information.

(q) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure.

(r) Social workers should protect the confidentiality of deceased clients consistent with the preceding standards.

1.08 Access to Records

(a) Social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files.

(b) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.

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1.09 Sexual Relationships

(a) Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced.

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

(c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

1.10 Physical Contact

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

1.11 Sexual Harassment

Social workers should not sexually harass clients. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

1.12 Derogatory Language

Social workers should not use derogatory language in their written or verbal communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients.

1.13 Payment for Services

(a) When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients' ability to pay.

(b) Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship.

(c) Social workers should not solicit a private fee or other remuneration for providing services to clients who are entitled to such available services through the social workers' employer or agency.

1.14 Clients Who Lack Decision-Making Capacity

When social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients.

1.15 Interruption of Services

Social workers should make reasonable efforts to ensure continuity of services in the event that services are interrupted by factors such as unavailability, relocation, illness, disability, or death.

1.16 Termination of Services

(a) Social workers should terminate services to clients and professional relationships with them when such services and

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(b) Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary.

(c) Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.

(d) Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.

(e) Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences.

(f) Social workers who are leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options.

2. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO COLLEAGUES

2.01 Respect

(a) Social workers should treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues.

(b) Social workers should avoid unwarranted negative criticism of colleagues in communications with clients or with other professionals. Unwarranted negative criticism may include demeaning comments that refer to colleagues' level of competence or to individuals' attributes such as race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability.

(c) Social workers should cooperate with social work colleagues and with colleagues of other professions when such cooperation serves the well-being of clients.

2.02 Confidentiality

Social workers should respect confidential information shared by colleagues in the course of their professional relationships and transactions. Social workers should ensure that such colleagues understand social workers' obligation to respect confidentiality and any exceptions related to it.

2.03 Interdisciplinary Collaboration

(a) Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established.

(b) Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistent with client well-being.

2.04 Disputes Involving Colleagues

(a) Social workers should not take advantage of a dispute between a colleague and an employer to obtain a position or otherwise advance the social workers' own interests.

(b) Social workers should not exploit clients in disputes with colleagues or engage clients in any inappropriate discussion of conflicts between social workers and their colleagues.

2.05 Consultation

(a) Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients.

(b) Social workers should keep themselves informed about colleagues' areas of expertise and competencies. Social workers should seek consultation only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation.

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(c) When consulting with colleagues about clients, social workers should disclose the least amount of information necessary to achieve the purposes of the consultation.

2.06 Referral for Services

(a) Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that additional service is required.

(b) Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers.

(c) Social workers are prohibited from giving or receiving payment for a referral when no professional service is provided by the referring social worker.

2.07 Sexual Relationships

(a) Social workers who function as supervisors or educators should not engage in sexual activities or contact with supervisees, students, trainees, or other colleagues over whom they exercise professional authority.

(b) Social workers should avoid engaging in sexual relationships with colleagues when there is potential for a conflict of interest. Social workers who become involved in, or anticipate becoming involved in, a sexual relationship with a colleague have a duty to transfer professional responsibilities, when necessary, to avoid a conflict of interest.

2.08 Sexual Harassment

Social workers should not sexually harass supervisees, students, trainees, or colleagues. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

2.09 Impairment of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that

colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.10 Incompetence of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's incompetence should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague is incompetent and has not taken adequate steps to address the incompetence should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.11 Unethical Conduct of Colleagues

(a) Social workers should take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues.

(b) Social workers should be knowledgeable about established policies and procedures for handling concerns about colleagues' unethical behavior. Social workers should be familiar with national, state, and local procedures for handling ethics complaints. These include policies and procedures created by NASW, licensing and regulatory bodies, employers, agencies, and other professional organizations.

(c) Social workers who believe that a colleague has acted unethically should seek resolution by discussing their concerns with the colleague when feasible and when such discussion is likely to be productive.

(d) When necessary, social workers who believe that a colleague has acted unethically should take action through appropriate formal channels (such as contacting a state licensing board or regulatory body, an NASW committee on inquiry, or other professional ethics committees).

(e) Social workers should defend and assist colleagues who are unjustly charged with unethical conduct.

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3. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES IN PRACTICE SETTINGS

3.01 Supervision and Consultation

- (a) Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.
- (b) Social workers who provide supervision or consultation are responsible for setting clear, appropriate, and culturally sensitive boundaries.
- (c) Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee.
- (d) Social workers who provide supervision should evaluate supervisees' performance in a manner that is fair and respectful.

3.02 Education and Training

- (a) Social workers who function as educators, field instructors for students, or trainers should provide instruction only within their areas of knowledge and competence and should provide instruction based on the most current information and knowledge available in the profession.
- (b) Social workers who function as educators or field instructors for students should evaluate students' performance in a manner that is fair and respectful.
- (c) Social workers who function as educators or field instructors for students should take reasonable steps to ensure that clients are routinely informed when services are being provided by students.
- (d) Social workers who function as educators or field instructors for students should not engage in any dual or multiple relationships with students in which there is a risk of exploitation or potential harm to the student. Social work educators and field instructors are responsible for setting clear, appropriate, and culturally sensitive boundaries.

3.03 Performance Evaluation

Social workers who have responsibility for evaluating the performance of others should fulfill such responsibility in a fair and considerate manner and on the basis of clearly stated criteria.

3.04 Client Records

- (a) Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided.
- (b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.
- (c) Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.
- (d) Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts.

3.05 Billing

Social workers should establish and maintain billing practices that accurately reflect the nature and extent of services provided and that identify who provided the service in the practice setting.

3.06 Client Transfer

- (a) When an individual who is receiving services from another agency or colleague contacts a social worker for services, the social worker should carefully consider the client's needs before agreeing to provide services. To minimize possible confusion and conflict, social workers should discuss with potential clients the nature of the clients' current relationship with other service providers and the implications, including possible benefits or risks, of entering into a relationship with a new service provider.
- (b) If a new client has been served by another agency or colleague, social workers should discuss with the client whether consultation with the previous service provider is in the client's best interest.

3.07 Administration

- (a) Social work administrators should advocate within and outside their agencies for adequate resources to meet clients' needs.
- (b) Social workers should advocate for resource allocation procedures that are open and fair. When not all clients' needs can

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be met, an allocation procedure should be developed that is
nondiscriminatory and based on appropriate and consistently
applied principles.

(c) Social workers who are administrators should take reason-
able steps to ensure that adequate agency or organizational
resources are available to provide appropriate staff supervision.

(d) Social work administrators should take reasonable steps to
ensure that the working environment for which they are respon-
sible is consistent with and encourages compliance with the *NASW
Code of Ethics*. Social work administrators should take reasonable
steps to eliminate any conditions in their organizations that
violate, interfere with, or discourage compliance with the *Code*.

3.08 Continuing Education and Staff Development

Social work administrators and supervisors should take reason-
able steps to provide or arrange for continuing education and
staff development for all staff for whom they are responsible.
Continuing education and staff development should address
current knowledge and emerging developments related to social
work practice and ethics.

3.09 Commitments to Employers

(a) Social workers generally should adhere to commitments made
to employers and employing organizations.

(b) Social workers should work to improve employing agencies'
policies and procedures and the efficiency and effectiveness of
their services.

(c) Social workers should take reasonable steps to ensure that
employers are aware of social workers' ethical obligations as set
forth in the *NASW Code of Ethics* and of the implications of
those obligations for social work practice.

(d) Social workers should not allow an employing organization's
policies, procedures, regulations, or administrative orders to
interfere with their ethical practice of social work. Social workers
should take reasonable steps to ensure that their employing
organizations' practices are consistent with the *NASW Code of
Ethics*.

(e) Social workers should act to prevent and eliminate discrimi-
nation in the employing organization's work assignments and in
its employment policies and practices.

(f) Social workers should accept employment or arrange student field placements only in organizations that exercise fair personnel practices.

(g) Social workers should be diligent stewards of the resources of their employing organizations, wisely conserving funds where appropriate and never misappropriating funds or using them for unintended purposes.

3.10 Labor–Management Disputes

(a) Social workers may engage in organized action, including the formation of and participation in labor unions, to improve services to clients and working conditions.

(b) The actions of social workers who are involved in labor–management disputes, job actions, or labor strikes should be guided by the profession’s values, ethical principles, and ethical standards. Reasonable differences of opinion exist among social workers concerning their primary obligation as professionals during an actual or threatened labor strike or job action. Social workers should carefully examine relevant issues and their possible impact on clients before deciding on a course of action.

4. SOCIAL WORKERS’ ETHICAL RESPONSIBILITIES AS PROFESSIONALS

4.01 Competence

(a) Social workers should accept responsibility or employment only on the basis of existing competence or the intention to acquire the necessary competence.

(b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.

(c) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.

4.02 Discrimination

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race,

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ethnicity, national origin, color, sex, sexual orientation, age,
marital status, political belief, religion, or mental or physical
disability.

4.03 Private Conduct

Social workers should not permit their private conduct to inter-
fere with their ability to fulfill their professional responsibilities.

4.04 Dishonesty, Fraud, and Deception

Social workers should not participate in, condone, or be associ-
ated with dishonesty, fraud, or deception.

4.05 Impairment

(a) Social workers should not allow their own personal prob-
lems, psychosocial distress, legal problems, substance abuse, or
mental health difficulties to interfere with their professional
judgment and performance or to jeopardize the best interests of
people for whom they have a professional responsibility.

(b) Social workers whose personal problems, psychosocial
distress, legal problems, substance abuse, or mental health
difficulties interfere with their professional judgment and perfor-
mance should immediately seek consultation and take appropri-
ate remedial action by seeking professional help, making adjust-
ments in workload, terminating practice, or taking any other
steps necessary to protect clients and others.

4.06 Misrepresentation

(a) Social workers should make clear distinctions between
statements made and actions engaged in as a private individual
and as a representative of the social work profession, a professional
social work organization, or the social worker's employing agency.

(b) Social workers who speak on behalf of professional social
work organizations should accurately represent the official and
authorized positions of the organizations.

(c) Social workers should ensure that their representations to
clients, agencies, and the public of professional qualifications,
credentials, education, competence, affiliations, services provided,
or results to be achieved are accurate. Social workers should
claim only those relevant professional credentials they actually
possess and take steps to correct any inaccuracies or misrepresen-
tations of their credentials by others.

4.07 Solicitations

(a) Social workers should not engage in uninvited solicitation of potential clients who, because of their circumstances, are vulnerable to undue influence, manipulation, or coercion.

(b) Social workers should not engage in solicitation of testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from current clients or from other people who, because of their particular circumstances, are vulnerable to undue influence.

4.08 Acknowledging Credit

(a) Social workers should take responsibility and credit, including authorship credit, only for work they have actually performed and to which they have contributed.

(b) Social workers should honestly acknowledge the work of and the contributions made by others.

5. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO THE SOCIAL WORK PROFESSION

5.01 Integrity of the Profession

(a) Social workers should work toward the maintenance and promotion of high standards of practice.

(b) Social workers should uphold and advance the values, ethics, knowledge, and mission of the profession. Social workers should protect, enhance, and improve the integrity of the profession through appropriate study and research, active discussion, and responsible criticism of the profession.

(c) Social workers should contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the social work profession. These activities may include teaching, research, consultation, service, legislative testimony, presentations in the community, and participation in their professional organizations.

(d) Social workers should contribute to the knowledge base of social work and share with colleagues their knowledge related to practice, research, and ethics. Social workers should seek to contribute to the profession's literature and to share their knowledge at professional meetings and conferences.

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activity, and participation in

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their knowledge related to
workers should seek to con-
tribute to share their knowledge
with others.

(e) Social workers should act to prevent the unauthorized and unqualified practice of social work.

5.02 Evaluation and Research

(a) Social workers should monitor and evaluate policies, the implementation of programs, and practice interventions.

(b) Social workers should promote and facilitate evaluation and research to contribute to the development of knowledge.

(c) Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice.

(d) Social workers engaged in evaluation or research should carefully consider possible consequences and should follow guidelines developed for the protection of evaluation and research participants. Appropriate institutional review boards should be consulted.

(e) Social workers engaged in evaluation or research should obtain voluntary and written informed consent from participants, when appropriate, without any implied or actual deprivation or penalty for refusal to participate; without undue inducement to participate; and with due regard for participants' well-being, privacy, and dignity. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research.

(f) When evaluation or research participants are incapable of giving informed consent, social workers should provide an appropriate explanation to the participants, obtain the participants' assent to the extent they are able, and obtain written consent from an appropriate proxy.

(g) Social workers should never design or conduct evaluation or research that does not use consent procedures, such as certain forms of naturalistic observation and archival research, unless rigorous and responsible review of the research has found it to be justified because of its prospective scientific, educational, or applied value and unless equally effective alternative procedures that do not involve waiver of consent are not feasible.

(h) Social workers should inform participants of their right to withdraw from evaluation and research at any time without penalty.

(i) Social workers should take appropriate steps to ensure that participants in evaluation and research have access to appropriate supportive services.

(j) Social workers engaged in evaluation or research should protect participants from unwarranted physical or mental distress, harm, danger, or deprivation.

(k) Social workers engaged in the evaluation of services should discuss collected information only for professional purposes and only with people professionally concerned with this information.

(l) Social workers engaged in evaluation or research should ensure the anonymity or confidentiality of participants and of the data obtained from them. Social workers should inform participants of any limits of confidentiality, the measures that will be taken to ensure confidentiality, and when any records containing research data will be destroyed.

(m) Social workers who report evaluation and research results should protect participants' confidentiality by omitting identifying information unless proper consent has been obtained authorizing disclosure.

(n) Social workers should report evaluation and research findings accurately. They should not fabricate or falsify results and should take steps to correct any errors later found in published data using standard publication methods.

(o) Social workers engaged in evaluation or research should be alert to and avoid conflicts of interest and dual relationships with participants, should inform participants when a real or potential conflict of interest arises, and should take steps to resolve the issue in a manner that makes participants' interests primary.

(p) Social workers should educate themselves, their students, and their colleagues about responsible research practices.

6. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO THE BROADER SOCIETY

6.01 Social Welfare

Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments. Social workers should advocate for living conditions conducive to the fulfillment of

appropriate steps to ensure that all people have access to appropriate

on or research should be conducted with physical or mental dis-

tribution of services should be provided for professional purposes and consistent with this information.

on or research should be conducted with the informed consent of participants and of the community. Records should inform participants of the measures that will be taken to ensure that their names are not in any records containing

on and research results should be disseminated with confidentiality by omitting identifying information unless it has been obtained autho-

ration and research findings should not be falsified and should be accurately reported in published data

on or research should be conducted in a way that respects dual relationships with clients and communities when a real or potential conflict of interest exists. Appropriate steps to resolve the conflict should be taken with the clients' interests primary.

themselves, their students, and the community. Research practices.

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eral welfare of society, the development of people, their dignity, and social workers should be committed to the fulfillment of

basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice.

6.02 Public Participation

Social workers should facilitate informed participation by the public in shaping social policies and institutions.

6.03 Public Emergencies

Social workers should provide appropriate professional services in public emergencies to the greatest extent possible.

6.04 Social and Political Action

(a) Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully. Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice.

(b) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups.

(c) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people.

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, or mental or physical disability.

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The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.



NASW

National Association of Social Workers

1735 K Street, N.E.

Washington, D.C. 20002-4242

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Standards for Continuing Professional Education
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1990 Edition

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NASW standards for the practice of clinical social work

Prepared by the NASW Provisional Council on
Clinical Social Work

*Approved by the NASW Board of Directors
June 1984*

Revised April 1989



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Introduction

Historically, the social work profession has focused on both people and their social environment. Clinical social work, whose focus is on individuals, families, and groups, has its roots in social casework, which always has been a primary method for the delivery of social work services. The number of clinical social workers has grown continuously, and clinical social work continues to contribute significantly to the development of knowledge and skills for the profession. In 1978, the National Association of Social Workers (NASW) formally recognized clinical social work as part of a process of organizational differentiation. At that time, NASW established the Task Force on Clinical Social Work, which became the Provisional Council on Clinical Social Work in 1982.

Clinical social workers have practiced in governmental and voluntary agencies and, since the time of pioneer social worker Mary Richmond, in private practice. In 1961, NASW defined private practice as a setting for the delivery of clinical social work services and published its first *Handbook on the Private Practice of Social Work* in 1967.

Clinical practice continues to be an integral part of the services delivered in agency settings. At the same time, an increasing number of clinical practitioners have been moving into independent private practice, which further attests to the commitment of trained and experienced professionals to the direct treatment of individuals, families, and groups. This development, encompassing solo and group practice as well as other arrangements, is in addition to the practice of clinical social work in traditional voluntary and governmental agency settings.

Many states require the legal regulation of social work practice; some states require a special license for practitioners of clinical social work as well as those in independent private practice. Generally, certification for clinical social work requires a master's degree in social work plus at least two years' experience as well as an examination.

Given the variations among the states regarding legal regulation and the needs of clinical social work practitioners, NASW has taken appropriate responsibility for establishing standards of practice for all clinical social workers in all settings. These standards are to be considered desirable for all clinical social workers and are designed to do the following:

- Guide clinical social work practice.
- Guide state regulatory agencies.
- Provide information to insurance carriers and others

who, under various health-benefit plans, reimburse clients for clinical social work services.

- Inform consumer groups.

The NASW Code of Ethics is the primary standard by which all members are bound. A summary of the Code of Ethics will be found following these standards.

Definitions

The following definition of clinical social work was accepted by the NASW Board of Directors at its January 1984 meeting:

Clinical social work shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and small groups. Clinical social work practice is the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders. It is based on knowledge of one or more theories of human development within a psychosocial context.

The perspective of person-in-situation is central to clinical social work practice. Clinical social work includes interventions directed to interpersonal interactions, intrapsychic dynamics, and life-support and management issues. Clinical social work services consist of assessment; diagnosis; treatment, including psychotherapy and counseling; client-centered advocacy; consultation; and evaluation. The process of clinical social work is undertaken within the objectives of social work and the principles and values contained in the NASW Code of Ethics.

In May 1961, the NASW Board of Directors endorsed the following definition of private practitioners of social work:

Private practitioners are social workers who, wholly or in part, practice social work outside a governmental or duly incorporated voluntary agency, who have responsibility for their own practice and set up conditions of exchange with their clients, and identify themselves as social work practitioners in offering services.

Goals and Objectives of the Standards

The goals of the standard are

- To maintain and improve the quality of services provided by clinical social workers.
- To establish professional expectations so social workers can monitor and evaluate their clinical practice.
- To provide a framework for clinical social workers to assess responsible professional behavior.
- To inform consumers, governmental regulatory bodies, and others, such as insurance carriers, about the profession's standards for clinical social work practice.

Toward the achievement of these goals, the standards

- Define and delineate clinical social work and the private practice of clinical social work.
- Establish specific ethical guidelines for the practice of clinical social work in agency or private practice settings.
- Provide documentation of professional expectations for agencies, peer review committees, state regulatory bodies, insurance carriers, and others.

Standards for the Practice of Clinical Social Work

Standard 1. Clinical social workers shall function in accordance with the ethics and the stated standards of the profession, including its accountability procedures.

Interpretation

All social workers have a fourfold responsibility: to clients, to the profession, to self, and to society. Social workers shall identify themselves as members of the social work profession. NASW members shall be familiar with and adhere to the NASW Code of Ethics and shall cooperate fully and in a timely fashion with the adjudication procedures of the Committee of Inquiry, peer review, and appropriate state boards. They shall be aware of and adhere to relevant stated professional standards for social work practice.

All clinical social workers shall be willing to have judgments and decisions reviewed by knowledgeable peers in a formal process. When requested by a client, the clinical social worker will provide information about how to file a complaint charging unethical behavior.

Standard 2. Clinical social workers shall have and continue to develop specialized knowledge and understanding of individuals, families, and groups and of therapeutic and preventive interventions.

Interpretation

Areas of knowledge about individuals, families, and groups required for effective clinical intervention encompass the following:

1. Social, psychological, and health factors and their interplay on psychosocial functioning, such as these:
 - theories of personality and behavior,
 - social-cultural influences,
 - environmental influences,
 - physical health, and
 - impairment and disability, including mental and emotional conditions.
2. Community resources
 - available social resources in the community and their operation and how to use them in the client's behalf and
 - how to identify appropriate services and negotiate a referral.
3. Specific practice skills, including the ability to
 - establish a relationship of mutual acceptance and trust,

- obtain, analyze, classify, and interpret social and personal data, including assessment and diagnosis,
- establish compatible goals of service with the client,
- bring about changes in behavior (thinking, feeling, or doing) or in the situation in accordance with the goals of service.

4. Knowledge about and skills in using research to evaluate the effectiveness of a service.

The clinical social worker shall have available a variety of appropriate social work therapeutic intervention techniques that he or she uses selectively, depending on the client's needs and capacity for change.

When knowledge and skills are acquired, other than those specific to social work, the practitioner is responsible for obtaining the appropriate training and certification. Clinical social workers shall maintain and enhance their skills through appropriate forms of professional development and continuing education (see *NASW Standards for Continuing Professional Education*) and are personally accountable for all aspects of their professional behavior and decisions.

Standard 3. Clinical social workers shall respond in a professional manner to all persons who seek their assistance.

Interpretation

Clinical social workers shall respond to each client regardless of the client's lifestyle, origin, race, sex, religion, or sexual orientation.

Clinical social workers shall limit their practice to those clients whom they have the skills and resources to serve. However, they shall be aware of and seek to ameliorate any of their attitudes and practices that may interfere with their ability to offer competent and equitable service. They have a professional responsibility to help a client establish contact with other appropriate resources when they cannot meet the needs for service of a particular client.

If the clinical social worker is unable to schedule a timely appointment for an initial assessment, he or she may screen the client by telephone to determine the urgency of the client's situation. The well-being of the client is the key factor in all decisions. In emergency situations in which the clinical social worker cannot be available to a new client, every effort should be made to find an appropriate source of immediate help.

On occasion, a client may decide to terminate treatment before a clinician judges the client to be ready. When the clinical social worker is sure that the termination is

premature but the client persists in his or her decision, it is the clinician's responsibility to refer the client to another appropriate treatment resource or, failing that, to help the client terminate treatment as constructively as possible, leaving the door open for the client to reapply for service at another time.

Standard 4. Clinical social workers shall be knowledgeable about the services available in the community and make appropriate referrals for their clients.

Interpretation

In accordance with the definition of clinical social work (see "Definitions"), the perspective of the person-in-situation is central to clinical practice. Therefore, clinical social workers must be alert to the clients' situations, especially those that affect the clients' behavior and functioning, and must be able to modify the environment, when possible, by referrals to other community services. There will also be occasions when advocacy on behalf of a client will be necessary to obtain needed services.

When a client is being served by other agencies, the clinical social worker shall maintain collaborative contacts as necessary with the other providers to ensure the coordination of services and the client's receipt of optimal benefits from the various services.

When the client is involved with more than one clinician, collaborative consultation shall be maintained as necessary to ensure delineation of the specific areas of responsibility. The clinician shall not share information about a client without the client's informed consent. (See Standard 6 for an elaboration of confidentiality.)

Standard 5. Clinical social workers shall maintain their accessibility to clients.

Interpretation

In the process of managing a therapeutic relationship, various factors or events may create problems of accessibility. The clinician shall be able to respond to the unanticipated needs of a client by, for example, having telephones answered, either by a person or machine, and messages relayed promptly and accurately. When the clinical social worker is unavailable because of vacation, illness, or any other reason, he or she should make arrangements for coverage by competent peers. These details should be discussed with the client at the beginning of treatment.

In establishing an office, the clinical social worker shall be aware that some clients may have or develop physical handicaps. Thus, the clinical social worker shall make every attempt to ensure that offices are free of impediments to mobility and that helping devices are available for sensorially impaired clients. The office's accessibility by public transportation, when it is available, also should be a consideration.

Standard 6. Clinical social workers shall safeguard the confidential nature of the treatment relationship and of the information obtained within that relationship.

Interpretation

Respect for the client as a person and for the client's right to privacy underlies the maintenance of confidentiality in the client-clinician relationship. Although assurance of this confidentiality enhances the therapeutic interaction, the client should be advised that there are circumstances in which confidentiality cannot be maintained. These circumstances would include but not necessarily be limited to the legally mandated requirement to report to appropriate authorities a suspicion of child abuse, including the sexual abuse of children, or to disclose information necessary to avert danger to the client or others. In some circumstances, a clinician may need to advise the parents of a child client's self-destructive behavior to ensure adequate protection for the child. In all such situations, the clinician shall advise the client of the exceptions to confidentiality and privilege, be prepared to share with the client the information that is being reported, and handle the feelings evoked. Except for such explicit, overriding requirements, the clinical social worker shares information only with the written and informed consent of the client.

Standard 7. Clinical social workers shall maintain access to professional case consultation.

Interpretation

In an agency setting, professional social work supervision or consultation should be available to all social work staff, either in the agency or through a contractual arrangement. If clinical social workers are not available, case con-

sultation may be obtained from qualified professionals of other disciplines.

The beginning clinical social worker requires regular case-consultation supervision. For the first two years of professional experience, at least one hour of supervision should be provided for every fifteen hours of face-to-face contact with clients. After the first two years, the ratio may be reduced to a minimum of one hour of case-consultation supervision for every thirty hours of face-to-face contact with clients. In some situations, additional consultation will be sought by the clinician, because of complex issues involving a client, or suggested by the consultant, because of difficulties the consultant perceives in the clinician's handling of a situation.

Clinicians with five years or more of experience should utilize consultation on an as-needed, self-determined basis. Although clinicians who are in independent practice shall utilize more case consultation when they first begin practicing, they should maintain consultative arrangements throughout the time they are in practice. Clinical social workers shall be knowledgeable about how and when to utilize the expertise of other professional disciplines in the area of medical problems, including pharmacology, and be alert to the effects of prescription drugs on a client so they can provide feedback to the client's physician.

Standard 8. Clinical social workers shall establish and maintain professional offices and procedures.

Interpretation

The clinical social worker keeps records of clients that substantiate service in a secure place. He or she maintains the records accurately and in a manner that is free from bias or prejudicial content. The social worker makes these records available to clients at their request.

The clinical social worker should ensure that appropriate insurance is maintained: agency liability, personal professional liability, premises protection, and other protective policies.

Clinical social workers shall establish a fee structure when in independent private practice or utilize the fee structure of the agency in which they are working. All fees and procedures for payment shall be discussed with the client at the beginning of treatment; to minimize misunderstanding, it is useful to present these policies in writing as well. This discussion should include the use of insurance reimbursement and how it will be handled; charges for missed or canceled appointments, vacations,

and collateral contacts; and any other financial issues.

Clinical social workers shall not refuse service to clients solely because the clients are not covered by insurance.

Billing procedures shall be included in the original discussion and clients' accounts shall be maintained according to acceptable accounting methods, with all bills and receipts provided on a regular and timely schedule. Clinical social workers shall discuss overdue accounts with clients and make every effort to avoid accrual of debt. When it is clear to a client and clinician that, for whatever reason, the client can no longer afford to pay for treatment, a mutually acceptable alternative plan for compensation or an orderly and appropriate termination or referral shall be instituted. Nothing in this standard shall be construed to rule out an individual clinician's decision to provide services on a *pro bono* basis.

When all efforts to collect an overdue account from a client have failed, the client should be informed that unpaid accounts may be turned over to a collection agency or small claims court or that other types of legal action will be taken. If there is a dispute over charges, the clinical social worker should make every effort to resolve it without damaging the therapeutic relationship.

Waiting rooms and offices should be kept clean, and the environment should be properly maintained to ensure a reasonable degree of comfort. Interviewing rooms should ensure privacy and be free of distractions. Steps should be taken to assure the client's and the social worker's personal security.

Standard 9. Clinical social workers shall represent themselves to the public with accuracy.

Interpretation

The public needs to know how to find help from qualified clinical social workers. Both agencies and independent private practitioners should ensure that their therapeutic services are made known to the public. In this regard, it is important that telephone listings be maintained in both the classified and alphabetical sections of the telephone directory, describing the clinical social work services available.

Although advertising in various media was thought to be questionable professional practice in the past, recent judicial decisions, Federal Trade Commission rulings as

well as current professional practices have made such advertising acceptable. The advertisement must be factual and should avoid false promises of cures.

The content of the advertisement should include the private practitioner's or agency's name and professional credentials and the address and telephone number or other contact information. It might also include the type of services provided (e.g., individual, family, or group therapy; alcoholism counseling; divorce mediation; and so forth) and the type of problems that are dealt with (e.g. marital distress, parent-child conflicts, eating disorders).

Standard 10. Social workers shall engage in the independent private practice of clinical social work only when qualified to do so.

Interpretation

Many states have legal regulations for social workers at a clinical or independent-practice level. If practitioners work in such a state, they must be licensed or certified at this level to engage in independent private practice.

The NASW standards for the independent practice of clinical social work are those required for inclusion in the *NASW Register of Clinical Social Workers*:

1. A graduate degree from a social work program accredited by the Council on Social Work Education.
2. Two years of full-time (or equivalent part-time) clinical social work experience supervised by a clinical social worker.
3. Current membership in the Academy of Certified Social Workers or a license or certification in a state at the appropriate level.

Standard 11. Clinical social workers shall have the right to establish an independent private practice.

Interpretation

Clinical social workers shall have the right to establish a separate independent practice as a form of secondary employment or after leaving a place of employment. When they establish such a practice, either alone or as part of a group, they are responsible for assuring that the diagnostic and treatment services meet professional standards. If such a practitioner hires clinical social workers or other employees, he or she, as an employer, is responsible for

the services provided, for maintaining all these standards, and for upholding all applicable local, state, or federal regulations.

Clinical social workers who are employed by agencies and have an independent private practice should not refer agency clients to themselves unless they have made a specific agreement with the agency and have offered alternative options to the clients. Agencies have the responsibility to establish written, reasonable guidelines or policies about secondary employment (see *NASW Standards for Social Work Personnel Practices*). When an agency does not have clear written policies, the clinical social worker may cite the relevant NASW standards.

When a clinical social worker leaves an agency to establish an independent private practice, he or she must take great care to explain fully the options available to clients. Clients in treatment may be offered various options after consultation with the agency. These options include (1) transferring to another staff member in the agency, (2) continuing with the same clinician in an independent setting, (3) transferring to another agency or to a different private practitioner, or (4) terminating treatment. The overriding principle is the client's right to self-determination and freedom of choice. That is, the client's best interests must always be paramount in these decisions.

Code of Ethics

SUMMARY OF MAJOR PRINCIPLES

I. The Social Worker's Conduct and Comportment as a Social Worker

A. *Propriety.* The social worker should maintain high standards of personal conduct in the capacity or identity as social worker.

B. *Competence and Professional Development.* The social worker should strive to become and remain proficient in professional practice and the performance of professional functions.

C. *Service.* The social worker should regard as primary the service obligation of the social work profession.

D. *Integrity.* The social worker should act in accordance with the highest standards of professional integrity.

E. *Scholarship and Research.* The social worker engaged in study and research should be guided by the conventions of scholarly inquiry.

II. The Social Worker's Ethical Responsibility to Clients

F. *Primacy of Clients' Interests.* The social worker's primary responsibility is to clients.

G. *Rights and Prerogatives of Clients.* The social worker should make every effort to foster maximum self-determination on the part of clients.

H. *Confidentiality and Privacy.* The social worker should respect the privacy of clients and hold in confidence all information obtained in the course of professional service.

I. *Fees.* When setting fees, the social worker should ensure that they are fair, reasonable, considerate, and commensurate with the service performed and with due regard for the clients' ability to pay.

III. The Social Worker's Ethical Responsibility to Colleagues

J. *Respect, Fairness, and Courtesy.* The social worker should treat colleagues with respect, courtesy, fairness, and good faith.

K. *Dealing with Colleagues' Clients.* The social worker has the responsibility to relate to the clients of colleagues with full professional consideration.

IV. The Social Worker's Ethical Responsibility to Employers and Employing Organizations

L. *Commitments to Employing Organizations.* The social worker should adhere to commitments made to the employing organizations.

V. The Social Worker's Ethical Responsibility to the Social Work Profession

M. *Maintaining the Integrity of the Profession.* The social worker should uphold and advance the values, ethics, knowledge, and mission of the profession.

N. *Community Service.* The social worker should assist the profession in making social services available to the general public.

O. *Development of Knowledge.* The social worker should take responsibility for identifying, developing, and fully utilizing knowledge for professional practice.

VI. The Social Worker's Ethical Responsibility to Society

P. *Promoting the General Welfare.* The social worker should promote the general welfare of society.

This summary is of the NASW Code of Ethics, effective July 1, 1980, as adopted by the 1979 NASW Delegate Assembly and revised by the 1990 and 1993 Delegate Assemblies. The complete text, including the preamble and expanded definitions of principles, is available on request.

About NASW

The National Association of Social Workers (NASW) is the largest organization of professional social workers in the world. As of July 1995, over 155,000 members participated in 55 chapters throughout the United States, Puerto Rico, the Virgin Islands, and the international community.

The association works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies. NASW provides a variety of membership benefits including credentials (NASW Diplomate in Clinical Social Work, Academy of Certified Social Workers, Academy of Certified Baccalaureate Social Workers, the Qualified Clinical Social Worker, and the School Social Worker Specialist) and insurance (professional liability, health, and life). The NASW Press, which produces *Social Work* and the *NASW News* as membership benefits as well as four other journals and numerous books each year, is a major service in professional development. In January 1991, the association released a major proposal for National Health Care, a single-payer system.

For more information on NASW membership or programs, write NASW, 750 First Street, NE, Suite 700, Washington, DC 20002-4241 (telephone: 1-800-638-8799 or 1-202-408-8600).

Professional Counselors

Sec. 08.29.110. Qualifications for licensure. (a) The board shall issue a professional counselor license to a person who applies for the license, submits the required fee, submits two letters of recommendation from professional counselors who are familiar with the applicant's practice of professional counseling, and presents evidence satisfactory to the board that the person

(1) is at least 18 years of age;
(2) is not under investigation in this or another jurisdiction for an act that would constitute a violation of this chapter;

(3) has not had a license related to the practice of counseling, psychology, marital and family therapy, or social work in this or another jurisdiction suspended, revoked, or surrendered in lieu of discipline unless the license has been fully reinstated in that jurisdiction;

(4) has passed a written examination as required by the board; the board may provide that passing a nationally recognized examination for professional counselors is sufficient to meet the examination requirement of this paragraph;

(5) has successfully completed either

(A) an earned doctoral degree in counseling or a related professional field from a regionally accredited institution of higher education approved by the board; or

(B) an earned master's degree in counseling or a related professional field, from a regionally or nationally accredited institution of higher education approved by the board, consisting of at least 48 semester hours and at least 12 other graduate semester hours in counseling during or after earning the master's degree, for a total of at least 60 hours; and

(6) has, after completing the requirement of either (5)(A) or (B) of this subsection, had at least 3,000 hours of supervised experience in the practice of professional counseling performed over a period of at least two years under the supervision of a supervisor approved under AS 08.29.210, with at least 1,000 hours of direct counseling with individuals, couples, families, or groups and at least 100 hours of face-to-face supervision by a supervisor approved under AS 08.29.210 unless, under regulations of the board, the board allows the supervision to be by telephonic or electronic means because of the remote location of the counselor.

(b) The board may, in its regulations, specify the areas of study that must be covered in order to meet the educational requirements of (a) of this section.

Sec. 08.29.120. Licensure by credential. (a) Except as provided in (b) of this section, the board may issue a license under this chapter to a person who is licensed in another jurisdiction to practice professional counseling if the board finds that the other jurisdiction has substantially the same or higher licensure requirements as this state.

(b) The board may not license under this section a person who is under investigation in this or another jurisdiction for an act that would constitute a violation of this chapter until the investigation is complete and disciplinary sanctions, if any, are imposed and the person has complied with the sanctions.

Sec. 08.29.130. Licensure of foreign-educated applicants. The board may issue a license under this chapter to a person who

(1) has completed a doctorate or master's degree educational program in counseling or a related professional field in a foreign college or university approved by the board;

(2) meets the requirements of AS 08.29.110 except for AS 08.29.110(a)(5); and

(3) demonstrates to the satisfaction of the board that the applicant's experience, command of the English language, and completed academic program meet the standards of a relevant academic program of an accredited educational institution in the United States.

Sec. 08.29.140. License renewal. Renewal of a license under this chapter may not be granted unless the licensee, within the 24 months immediately preceding the renewal date, has completed the continuing education requirements established by the board.

ARTICLE 3. MISCELLANEOUS PROVISIONS.

Sec. 08.29.200. Confidentiality of communications. (a) A person licensed under this chapter may not reveal to another person a communication made to the licensee by a client about a matter concerning which the client has employed the licensee in a professional capacity. This section does not apply to

(1) a communication to a potential victim, the family of a potential victim, law enforcement authorities, or other appropriate authorities concerning a clear and immediate probability of physical harm to the client, other individuals, or society;

(2) a case conference or case consultation with other mental health professionals at which the patient is not identified;

(3) the release of information that the client in writing authorized the licensee to reveal;

Professional Counselors

(4) information released to the board during the investigation of a complaint or as part of a disciplinary or other proceeding; or

(5) situations where the rules of evidence applicable to the psychotherapist-patient privilege allow the release of the information.

(b) Notwithstanding (a) of this section, a person licensed under this chapter shall report incidents of

(1) child abuse or neglect as required by AS 47.17;

(2) harm or assaults suffered by an elderly person or disabled adult as required by AS 47.24.

(c) Information obtained by the board under (a)(4) of this section is confidential and is not a public record for purposes of AS 09.25.110 - 09.25.140.

Sec. 08.29.210. Supervisor certification. (a) The board shall approve and certify a person as an approved counselor supervisor for the purposes of this chapter if the person

(1) is licensed under this chapter as a professional counselor or is a licensed physician, licensed advanced nurse practitioner who is certified to provide psychiatric or mental health services, licensed clinical social worker, licensed marital and family therapist, licensed psychologist, or licensed psychological associate;

(2) submits an application for certification and the appropriate fee;

(3) has five years of counseling experience;

(4) provides to the board for its approval or disapproval a statement that details the person's supervision philosophy, orientation, and experience; and

(5) meets other criteria that may be established by the board in regulations.

(b) Certification under (a) of this section remains in effect, without the need for renewal of the certification, until the person's licensure as a professional counselor is revoked, suspended, or otherwise lapses.

Sec. 08.29.220. Disclosure statement. A client may not be charged a fee for professional counseling services unless, before the performance of the services, the client was furnished a copy of a professional disclosure statement that contained

(1) the name, title, business address, and business telephone number of the professional counselor;

(2) a description of the formal professional education of the professional counselor, including the institutions attended and the degrees received from them;

(3) the professional counselor's areas of specialization and the services available;

(4) the professional counselor's fee schedule listed by type of service or hourly rate;

(5) at the bottom of the first page of the statement, the following sentence: "This information is required by the Board of Professional Counselors which regulates all licensed professional counselors," followed by the name, address, and telephone number of the board's office.

Sec. 08.29.230. Limitation of practice. Notwithstanding that a specific act is within the definition of the "practice of professional counseling," a person licensed under this chapter may not perform the act if the person lacks appropriate education or training related to the act. Article 4. General Provisions.

Sec. 08.29.400. Grounds for denial of license or for disciplinary sanctions. The board may impose a disciplinary sanction under AS 09.01.075 on a person licensed under this chapter or deny a license to a person when the board finds that the person

(1) has an addiction to, or severe dependency on, alcohol or other drugs that impairs the person's ability to engage safely in the practice of professional counseling;

(2) has been convicted of a felony and has not been sufficiently rehabilitated to merit the public trust;

(3) used fraud, deception, misrepresentation, or bribery in securing a license under this chapter or in obtaining permission to take an examination required under this chapter;

(4) is incompetent or has committed misconduct, fraud, misrepresentation, or dishonesty in the performance of the functions of a licensed professional counselor;

(5) violated, or assisted another individual to violate, a provision of this chapter or a regulation adopted under this chapter;

(6) impersonated a person who holds a license under this chapter;

(7) has had a license related to the practice of counseling, psychology, marital and family therapy, or social work in this or another jurisdiction revoked, suspended, limited, or surrendered in lieu of discipline upon grounds for which a license issued under this chapter could be revoked, suspended, limited, or surrendered in lieu of discipline; this paragraph does not apply to license actions for failure to pay a renewal fee;

(8) assisted another person who is not licensed under this chapter in an attempt to represent the person to the public as a licensed professional counselor;

(9) was issued a license based on a material mistake of fact;

(10) used an advertisement or solicitation that is false, misleading, or deceptive to the general public or the person to whom the advertisement was primarily directed; or

12 AAC 62.900. CODE OF ETHICS AND STANDARDS OF PRACTICE. (a) The "Code of Ethics and Standards of Practice", American Counseling Association (ACA), 1997 edition, is adopted by reference as the code of ethics for professional counselors in the state. A professional counselor licensed in the state must adhere to the code of ethics.

(b) When using or administering assessment instruments described in AS 08.29.490(1)(C), a professional counselor must comply with Section E: Evaluation, Assessment, and Interpretation of the "Code of Ethics and Standards of Practice" adopted by reference in (a) of this section.

Editor's Note: A copy of the "Code of Ethics and Standards of Practice", American Counseling Association, 1997 edition, described in 12 AAC 62.900 is available for inspection at the Department of Community and Economic Development, Division of Occupational Licensing, P.O. Box 110806, Juneau, Alaska, 99811, or may be obtained from the American Counseling Association, 5999 Stevenson Avenue, Alexandria, VA 22304 - 3300; telephone: (703) 823-9800; internet: <http://www.counseling.org>.

12 AAC 62.930. WRITTEN NOTICE WITH DISCLOSURE STATEMENT. In addition to the professional disclosure statement required by AS 08.29.220, a licensee must provide written notice to the client that

(1) the treatment program may be discussed with other professionals and, if that occurs, the client's confidentiality will be maintained; and

(2) the name and identity of the client will be disclosed only in compliance with AS 08.29.200.

12 AAC 62.990. DEFINITIONS. (a) In AS 08.29,

(1) "direct counseling" means professional counseling provided face-to-face with individuals, couples, families, or groups;

(2) "incompetent" means lacking sufficient knowledge, skills, or professional judgement in counseling, to a degree likely to endanger the mental health or well being of a client;

(b) In AS 08.29 and sec. 6, ch. 75, SLA 1998, as amended by sec. 7, ch. 49, SLA 1999, "related field" or "related professional field" includes psychology, marital and family therapy, social work, and applied behavioral science;

(c) In AS 08.29 and this chapter,

(1) "approved counselor supervisor" means a counselor supervisor certified under 12 AAC 62.200;

(2) "board" means the Board of Professional Counselors;

(3) "department" means the Department of Community and Economic Development;

(4) "professional counselor" means a person who is in the practice of professional counseling as defined in AS 08.29.490(1).

CHAPTER 01. CENTRALIZED LICENSING.

Section

10. Applicability of chapter
20. Board organization
25. Public members
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50. Administrative duties of department
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103. Procedure and form of citation
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110. Definitions

Professional Counselors

12 AAC 62.900
1995 Version

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DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

& ACA Code of Ethics
Standards of Practice

(and related documents)

Preamble

THE AMERICAN COUNSELING ASSOCIATION is an educational, scientific and professional organization whose members are dedicated to the enhancement of human development throughout the life span. Association members recognize diversity in our society and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of each individual.

The specification of a code of ethics enables the association to clarify to current and future members, and to those served by members, the nature of the ethical responsibilities held in common by its members. As the code of ethics of the association, this document establishes principles that define the ethical behavior of association members. All members of the American Counseling Association are required to adhere to the *ACA Code of Ethics & Standards of Practice*. The *ACA Code of Ethics & Standards of Practice* will serve as the basis for processing ethical complaints initiated against members of the association.

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Section A: The Counseling Relationship

A.1. CLIENT WELFARE

a. *Primary Responsibility.*

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

b. *Positive Growth and Development.*

Counselors encourage client growth and development in ways that foster the clients' interest and welfare; counselors avoid fostering dependent counseling relationships.

c. *Counseling Plans.*

Counselors and their clients work jointly in devising integrated, individual counseling plans that offer reasonable promise of success and are consistent with abilities and circumstances of clients. Counselors and clients regularly review counseling plans to ensure their continued viability and effectiveness respecting clients' freedom of choice. (See A.3.b.)

d. *Family Involvement.*

Counselors recognize that families are usually important in clients' lives and strive to enlist family understanding and involvement as a positive resource when appropriate.

e. *Career and Employment Needs.*

Counselors work with their clients in considering employment in jobs and circumstances that are consistent with the clients' overall abilities, vocational limitations, physical restrictions, general temperament, interest and aptitude patterns, social skills, education, general qualifications, and other relevant characteristics and needs. Counselors neither place nor participate in placing clients in positions that will result in damaging the interest and the welfare of clients, employers, or the public.

A.2. RESPECTING DIVERSITY

a. *Nondiscrimination.*

Counselors do not condone or engage in discrimination based on age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status, or socioeconomic status. (See C.5.a., C.5.b., and D.1.i.)

b. *Respecting Differences.*

Counselors will actively attempt to understand the diverse cultural backgrounds of the clients with whom they work. This includes, but is not limited to, learning how the counselor's own cultural/ethnic/racial identity

impacts her/his values and beliefs about the counseling process. (See E.8. and F.2.i.)

A.3. CLIENT RIGHTS

a. *Disclosure to Clients.*

When counseling is initiated, and throughout the counseling process as necessary, counselors inform clients of the purposes, goals, techniques, procedures, limitations, potential risks and benefits of services to be performed, and other pertinent information. Counselors take steps to ensure that clients understand the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements. Clients have the right to expect confidentiality and to be provided with an explanation of its limitations, including supervision and/or treatment team professionals; to obtain clear information about their case records; to participate in the ongoing counseling plans; and to refuse any recommended services and be advised of the consequences of such refusal. (See E.5.a. and G.2.)

b. *Freedom of Choice.*

Counselors offer clients the freedom to choose whether to enter into a counseling relationship and to determine which professional(s) will provide counseling. Restrictions that limit choices of clients are fully explained. (See A.1.c.)

c. *Inability to Give Consent.*

When counseling minors or persons unable to give voluntary informed consent, counselors act in these clients' best interests. (See B.3.)

A.4. CLIENTS SERVED BY OTHERS

If a client is receiving services from another mental health professional, counselors, with client consent, inform the professional persons already involved and develop clear agreements to avoid confusion and conflict for the client. (See C.6.c.)

A.5. PERSONAL NEEDS AND VALUES

a. *Personal Needs.*

In the counseling relationship, counselors are aware of the intimacy and responsibilities inherent in the counseling relationship, maintain respect for clients, and avoid actions that seek to meet their personal needs at the expense of clients.

b. *Personal Values.*

Counselors are aware of their own values, attitudes, beliefs, and behaviors and how these apply in a diverse society and avoid imposing their values on clients. (See C.5.a.)

A.6. DUAL RELATIONSHIPS

a. *Avoid When Possible.*

Counselors are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of clients. Counselors make every effort to avoid dual relationships with clients that could impair professional judgment or increase the risk of harm to clients. (Examples of such relationships include, but are not limited to, familial, social, financial, business, or close personal relationships with clients.) When a dual relationship cannot be avoided, counselors take appropriate professional precautions, such as informed consent, consultation, supervision, and documentation, to ensure that judgment is not impaired and no exploitation occurs. (See F.1.b.)

b. *Superior/Subordinate Relationships.*

Counselors do not accept as clients superiors or subordinates with whom they have administrative, supervisory, or evaluative relationships.

A.7. SEXUAL INTIMACIES WITH CLIENTS

a. *Current Clients.*

Counselors do not have any type of sexual intimacies with clients and do not counsel persons with whom they have had a sexual relationship.

b. *Former Clients.*

Counselors do not engage in sexual intimacies with former clients within a minimum of two years after terminating the counseling relationship. Counselors who engage in such relationship after two years following termination have the responsibility to thoroughly examine and document that such relations did not have an exploitative nature, based on factors, such as duration of counseling, amount of time since counseling, termination circumstances, client's personal history and mental status, adverse impact on the client, and actions by the counselor suggesting a plan to initiate a sexual relationship with the client after termination.

A.8. MULTIPLE CLIENTS

When counselors agree to provide counseling services to two or more persons who have a relationship (such as husband and wife, or parents and children), counselors clarify at the outset which person or persons are clients and the nature of the relationships they will have with each involved person. If it becomes apparent that counselors may be called upon to perform potentially conflicting roles, they clarify, adjust, or withdraw from roles appropriately. (See B.2. and B.4.d.)

A.9. GROUP WORK

a. *Screening.*

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

b. *Protecting Clients.*

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

A.10. FEES AND BARTERING

(See D.3.a. and D.3.b.)

a. *Advance Understanding.*

Counselors clearly explain to clients, prior to entering the counseling relationship, all financial arrangements related to professional services including the use of collection agencies or legal measures for nonpayment. (A.11.c.)

b. *Establishing Fees.*

In establishing fees for professional counseling services, counselors consider the financial status of clients and locality. In the event that the established fee structure is inappropriate for a client, assistance is provided in attempting to find comparable services of acceptable cost. (See A.10.d., D.3.a., and D.3.b.)

c. *Bartering Discouraged.*

Counselors ordinarily refrain from accepting goods or services from clients in return for counseling services because such arrangements create inherent potential for conflicts, exploitation, and distortion of the professional relationship. Counselors may participate in bartering only if the relationship is not exploitive, if the client requests it, if a clear written contract is established, and if such arrangements are an accepted practice among professionals in the community. (See A.6.a.)

d. *Pro Bono Service.*

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

A.11. TERMINATION AND REFERRAL

a. *Abandonment Prohibited.*

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

b. *Inability to Assist Clients.*

If counselors determine an inability to be of professional assistance to clients, they avoid entering or immediately terminate a counseling relationship. Counselors are knowledgeable about referral resources and suggest appropriate alternatives. If clients decline the suggested referral, counselors should discontinue the relationship.

c. *Appropriate Termination.*

Counselors terminate a counseling relationship, securing client agreement when possible, when it is reasonably clear that the client is no longer benefiting, when services are no longer required, when counseling no longer serves the client's needs or interests, when clients do not pay fees charged, or when agency or institution limits do not allow provision of further counseling services. (See A.10.b. and C.2.g.)

A.12. COMPUTER TECHNOLOGY

a. *Use of Computers.*

When computer applications are used in counseling services, counselors ensure that (1) the client is intellectually, emotionally, and physically capable of using the computer application; (2) the computer application is appropriate for the needs of the client; (3) the client understands the purpose and operation of the computer applications; and (4) a follow-up of client use of a computer application is provided to correct possible misconceptions, discover inappropriate use, and assess subsequent needs.

b. *Explanation of Limitations.*

Counselors ensure that clients are provided information as a part of the counseling relationship that adequately explains the limitations of computer technology.

c. *Access to Computer Applications.*

Counselors provide for equal access to computer applications in counseling services. (See A.2.a.)

Section B: Confidentiality

B.1. RIGHT TO PRIVACY

a. *Respect for Privacy.*

Counselors respect their clients' right to privacy and avoid illegal and unwarranted disclosures of confidential information. (See A.3.a. and B.6.a.)

b. *Client Waiver.*

The right to privacy may be waived by the client or their legally recognized representative.

c. *Exceptions.*

The general requirement that counselors keep

information confidential does not apply when disclosure is required to prevent clear and imminent danger to the client or others or when legal requirements demand that confidential information be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception.

d. *Contagious, Fatal Diseases.*

A counselor who receives information confirming that a client has a disease commonly known to be both communicable and fatal is justified in disclosing information to an identifiable third party, who by his or her relationship with the client is at a high risk of contracting the disease. Prior to making a disclosure the counselor should ascertain that the client has not already informed the third party about his or her disease and that the client is not intending to inform the third party in the immediate future. (See B.1.c and B.1.f.)

e. *Court Ordered Disclosure.*

When court ordered to release confidential information without a client's permission, counselors request to the court that the disclosure not be required due to potential harm to the client or counseling relationship. (See B.1.c.)

f. *Minimal Disclosure.*

When circumstances require the disclosure of confidential information, only essential information is revealed. To the extent possible, clients are informed before confidential information is disclosed.

g. *Explanation of Limitations.*

When counseling is initiated and throughout the counseling process as necessary, counselors inform clients of the limitations of confidentiality and identify foreseeable situations in which confidentiality must be breached. (See G.2.a.)

h. *Subordinates.*

Counselors make every effort to ensure that privacy and confidentiality of clients are maintained by subordinates including employees, supervisees, clerical assistants, and volunteers. (See B.1.a.)

i. *Treatment Teams.*

If client treatment will involve a continued review by a treatment team, the client will be informed of the team's existence and composition.

B.2. GROUPS AND FAMILIES

a. *Group Work.*

In group work, counselors clearly define confidentiality and the parameters for the specific group being entered, explain its importance, and discuss the difficulties related to confidentiality involved in group work. The fact that

confidentiality cannot be guaranteed is clearly communicated to group members

b. Family Counseling.

In family counseling, information about one family member cannot be disclosed to another member without permission. Counselors protect the privacy rights of each family member. (See A.8., B.3., and B.4.d.)

B.3 MINOR OR INCOMPETENT CLIENTS

When counseling clients who are minors or individuals who are unable to give voluntary, informed consent, parents or guardians may be included in the counseling process as appropriate. Counselors act in the best interests of clients and take measures to safeguard confidentiality. (See A.3.c.)

B.4. RECORDS

a. Requirement of Records.

Counselors maintain records necessary for rendering professional services to their clients and as required by laws, regulations, or agency or institution procedures.

b. Confidentiality of Records.

Counselors are responsible for securing the safety and confidentiality of any counseling records they create, maintain, transfer, or destroy whether the records are written, taped, computerized, or stored in any other medium. (See B.1.a.)

c. Permission to Record or Observe.

Counselors obtain permission from clients prior to electronically recording or observing sessions. (See A.3.a.)

d. Client Access.

Counselors recognize that counseling records are kept for the benefit of clients and, therefore, provide access to records and copies of records when requested by competent clients unless the records contain information that may be misleading and detrimental to the client. In situations involving multiple clients, access to records is limited to those parts of records that do not include confidential information related to another client. (See A.8., B.1.a., and B.2.b.)

e. Disclosure or Transfer.

Counselors obtain written permission from clients to disclose or transfer records to legitimate third parties unless exceptions to confidentiality exist as listed in Section B.1. Steps are taken to ensure that receivers of counseling records are sensitive to their confidential nature.

B.5. RESEARCH AND TRAINING

a. Data Disguise Required.

Use of data derived from counseling relationships for purposes of training, research, or publication is confined to content that is disguised to ensure the anonymity of the individuals involved. (See B.1.g. and G.3.d.)

b. Agreement for Identification.

Identification of a client in a presentation or publication is permissible only when the client has reviewed the material and has agreed to its presentation or publication. (See G.3.d.)

B.6. CONSULTATION

a. Respect for Privacy.

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

b. Cooperating Agencies.

Before sharing information, counselors make efforts to ensure that there are defined policies in other agencies serving the counselor's clients that effectively protect the confidentiality of information.

Professional Responsibility

C.1. STANDARDS KNOWLEDGE

Counselors have a responsibility to read, understand, and follow the Code of Ethics and the Standards of Practice.

C.2. PROFESSIONAL COMPETENCE

a. Boundaries of Competence.

Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors will demonstrate a commitment to gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population.

b. New Specialty Areas of Practice.

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

c. Qualified for Employment.

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

d. Monitor Effectiveness.

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

e. Ethical Issues Consultation.

Counselors take reasonable steps to consult with other counselors or related professionals when they have questions regarding their ethical obligations or professional practice. (See H.1)

f. Continuing Education.

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

g. Impairment.

Counselors refrain from offering or accepting professional services when their physical, mental or emotional problems are likely to harm a client or others. They are alert to the signs of impairment, seek assistance for problems, and, if necessary, limit, suspend, or terminate their professional responsibilities. (See A.11.c.)

C.3. ADVERTISING AND SOLICITING CLIENTS

a. Accurate Advertising.

There are no restrictions on advertising by counselors except those that can be specifically justified to protect the public from deceptive practices. Counselors advertise or represent their services to the public by identifying their credentials in an accurate manner that is not false, misleading, deceptive, or fraudulent. Counselors may only advertise the highest degree earned which is in counseling or a closely related field from a college or university that was accredited when the degree was awarded by one of the regional accrediting bodies recognized by the Council for Higher Education Accreditation.

b. Testimonials.

Counselors who use testimonials do not solicit them from clients or other persons who, because

of their particular circumstances, may be vulnerable to undue influence.

c. Statements by Others.

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

d. Recruiting Through Employment.

Counselors do not use their places of employment or institutional affiliation to recruit or gain clients, supervisees, or consultees for their private practices. (See C.5.e.)

e. Products and Training Advertisements.

Counselors who develop products related to their profession or conduct workshops or training events ensure that the advertisements concerning these products or events are accurate and disclose adequate information for consumers to make informed choices.

f. Promoting to Those Served.

Counselors do not use counseling, teaching, training, or supervisory relationships to promote their products or training events in a manner that is deceptive or would exert undue influence on individuals who may be vulnerable. Counselors may adopt textbooks they have authored for instruction purposes.

g. Professional Association Involvement.

Counselors actively participate in local, state, and national associations that foster the development and improvement of counseling.

C.4. CREDENTIALS

a. Credentials Claimed.

Counselors claim or imply only professional credentials possessed and are responsible for correcting any known misrepresentations of their credentials by others. Professional credentials include graduate degrees in counseling or closely related mental health fields, accreditation of graduate programs, national voluntary certifications, government-issued certifications or licenses, ACA professional membership, or any other credential that might indicate to the public specialized knowledge or expertise in counseling.

b. ACA Professional Membership.

ACA professional members may announce to the public their membership status. Regular members may not announce their ACA membership in a manner that might imply they are credentialled counselors.

c. Credential Guidelines.

Counselors follow the guidelines for use of credentials that have been established by the entities that issue the credentials.

d. Misrepresentation of Credentials.

Counselors do not attribute more to their credentials than the credentials represent and do not imply that other counselors are not qualified because they do not possess certain credentials.

e. Doctoral Degrees From Other Fields.

Counselors who hold a master's degree in counseling or a closely related mental health field but hold a doctoral degree from other than counseling or a closely related field do not use the title, "Dr.," in their practices and do not announce to the public in relation to their practice or status as a counselor that they hold a doctorate.

C.5. PUBLIC RESPONSIBILITY

a. Nondiscrimination.

Counselors do not discriminate against clients, students, or supervisees in a manner that has a negative impact based on their age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, or socioeconomic status, or for any other reason. (See A.2.a.)

b. Sexual Harassment.

Counselors do not engage in sexual harassment. Sexual harassment is defined as sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with professional activities or roles, and that either (1) is unwelcome, is offensive, or creates a hostile workplace environment, and counselors know or are told this; or (2) is sufficiently severe or intense to be perceived as harassment to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or multiple persistent or pervasive acts.

c. Reports to Third Parties.

Counselors are accurate, honest, and unbiased in reporting their professional activities and judgments to appropriate third parties including courts, health insurance companies, those who are the recipients of evaluation reports, and others. (See B.1.g.)

d. Media Presentations.

When counselors provide advice or comment by means of public lectures, demonstrations, radio or television programs, prerecorded tapes, printed articles, mailed material, or other media, they take reasonable precautions to ensure that (1) the statements are based on appropriate professional counseling literature and practice; (2) the statements are otherwise consistent with the Code of Ethics and the Standards of Practice; and (3) the recipients of the information are not encouraged to infer that a professional counseling relationship has been established. (See C.6.b.)

e. Unjustified Gains.

Counselors do not use their professional positions to seek or receive unjustified personal gains, sexual favors, unfair advantage, or unearned goods or services. (See C.3.d.)

C.6. RESPONSIBILITY TO OTHER PROFESSIONALS

a. Different Approaches.

Counselors are respectful of approaches to professional counseling that differ from their own. Counselors know and take into account the traditions and practices of other professional groups with which they work.

b. Personal Public Statements.

When making personal statements in a public context, counselors clarify that they are speaking from their personal perspectives and that they are not speaking on behalf of all counselors or the profession. (See C.5.d.)

c. Clients Served by Others.

When counselors learn that their clients are in a professional relationship with another mental health professional, they request release from clients to inform the other professionals and strive to establish positive and collaborative professional relationships. (See A.4.)

**Section D:
Relationships With Other
Professionals**

D.1. RELATIONSHIPS WITH EMPLOYERS AND EMPLOYEES

a. Role Definition.

Counselors define and describe for their employers and employees the parameters and levels of their professional roles.

b. Agreements.

Counselors establish working agreements with supervisors, colleagues, and subordinates regarding counseling or clinical relationships, confidentiality, adherence to professional standards, distinction between public and private material, maintenance and dissemination of recorded information, workload, and accountability. Working agreements in each instance are specified and made known to those concerned.

c. Negative Conditions.

Counselors alert their employers to conditions that may be potentially disruptive or damaging to the counselor's professional responsibilities or that may limit their effectiveness.

d. Evaluation.

Counselors submit regularly to professional review and evaluation by their supervisor or the appropriate representative of the employer.

c. In-Service.

Counselors are responsible for in-service development of self and staff.

f. Goals.

Counselors inform their staff of goals and programs.

g. Practices.

Counselors provide personnel and agency practices that respect and enhance the rights and welfare of each employee and recipient of agency services. Counselors strive to maintain the highest levels of professional services.

h. Personnel Selection and Assignment.

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

i. Discrimination.

Counselors, as either employers or employees, do not engage in or condone practices that are inhumane, illegal, or unjustifiable (such as considerations based on age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, or socioeconomic status) in hiring, promotion, or training. (See A.2.a. and C.5.b.)

j. Professional Conduct.

Counselors have a responsibility both to clients and to the agency or institution within which services are performed to maintain high standards of professional conduct.

k. Exploitive Relationships.

Counselors do not engage in exploitive relationships with individuals over whom they have supervisory, evaluative, or instructional control or authority.

l. Employer Policies.

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

D.2. CONSULTATION (See B.6.)

a. Consultation as an Option.

Counselors may choose to consult with any other professionally competent persons about their clients. In choosing consultants, counselors avoid placing the consultant in a conflict of interest situation that would preclude the consultant being a proper party to the counselor's efforts to help the client. Should counselors be engaged in a work setting that compromises this consultation standard, they consult with other professionals whenever possible to consider justifiable alternatives.

b. Consultant Competency.

Counselors are reasonably certain that they have or the organization represented has the necessary competencies and resources for giving the kind of consulting services needed and that appropriate referral resources are available.

c. Understanding with Clients.

When providing consultation, counselors attempt to develop with their clients a clear understanding of problem definition, goals for change, and predicted consequences of interventions selected.

d. Consultant Goals.

The consulting relationship is one in which client adaptability and growth toward self-direction are consistently encouraged and cultivated. (See A.1.b.)

D.3. FEES FOR REFERRAL

a. Accepting Fees from Agency Clients.

Counselors refuse a private fee or other remuneration for rendering services to persons who are entitled to such services through the counselor's employing agency or institution. The policies of a particular agency may make explicit provisions for agency clients to receive counseling services from members of its staff in private practice. In such instances, the clients must be informed of other options open to them should they seek private counseling services. (See A.10.a., A.11.b., and C.3.d.)

b. Referral Fees.

Counselors do not accept a referral fee from other professionals.

D.4. SUBCONTRACTOR ARRANGEMENTS

When counselors work as subcontractors for counseling services for a third party, they have a duty to inform clients of the limitations of confidentiality that the organization may place on counselors in providing counseling services to clients. The limits of such confidentiality ordinarily are discussed as part of the intake session. (See B.1.e. and B.1.f.)

Section E:
**Evaluation, Assessment,
and Interpretation**

E.1. General

a. Appraisal Techniques.

The primary purpose of educational and psychological assessment is to provide measures that are objective and interpretable in either comparative or absolute terms. Counselors recognize the need to interpret the statements in this section as applying to the whole range of

appraisal techniques including test and nontest data.

b. Client Welfare.

Counselors promote the welfare and best interests of the client in the development, publication, and utilization of educational and psychological assessment techniques. They do not misuse assessment results and interpretations and take reasonable steps to prevent others from misusing the information these techniques provide. They respect the client's right to know the results, the interpretations made, and the basis for their conclusions and recommendations.

E.2. COMPETENCE TO USE AND INTERPRET TESTS

a. Limits of Competence.

Counselors recognize the limits of their competence and perform only those testing and assessment services for which they have been trained. They are familiar with reliability, validity, related standardization, error of measurement, and proper application of any technique utilized. Counselors using computer-based test interpretations are trained in the construct being measured and the specific instrument being used prior to using this type of computer application. Counselors take reasonable measures to ensure the proper use of psychological assessment techniques by persons under their supervision.

b. Appropriate Use.

Counselors are responsible for the appropriate application, scoring, interpretation, and use of assessment instruments whether they score and interpret such tests themselves or use computerized or other services.

c. Decisions Based on Results.

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

d. Accurate Information.

Counselors provide accurate information and avoid false claims or misconceptions when making statements about assessment instruments or techniques. Special efforts are made to avoid unwarranted connotations of such terms as IQ and grade equivalent scores. (See C.5.c.)

E.3. INFORMED CONSENT

a. Explanation to Clients.

Prior to assessment, counselors explain the nature and purposes of assessment and the specific use of results in language the client (or other legally authorized person on behalf of the client) can understand unless an explicit excep-

tion to this right has been agreed upon in advance. Regardless of whether scoring and interpretation are completed by counselors, by assistants, or by computer or other outside services, counselors take reasonable steps to ensure that appropriate explanations are given to the client.

b. Recipients of Results.

The examinee's welfare, explicit understanding, and prior agreement determine the recipients of test results. Counselors include accurate and appropriate interpretations with any release of individual or group test results. (See B.1.a. and C.5.c.)

E.4. RELEASE OF INFORMATION TO COMPETENT PROFESSIONALS

a. Misuse of Results.

Counselors do not misuse assessment results, including test results, and interpretations and take reasonable steps to prevent the misuse of such by others. (See C.5.c.)

b. Release of Raw Data.

Counselors ordinarily release data (e.g. protocols, counseling or interview notes, or questionnaires) in which the client is identified only with the consent of the client or the client's legal representative. Such data are usually released only to persons recognized by counselors as competent to interpret the data. (See B.1.a.)

E.5. PROPER DIAGNOSIS OF MENTAL DISORDERS

a. Proper Diagnosis.

Counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interview) used to determine client care (e.g., locus of treatment, type of treatment, or recommended follow-up) are carefully selected and appropriately used. (See A.3.a. and C.5.c.)

b. Cultural Sensitivity.

Counselors recognize that culture affects the manner in which clients' problems are defined. Clients' socioeconomic and cultural experience is considered when diagnosing mental disorders.

E.6. TEST SELECTION

a. Appropriateness of Instruments.

Counselors carefully consider the validity, reliability, psychometric limitations, and appropriateness of instruments when selecting tests for use in a given situation or with a particular client.

b. Culturally Diverse Populations.

Counselors are cautious when selecting tests for culturally diverse populations to avoid inappropriateness of testing that may be outside of socialized behavioral or cognitive patterns.

E.7. CONDITIONS OF TEST ADMINISTRATION

a. Administration Conditions.

Counselors administer tests under the same conditions that were established in their standardization. When tests are not administered under standard conditions or when unusual behavior or irregularities occur during the testing session, those conditions are noted in interpretation, and the results may be designated as invalid or of questionable validity.

b. Computer Administration.

Counselors are responsible for ensuring that administration programs function properly to provide clients with accurate results when a computer or other electronic methods are used for test administration. (See A.12.b.)

c. Unsupervised Test-Taking.

Counselors do not permit unsupervised or inadequately supervised use of tests or assessments unless the tests or assessments are designed, intended, and validated for self-administration and/or scoring.

d. Disclosure of Favorable Conditions.

Prior to test administration, conditions that produce most favorable test results are made known to the examinee.

E.8. DIVERSITY IN TESTING

Counselors are cautious in using assessment techniques, making evaluations, and interpreting the performance of populations not represented in the norm group on which an instrument was standardized. They recognize the effects of age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, and socioeconomic status on test administration and interpretation and place test results in proper perspective with other relevant factors. (See A.2.a.)

E.9. TEST SCORING AND INTERPRETATION

a. Reporting Reservations.

In reporting assessment results, counselors indicate any reservations that exist regarding validity or reliability because of the circumstances of the assessment or the inappropriateness of the norms for the person tested.

b. Research Instruments.

Counselors exercise caution when interpreting the results of research instruments possessing insufficient technical data to support respondent results. The specific purposes for the use of such instruments are stated explicitly to the examinee.

c. Testing Services.

Counselors who provide test scoring and test interpretation services to support the assessment

process confirm the validity of such interpretations. They accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use. The public offering of an automated test interpretations service is considered a professional-to-professional consultation. The formal responsibility of the consultant is to the consultee, but the ultimate and overriding responsibility is to the client.

E.10. TEST SECURITY

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

E.11. OBSOLETE TESTS AND OUTDATED TEST RESULTS

Counselors do not use data or test results that are obsolete or outdated for the current purpose. Counselors make every effort to prevent the misuse of obsolete measures and test data by others.

E.12. TEST CONSTRUCTION

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

**Section F:
Teaching, Training,
and Supervision**

F.1. COUNSELOR EDUCATORS AND TRAINERS

a. Educators as Teachers and Practitioners.

Counselors who are responsible for developing, implementing, and supervising educational programs are skilled as teachers and practitioners. They are knowledgeable regarding the ethical, legal, and regulatory aspects of the profession, are skilled in applying that knowledge, and make students and supervisees aware of their responsibilities. Counselors conduct counselor education and training programs in an ethical manner and serve as role models for professional behavior. Counselor educators should make an effort to infuse material related to human diversity into all courses and/or workshops that are designed to promote the development of professional counselors.

b. Relationship Boundaries with Students and Supervisees.

Counselors clearly define and maintain ethical, professional, and social relationship boundaries with their students and supervisees. They are aware of the differential in power that exists and the student's or supervisee's possible incomprehension of that power differential. Counselors explain to students and supervisees the potential for the relationship to become exploitive.

c. Sexual Relationships.

Counselors do not engage in sexual relationships with students or supervisees and do not subject them to sexual harassment. (See A.6. and C.5.b)

d. Contributions to Research.

Counselors give credit to students or supervisees for their contributions to research and scholarly projects. Credit is given through coauthorship, acknowledgment, footnote statement, or other appropriate means in accordance with such contributions. (See G.4.b. and G.4.c.)

e. Close Relatives.

Counselors do not accept close relatives as students or supervisees.

f. Supervision Preparation.

Counselors who offer clinical supervision services are adequately prepared in supervision methods and techniques. Counselors who are doctoral students serving as practicum or internship supervisors to master's level students are adequately prepared and supervised by the training program.

g. Responsibility for Services to Clients.

Counselors who supervise the counseling services of others take reasonable measures to ensure that counseling services provided to clients are professional.

h. Endorsement.

Counselors do not endorse students or supervisees for certification, licensure, employment, or completion of an academic or training program if they believe students or supervisees are not qualified for the endorsement. Counselors take reasonable steps to assist students or supervisees who are not qualified for endorsement to become qualified.

E.2. COUNSELOR EDUCATION AND TRAINING PROGRAMS

a. Orientation.

Prior to admission, counselors orient prospective students to the counselor education or training program's expectations including but not limited to the following: (1) the type and level of skill acquisition required for successful completion of the training, (2) subject matter to be covered, (3) basis for evaluation, (4) training components that encourage self-growth or self-disclosure as part of the training process, (5) the type of supervision settings

and requirements of the sites for required clinical field experiences, (6) student and supervisee evaluation and dismissal policies and procedures, and (7) up-to-date employment prospects for graduates.

b. Integration of Study and Practice.

Counselors establish counselor education and training programs that integrate academic study and supervised practice.

c. Evaluation.

Counselors clearly state to students and supervisees, in advance of training, the levels of competency expected, appraisal methods, and timing of evaluations for both didactic and experiential components. Counselors provide students and supervisees with periodic performance appraisal and evaluation feedback throughout the training program.

d. Teaching Ethics.

Counselors make students and supervisees aware of the ethical responsibilities and standards of the profession and the students' and supervisees' ethical responsibilities to the profession. (See C.1. and F.3.e.)

e. Peer Relationships.

When students or supervisees are assigned to lead counseling groups or provide clinical supervision for their peers, counselors take steps to ensure that students and supervisees placed in these roles do not have personal or adverse relationships with peers and that they understand they have the same ethical obligations as counselor educators, trainers, and supervisors. Counselors make every effort to ensure that the rights of peers are not compromised when students or supervisees are assigned to lead counseling groups or provide clinical supervision.

f. Varied Theoretical Positions.

Counselors present varied theoretical positions so that students and supervisees may make comparisons and have opportunities to develop their own positions. Counselors provide information concerning the scientific basis of professional practice. (See C.6.a.)

g. Field Placements.

Counselors develop clear policies within their training program regarding field placement and other clinical experiences. Counselors provide clearly stated roles and responsibilities for the student or supervisee, the site supervisor, and the program supervisor. They confirm that site supervisors are qualified to provide supervision and are informed of their professional and ethical responsibilities in this role.

h. Dual Relationships as Supervisors.

Counselors avoid dual relationships, such as performing the role of site supervisor and training

program supervisor in the student's or supervisee's training program. Counselors do not accept any form of professional services, fees, commissions, reimbursement, or remuneration from a site for student or supervisee placement.

i. Diversity in Programs.

Counselors are responsive to their institution's and programs recruitment and retention needs for training program administrators, faculty, and students with diverse backgrounds and special needs. (See A.2.a.)

F.3. STUDENTS AND SUPERVISEES

a. Limitations.

Counselors, through ongoing evaluation and appraisal, are aware of the academic and personal limitations of students and supervisees that might impede performance. Counselors assist students and supervisees in securing remedial assistance when needed and dismiss from the training program supervisees who are unable to provide competent service due to academic or personal limitations. Counselors seek professional consultation and document their decision to dismiss or refer students or supervisees for assistance. Counselors assure that students and supervisees have recourse to address decisions made, to require them to seek assistance, or to dismiss them.

b. Self-Growth Experiences.

Counselors use professional judgment when designing training experiences conducted by the counselors themselves that require student and supervisee self-growth or self-disclosure. Safeguards are provided so that students and supervisees are aware of the ramifications their self-disclosure may have on counselors whose primary role as teacher, trainer, or supervisor requires acting on ethical obligations to the profession. Evaluative components of experiential training experiences explicitly delineate predetermined academic standards that are separate and not dependent on the student's level of self-disclosure. (See A.6.)

c. Counseling for Students and Supervisees.

If students or supervisees request counseling, supervisors or counselor educators provide them with acceptable referrals. Supervisors or counselor educators do not serve as counselor to students or supervisees over whom they hold administrative, teaching, or evaluative roles unless this is a brief role associated with a training experience. (See A.6.b.)

d. Clients of Students and Supervisees.

Counselors make every effort to ensure that the clients at field placements are aware of the services rendered and the qualifications of the students and supervisees rendering those services. Clients receive professional disclosure information and are informed of the limits of

confidentiality. Client permission is obtained in order for the students and supervisees to use any information concerning the counseling relationship in the training process. (See B.1.e.)

c. Standards for Students and Supervisees.

Students and supervisees preparing to become counselors adhere to the Code of Ethics and the Standards of Practice. Students and supervisees have the same obligations to clients as those required of counselors. (See H.1.)

Section G:

Research and Publication

G.1. RESEARCH RESPONSIBILITIES

a. Use of Human Subjects.

Counselors plan, design, conduct, and report research in a manner consistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research with human subjects. Counselors design and conduct research that reflects cultural sensitivity appropriateness.

b. Deviation from Standard Practices.

Counselors seek consultation and observe stringent safeguards to protect the rights of research participants when a research problem suggests a deviation from standard acceptable practices. (See B.6.)

c. Precautions to Avoid Injury.

Counselors who conduct research with human subjects are responsible for the subjects' welfare throughout the experiment and take reasonable precautions to avoid causing injurious psychological, physical, or social effects to their subjects.

d. Principal Researcher Responsibility.

The ultimate responsibility for ethical research practice lies with the principal researcher. All others involved in the research activities share ethical obligations and full responsibility for their own actions.

e. Minimal Interference.

Counselors take reasonable precautions to avoid causing disruptions in subjects' lives due to participation in research.

f. Diversity.

Counselors are sensitive to diversity and research issues with special populations. They seek consultation when appropriate. (See A.2.a. and B.6.)

G.2. INFORMED CONSENT

a. Topics Disclosed.

In obtaining informed consent for research, counselors use language that is understandable to research participants and that (1) accu-

rately explains the purpose and procedures to be followed; (2) identifies any procedures that are experimental or relatively untried; (3) describes the attendant discomforts and risks; (4) describes the benefits or changes in individuals or organizations that might be reasonably expected; (5) discloses appropriate alternative procedures that would be advantageous for subjects; (6) offers to answer any inquiries concerning the procedures; (7) describes any limitations on confidentiality; and (8) instructs that subjects are free to withdraw their consent and to discontinue participation in the project at any time. (See B.1.f.)

b. Deception.

Counselors do not conduct research involving deception unless alternative procedures are not feasible and the prospective value of the research justifies the deception. When the methodological requirements of a study necessitate concealment or deception, the investigator is required to explain clearly the reasons for this action as soon as possible.

c. Voluntary Participation.

Participation in research is typically voluntary and without any penalty for refusal to participate. Involuntary participation is appropriate only when it can be demonstrated that participation will have no harmful effects on subjects and is essential to the investigation.

d. Confidentiality of Information.

Information obtained about research participants during the course of an investigation is confidential. When the possibility exists that others may obtain access to such information, ethical research practice requires that the possibility, together with the plans for protecting confidentiality, be explained to participants as a part of the procedure for obtaining informed consent. (See B.1.e.)

e. Persons Incapable of Giving Informed Consent.

When a person is incapable of giving informed consent, counselors provide an appropriate explanation, obtain agreement for participation and obtain appropriate consent from a legally authorized person.

f. Commitments to Participants.

Counselors take reasonable measures to honor all commitments to research participants.

g. Explanations After Data Collection.

After data are collected, counselors provide participants with full clarification of the nature of the study to remove any misconceptions. Where scientific or human values justify delaying or withholding information, counselors take reasonable measures to avoid causing harm.

h. Agreements to Cooperate.

Counselors who agree to cooperate with another

individual in research or publication incur an obligation to cooperate as promised in terms of punctuality of performance and with regard to the completeness and accuracy of the information required.

i. Informed Consent for Sponsors.

In the pursuit of research, counselors give sponsors, institutions, and publication channels the same respect and opportunity for giving informed consent that they accord to individual research participants. Counselors are aware of their obligation to future research workers and ensure that host institutions are given feedback information and proper acknowledgment.

G.3. REPORTING RESULTS

a. Information Affecting Outcome.

When reporting research results, counselors explicitly mention all variables and conditions known to the investigator that may have affected the outcome of a study or the interpretation of data.

b. Accurate Results.

Counselors plan, conduct, and report research accurately and in a manner that minimizes the possibility that results will be misleading. They provide thorough discussions of the limitations of their data and alternative hypotheses. Counselors do not engage in fraudulent research, distort data, misrepresent data, or deliberately bias their results.

c. Obligation to Report Unfavorable Results.

Counselors communicate to other counselors the results of any research judged to be of professional value. Results that reflect unfavorably on institutions, programs, services, prevailing opinions, or vested interests are not withheld.

d. Identity of Subjects.

Counselors who supply data, aid in the research of another person, report research results, or make original data available take due care to disguise the identity of respective subjects in the absence of specific authorization from the subjects to do otherwise. (See B.1.g. and B.5.a.)

e. Replication Studies.

Counselors are obligated to make available sufficient original research data to qualified professionals who may wish to replicate the study.

G.4. PUBLICATION

a. Recognition of Others.

When conducting and reporting research, counselors are familiar with and give recognition to previous work on the topic, observe copyright laws, and give full credit to those to whom credit is due. (See E.1.d. and G.4.c.)

b. Contributors.

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

c. Student Research.

For an article that is substantially based on a student's dissertation or thesis, the student is listed as the principal author. (See F.1.d. and G.4.a.)

d. Duplicate Submission.

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

e. Professional Review.

Counselors who review material submitted for publication, research, or other scholarly purposes respect the confidentiality and proprietary rights of those who submitted it.

**Section H:
Resolving Ethical Issues**

H.1. KNOWLEDGE OF STANDARDS

Counselors are familiar with the Code of Ethics and the Standards of Practice and other applicable ethics codes from other professional organizations of which they are member or from certification and licensure bodies. Lack of knowledge or misunderstanding of an ethical responsibility is not a defense against a charge of unethical conduct. (See E.3.e.)

H.2. SUSPECTED VIOLATIONS

a. Ethical Behavior Expected.

Counselors expect professional associates to adhere to Code of Ethics. When counselors possess reasonable cause that raises doubts as to whether a counselor is acting in an ethical manner, they take appropriate action. (See H.2.d. and H.2.e.)

b. Consultation.

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

c. Organization Conflicts.

If the demands of an organization with which counselors are affiliated pose a conflict with Code of Ethics, counselors specify the nature of such conflicts and express to their supervisors or other responsible officials their commitment

to Code of Ethics. When possible, counselors work toward change within the organization to allow full adherence to Code of Ethics.

d. Informal Resolution.

When counselors have reasonable cause to believe that another counselor is violating an ethical standard, they attempt to first resolve the issue informally with the other counselor if feasible providing that such action does not violate confidentiality rights that may be involved.

e. Reporting Suspected Violations.

When an informal resolution is not appropriate or feasible, counselors, upon reasonable cause, take action, such as reporting the suspected ethical violation to state or national ethics committees, unless this action conflicts with confidentiality rights that cannot be resolved.

f. Unwarranted Complaints.

Counselors do not initiate, participate in, or encourage the filing of ethics complaints that are unwarranted or intend to harm a counselor rather than to protect clients or the public.

H.3. COOPERATION WITH ETHICS COMMITTEES

Counselors assist in the process of enforcing Code of Ethics. Counselors cooperate with investigations, proceedings, and requirements of the ACA Ethics Committee or ethics committees of other duly constituted associations or boards having jurisdiction over those charged with a violation. Counselors are familiar with the ACA Policies and Procedures and use it as a reference in assisting the enforcement of the Code of Ethics.

Approved by the ACA Governing Council,
October 1999

These guidelines establish appropriate standards for the use of electronic communications over the Internet to provide on-line counseling services, and should be used only in conjunction with the latest ACA Code of Ethics & Standards of Practice.

Confidentiality

1. PRIVACY INFORMATION

Professional counselors ensure that clients are provided sufficient information to adequately address and explain the limitations of (i) computer technology in the counseling process in general and (ii) the difficulties of ensuring complete client confidentiality of information transmitted through electronic communications over the Internet through on-line counseling. (See A.12.a., B.1.a., B.1.g.)

a. Secured Sites.

To mitigate the risk of potential breaches of confidentiality, professional counselors provide one-on-one on-line counseling only through "secure" Web sites or e-mail communications applications which use appropriate encryption technology designed to protect the transmission of confidential information from access by unauthorized third parties.

b. Non-Secured Sites.

To mitigate the risk of potential breaches of confidentiality, professional counselors provide only general information from "non-secure" Web sites or e-mail communications applications.

c. General Information.

Professional counselors may provide general information from either "secure" or "non-secure" Web sites, or through e-mail communications. General information includes non-client-specific, topical information on matters of general interest to the professional counselor's clients as a whole, third-party resource and referral information, addresses and phone numbers, and the like. Additionally, professional counselors using either "secure" or "non-secure" Web sites may provide "hot links" to third-party Web sites such as licensure boards, certification bodies, and other resource information providers. Professional counselors investigate and continually update the content, accuracy

and appropriateness for the client of material contained in any "hot links" to third-party Web sites.

d. Limits of Confidentiality.

Professional counselors inform clients of the limitations of confidentiality and identify foreseeable situations in which confidentiality must be breached in light of the law in both the state in which the client is located and the state in which the professional counselor is licensed.

2. INFORMATIONAL NOTICES

a. Security of Professional Counselor's Site.

Professional counselors provide a readily visible notice that (i) information transmitted over a Web site or e-mail server may not be secure; (ii) whether or not the professional counselor's site is secure; (iii) whether the information transmitted between the professional counselor and the client during on-line counseling will be encrypted; and (iv) whether the client will need special software to access and transmit confidential information and, if so, whether the professional counselor provides the software as part of the on-line counseling services. The notice should be viewable from all Web site and e-mail locations from which the client may send information. (See B.1.g.)

b. Professional Counselor Identification.

Professional counselors provide a readily visible notice advising clients of the identities of all professional counselor(s) who will have access to the information transmitted by the client and, in the event that more than one professional counselor has access to the Web site or e-mail system, the manner, if any, in which the client may direct information to a particular professional counselor. Professional counselors inform clients if any or all of the sessions are supervised. Clients are also informed if and how the supervisor preserves session transcripts. Professional counselors provide background information on all professional counselor(s) and supervisor(s) with access to the on-line communications, including education, licensure and certification, and practice area information. (See B.1.g.)

c. Client Identification.

Professional counselors identify clients, verify identities of clients, and obtain alternative methods of contacting clients in emergency situations.

3. CLIENT WAIVER

Professional counselors require clients to execute client waiver agreements stating that the client (i) acknowledges the limitations inherent in ensuring client confidentiality of information transmitted through on-line counseling and (ii) agrees to waive the client's privilege of confidentiality with respect to any confidential information transmitted through on-line counseling that may be accessed by any third party without authorization of the client and despite the reasonable efforts of the professional counselor to arrange a secure on-line environment. Professional counselors refer clients to more traditional methods of counseling and do not provide on-line counseling services if the client is unable or unwilling to consent to the client waiver. (See B.1.b.)

4. RECORDS OF ELECTRONIC COMMUNICATIONS

Professional counselors maintain appropriate procedures for ensuring the safety and confidentiality of client information acquired through electronic communications, including but not limited to encryption software; proprietary on-site file servers with fire walls; saving on-line or e-mail communications to the hard drive or file server computer systems; creating regular tape or diskette back-up copies; creating hard-copies of all electronic communications; and the like. Clients are informed about the length of time for, and method of, preserving session transcripts. Professional counselors warn clients of the possibility or frequency of technology failures and time delays in transmitting and receiving information. (See B.4.a., B.4.b.)

5. ELECTRONIC TRANSFER OF CLIENT INFORMATION

Professional counselors electronically transfer client confidential information to authorized third-party recipients only when (i) both the professional counselor and the authorized recipient have "secure" transfer and acceptance communication capabilities, (ii) the recipient is able to effectively protect the confidentiality of the client confidential information to be transferred; and (iii) the informed written consent of the client, acknowledging the limits of confidentiality, has been obtained. (See B.4.e., B.6.a., B.6.b.)

Establishing the On-Line Counseling Relationship

1. THE APPROPRIATENESS OF ON-LINE COUNSELING

Professional counselors develop an appropriate in-take procedure for potential clients to determine whether on-line counseling is appropriate for the needs of the client. Professional counselors warn potential clients that on-line counseling services may not be appropriate in certain situations and, to the extent possible, informs the client of specific limitations, potential risks, and/or potential benefits relevant to the client's anticipated use of on-line counseling services. Professional counselors ensure that clients are intellectually, emotionally, and physically capable of using the on-line counseling services, and of understanding the potential risks and/or limitations of such services. (See A.3.a., A.3.b.)

2. COUNSELING PLANS

Professional counselors develop individual on-line counseling plans that are consistent with both the client's individual circumstances and the limitations of on-line counseling. Professional counselors shall specifically take into account the limitations, if any, on the use of any or all of the following in on-line counseling: initial client appraisal, diagnosis, and assessment methods employed by the professional counselor. Professional counselors who determine that on-line counseling is inappropriate for the client should avoid entering into or immediately terminate the on-line counseling relationship and encourage the client to continue the counseling relationship through an appropriate alternative method of counseling. (See A.11.b., A.11.c.)

3. CONTINUING COVERAGE

Professional counselors provide clients with a schedule of times during which the on-line counseling services will be available, including reasonable anticipated response times, and provide clients with an alternate means of contacting the professional counselor at other times, including in the event of emergencies. Professional counselors obtain from, and provide clients with, alternative means of communication, such as telephone numbers or pager numbers, for back-up purposes in the event the on-line counseling service is unavailable for any reason. Professional counselors provide clients with the name of at least one other professional counselor who will be able to respond to the client in the event the professional counselor is unable to do so for any extended period of time. (See A.11.a.)

4. BOUNDARIES OF COMPETENCE

Professional counselors provide on-line counseling services only in practice areas within their expertise and do not provide on-line counseling services to clients located in states in which professional counselors are not licensed. (See C.2.a., C.2.b.)

5. MINOR OR INCOMPETENT CLIENTS

Professional counselors must verify that clients are above the age of minority, are competent to enter into the counseling relationship with a professional counselor, and are able to give informed consent. In the event clients are minor children, incompetent, or incapable of giving informed consent, professional counselors must obtain the written consent of the legal guardian or other authorized legal representative of the client prior to commencing on-line counseling services to the client.

Legal Considerations

Professional counselors confirm that their liability insurance provides coverage for on-line counseling services, and that the provision of such services is not prohibited by or otherwise violate any applicable (i) state or local statutes, rules, regulations, or ordinances; (ii) codes of professional membership organizations and certifying boards; and/or (iii) codes of state licensing boards.

Professional counselors seek appropriate legal and technical assistance in the development and implementation of their on-line counseling services.