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Professional and Ethical Standards of Case Management[1]

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Ethics

Socrates devoted the better part of his life defining and better understanding moral values within a cultural context and extending those values more broadly into the study of ethics. As such, he laid the foundation of our understanding of an ethic as defined as "a set of principals of right conduct" and "the study of the general nature of morals and of the specific moral choices to be made by a person." (Houghton 2009) So what does this mean to you, the reader today and how can you apply ethics to your study and practice in the field of Recovery?

Purpose of Standards

Imagine a world with no laws or rules by which to govern. If you are a real thrill seeker, this may sound exciting to you. However, for most we rely heavily on rules to give us guidance and a sense of safety and security. I once traveled to China to study the culture and language. It was a wonderful experience that I would highly recommend. However, beware of driving or even riding a bike for that matter. The traffic is a nightmare. There are no traffic signals! For a country with one-sixth of the earth's population, can you imagine driving there with no traffic signals? How would you know when to stop for others or when you have the right of way? In most cities, cars driving opposite the flow of the intersection simply begin advancing together slowly until they "choke off" the opposite flow and then it is their turn until they experience the same. Can you imagine living in a major metropolitan area in which there were little or no rules to driving? There would be complete chaos. The same is true for professional fields of practice. The establishment of ethics as "a set of principals" allows for the proper governance of the field and establishes a standard of care that protects both the professional and client alike. The remainder of this article will discuss several important issues in the study of Professional & Ethical Standards of Case Management and Counseling in the Addiction Treatment Professions. While its intent is to be thorough in the discussion matter, it is not intended to be all-inclusive. The best advice to offer is, when in doubt, consult with your clinical supervisor, your Drug & Alcohol Certifying Board, the California Board of Behavioral Sciences or other relevant parties as the situation may mandate.

Confidentiality

All clients are afforded the right to know that the information disclosed by them whether in a counseling session or in a medical office is strictly confidential. To better understand how we can protect our client's confidentiality, we must begin to fully understand the boundaries and limitations of confidentiality in a treatment environment. Two overarching laws and regulations offer us guidance. The first is the Health Insurance Portability & Accountability Act (HIPAA) of which most of us know. The second is 42 Code of Federal Regulations Part 2 which is largely unknown. HIPAA was designed with four major purposes in mind. The first was to protect the privacy of a patient's personal and health information. The second was to provide for the physical and electronic security of personal and health information. Third, was to simplify billing and other transactions with Standardized Code Sets and Transactions. Fourth, was to specify new rights for patients to approve access/use of their medical information. 42 Code of Federal Regulations Part 2 was designed more specifically to protect persons seeking treatment. This law forbids disclosure of any treatment related information to third parties unless one or more of the following provisions are met: a court order is issued; valid written consent is received from the patient, pursuant to an agreement for the qualified service organization or business associate; for research audit or evaluation purpose; to report a crime on an institution's premises or against an institution's personnel; to medical personnel in a medical emergency.

Mandated Reporting

California Penal Code 11166. Child Abuse and Neglect Reporting; Duty; Time
"Except as provided in subdivision (d), and in Section 11166.05, a mandated reporter shall make a report to an agency specified in Section 11165.9 whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter shall make an initial report to the agency immediately or as soon as is practicably possible by telephone and the mandated reporter shall prepare and send, fax, or electronically transmit a written follow up report thereof within 36 hours of receiving the information concerning the incident. The mandated reporter may include with the report any non-privileged documentary evidence the mandated reporter possesses relating to the incident."(Board of Behavioral Sciences, 2009) Do you see any potential conflicts with what we have learned already about reportable information contained within HIPAA or 42 Code of Federal Regulations Part 2? The answer is yes. There is a potential that in reporting child abuse we may disclose information that is treatment related and thus strictly confidential under federal regulations.

Case Example: Sofia
Sofia is a 28 year-old single mother of two children ages 3 & 5. Sofia is currently pregnant and has been struggling with staying "clean" and has turned in 3 consecutive heroin positive drug tests. Sofia has missed several appointments with both the doctor and her primary caseload manager. She was given a behavioral agreement that she is failing. Sofia finally meets with her caseload manager and reports that the other day, she was so tired that she let her two children

walk to a friend's house 4 doors down so that she could get some rest.

Does any information in this case study rise to the level of a mandatory report? What about her being pregnant and using, is that considered reportable or treatment related? If yes, then what specific information? If no, then why not? The answer is yes, there is reportable information in this scenario. Sofia allowing her 2 children ages 3 & 5 to walk unsupervised to a neighbor's house is reportable. All other information is related to treatment and may not be reported unless one of the exclusionary reasons is met.

Case Example: Sam & Lisa
Sam is a 35 year-old who is in treatment with his wife Lisa, age 37, for opiate addiction with poly-substance use as well. They have 2 children ages 10 & 15. During a counseling session, Lisa's counselor discusses her recent positive UA for heroin and amphetamines and works to better understand the situation that led up to her use. Lisa discloses that Sam and she went to a party last Friday night and the pressure was too much. They both used and got wasted. She goes on to say that she also has guilt about leaving their 10 year-old in the custody of their older daughter who is 15. While both girls were asleep and unharmed upon their return at 2 am, she expresses that this was not okay. Does any information in this case study rise to the level of a mandatory report? Is there any treatment related information that is protected? If yes, then what specific information? If no, then why not? The answer is that it is unclear. Seek consultation about the 10 year-old being left with her older 15 year-old sister. All other information is treatment related and may not be disclosed unless one of the exclusionary reasons are met.

California Welfare and Institution Code 15630. Elder Abuse Reporting
"Any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter. (b) (1) Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days." (Board of Behavioral Sciences, 2009)

Case Example: Bobby
Bobby is a 54 year-old who is a model patient. He attends all counseling appointments, and has been illicit drug free for about 5 years now. He is also in good shape mentally & physically except for the occasional stiff knee from an old football injury. In the course of a counseling

session, Bobby discloses that his 23 year-old son has extreme anger issues and has been beating him. Does any information in this case study rise to the level of a mandatory report? If yes, then what specific information? If no, then why not? The answer is: No. Bobby would not meet the traditional definition of elder abuse in that he is not 65 or older, developmentally disabled, mentally ill/disabled, physically disabled or otherwise not able to care for his needs. This is a matter for law enforcement.

Case Example: Bobby (part 2)
A week later, Bobby discloses in a counseling session that his 23 year-old son has been screaming and cussing at his 83 year-old grandmother. Bobby has been present when this occurred. Bobby is unsure if the son has ever hit her though. Does any information in this case study rise to the level of a mandatory report? If yes, then what specific information. If no, then why not? The answer is: Yes. The fact that Bobby's 23 year-old son has been verbally abusing his 83 year-old grandmother is considered a mandatory reporting issue. Bobby's mere question as to whether his mother has been physically abused by her grandson without any reasonable suspicion (e.g. report, bruises, etc.) is most likely not. However, when in doubt, consult a supervisor and call APS for a consultation without identifying confidential information until it is determined that elder abuse is likely to exist.

Duty to Protect

Tarasoff v. Regents of University of California
In the fall of 1967, Prosenjit Poddar came to the University of California Berkley as a graduate student studying naval architecture. During his studies, he became introduced to Tatiana Tarasoff, a student at the University as well. The two saw each other regularly while attending a class. Poddar developed feelings for Tatiana and felt they had a special relationship together. The depths of his feelings were not reciprocated by Tatiana. Feeling rebuffed, Poddar stated in a therapy session that he was going to kill Tarasoff. Poddar's therapist requested that the campus police detain Poddar and recommended that he be civilly committed as a dangerous person. Poddar was detained but released shortly thereafter. No one warned Tarasoff or her family of the threat and several months later on October 27, 1969, Poddar killed Tarasoff. Tarasoff's parents sued the Psychologist as well as the University Police, Regents and several others for failing to warn them that their daughter was in danger. In 1974, the California Supreme Court reversed the lower court's decision to dismiss the case and ruled in favor of Tarasoff stating that "When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps. Thus, it may call for him to warn the intended victim, to notify the police, or to take whatever steps are reasonably necessary under the circumstances." (Berger & Berger, 2009)

Tarasoff has been adopted throughout the country and exists as the standard of care in most states. However, considerable confusion remains about the duty to warn. This is largely due to the verbiage used in the ruling in 1974. However, Tarasoff II issued in 1976, now states that a therapist actually has the duty to protect the intended victim by warning them or others who will

likely warn them in addition to notifying the police and taking all reasonable steps to protect the intended victim given the circumstances faced. Should a therapist be found to both make all reasonable attempts to notify the intended victim as well as notify the police, there should be no liability for the therapist. However, when in doubt, the best advice is to consult with the police. This can be accomplished without identifying any confidential information until it is established that the situation rises to the level of the Tarasoff ruling.

Transference versus Countertransference

It would be foolish to believe that a therapist would never encounter either transference or countertransference. I recall a time in which I was a young professional working in a Masters & Johnson Program for those with sexual trauma issues. I remember walking into the unit and being approached by a new patient who told me that she hated me. I had never met her in my life. Why would someone hate someone they had never met? In a word: transference. The client was projecting onto me her own feelings, beliefs and attitudes based on her experiences with men. It was a great lesson for me as it equipped me to better understand her behavior as a symptom not the real problem. The real problem was that she had been molested as a child by her father and generalized that pain and betrayal to the conclusion that all men were the same. It wasn't about me at all. Working in a treatment environment for substance abuse disorders is similar. Patients will routinely project onto the case manager, clinic manager, doctor et al their personal feelings, beliefs and attitudes because to them that is reality. I have found taking a step back and asking myself the question, "what is this patient trying to communicate to me behind this presentation" very helpful? In doing so, I am better able to understand the human condition as well as detach my personal feeling from the moment. As we all know, the less we allow our personal feelings to get involved the more we are able to assist our clients.

Countertransference onto a client can be equally destructive. We are all familiar with the phrase, "Counselor, know thyself." Simply put, this is so that we know what is ours and what is our client's, and why personal therapy is so vital for our on-going professional and personal health. Countertransference is the idea that we project onto our clients our own feelings, beliefs or attitudes. The danger in doing this is that the issues become clouded and, left unchecked, can become more about the therapist than the client seeking help. In a treatment environment it is important that we demonstrate a healthy boundary of our own issues as well, especially if emerging from a similar addiction. While this may be a somewhat controversial statement, I have yet to find indisputable proof that having "been there, done that" and projecting one's own way in recovery onto another has produced any better results than those working with people suffering with addictions having a therapist or case manager with no personal experience in that struggle. Having run a treatment program and now overseeing more than one-hundred forty caseload managers, counselors and licensed clinicians, I have found the most critical elements to assisting patients into recovery are having the ability to establish therapeutic rapport whereby a client trusts the therapeutic relationship and secondly having an identity of professionalism. A true professional understands that the issues a client or patient are suffering from and the experiences that brought them to that place are as unique as a fingerprint. Hence, the assumption of all addicts being the same and having a one-size fits all treatment paradigm is a grave mistake. Counselors should approach every client as if they know nothing about them

and allow the client to fill in the picture. After all, the client is the true expert on their own clinical conditions.

Dual Relationships

Professional Boundaries

Sometimes it is next to impossible to avoid having some semblance of a relationship with a client outside of the counseling session, but whenever possible, this should be strictly avoided. So what does rise to the level of having a dual relationship with a client? A dual relationship is generally understood as having another relationship, often known as a multiple relationship, with a client outside of the therapeutic relationship. This could be having a sexual relationship with a client, buying or selling products from or to a client, bartering for services or as simple as accepting gifts from a client due to the inherent power a clinician has over those seeking counseling. A general rule of thumb is to maintain no relationships whatsoever other than that of a counselor and a client. This standard will allow for the counselor to assert more objectivity during treatment and produce a better outcome for the client.

Dangers of Imposing Personal Values on Clients

The counselor-client relationship can be a tenuous one especially in treatment. With nearly 80% of clients suffering from co-occurring disorders in addition to a substance abuse disorder, professionals should be especially sensitive to the power differential that is inherent in a counseling relationship for the mere reason that our clients are vulnerable and susceptible to abuse. Imagine a professional that has assisted a client through the most difficult part in his life. Now imagine the respect and admiration that client has for the professional. The very nature of this potential can open the door for even the most altruistic professional to begin imposing their own personal values on their clients.

Self-Care

I once heard that the average life of a counseling professional was only ten years. What? Those with advanced degrees spend nearly that much time in college, graduate school and post-masters practicum. “Perhaps this wasn’t the best field in which to choose a career,” was my thought. Ten years later, I am still going strong. The best advice I ever received regarding my chosen profession is practice self-care. So what is self-care? It is whatever gives back to you in such a way as to recharge you emotionally and physically so that you can be the best professional you can be. I recall a time in which I was working in an inpatient psychiatric unit as well as working with adolescents at a youth ranch. To hear the stories of neglect and abuse would shake the most seasoned among us. My supervisor came to me and expressed concern as she did not want me to take on more than I could handle. Being the Type-A personality I am, I responded that I would be fine. Several months later, I noticed that I was having difficulty sleeping and when I did sleep I dreamed about “my kids” as I came to speak of them. I was irritable and otherwise little fun to be around. In meeting with one of my clinical mentors, he suggested that I had developed secondary post-traumatic stress disorder by hearing and internalizing “my kid’s” trauma. Whether the diagnosis was correct or not, the message was

clear; I needed to balance my life in such a way as to be useful while in a professional role and still healthy outside of that role. Simply put, whatever you choose to do to practice self-care, your life outside of counseling should be larger than your life in it. If you find this to not be the case, you will need to do what I did and introduce meaningful things into your life to help you achieve this balance.

Counselor Responsibilities: A Different Look

From the AAMFT Code of Ethics to the individual State Drug & Alcohol Certifying Organization, much has been written and re-written to express to counselors their responsibility in the helping professions, and rightly so. We as case managers, counselors and therapists have a good working knowledge of what we are not to do. For the true professional, we understand the gravity and importance of our positions. We entered this field to make a difference and take seriously the responsibilities entrusted to us. The problem is with all we have learned not to do, we are sometimes ill-equipped in what we should do instead.

I remember the day my wife told me that we were expecting our first child; the joy, the pride and the panic. As two well-educated individuals, we did what we always did and that was to buy books and read them. We developed a small library with all the advice there was to be had. Then came the relatives and their stories of times when little Timmy did this and that and how they handled it. We went to labor coaching classes and practiced on that huge ball while breathing in through the nose and out through the mouth. We exercised daily, went on an all-organic no meat diet and practiced calmness, whatever the heck that is. Then the day of our daughter's birth arrived. We felt good. We were confident and in the zone. 40 hours later we had this little darling and had no idea of what to do with her. With all the preparation we had done in what to expect in this situation and that, nothing had fully prepared us for having to be solely responsible for this precious little gift. So it is true of being a counselor. With all of your preparation through study and role plays, you are only partially equipped for the onset of your professional career and the responsibilities therein. In that light, I would like to share with you seven responsibilities I believe, if put in practice, will assist you in better meeting your goal of becoming an effective counselor in the addiction treatment profession.

First, you must always remember that the client is the expert on their clinical condition, not you. Over the years, I have had the privilege of interviewing literally hundreds of counselors wanting to work in the company in which I do. As most are young in the field, I have a standard question I ask them which is "what would you say to one of our clients who stated to you, why should I listen to what you have to say, you're the age of my daughter or you've never experienced what I have?" I'm consistently amazed at the ones who ramble on about their practicum with this or that agency or the ones that state I know exactly what they are going through because I have been there myself. With all due respect, neither is a good answer in my opinion nor shows the identity of someone who understands their role and responsibility as a counselor. As was mentioned earlier in this article, we are as unique as a fingerprint and the fact that we share similarities in a few areas does not permit us to discount the hundreds in which we do not. No two people share the exact life experiences as the other. Even those that grow up in the same home with the same environment will experience and interpret that experience through different

lenses even if it is slightly. A true understanding of this principle allows us to answer the question quite differently and state to the client "you're right, but I was hoping that you would teach me about you and your experiences."

Second, you will be well-served to foster an environment in which a motivated client may experience change. This is not meant to convey the idea that a counselor is solely responsible for the outcome; quite to the contrary. However, the counselor is responsible for the process. I recall a time in which I was providing therapy for a young girl who had witnessed her mother attack her father resulting in her and her younger siblings being placed in out of home care. It was really a heart-breaking case in which I could sense that she wanted to talk about what had happened, but was scared to do so. I tried every therapeutic technique I knew to employ and others I made up on the spot all to no avail. In meeting with my clinical supervisor and explaining my own frustration with not being able to reach her, he gave me very solid advice. He said, "Get in, shut up and hold on to where she wants to take the session, not the other way around." "Well, I've certainly never heard of that technique" was my first thought, but desperate to see her progress I pledged to try it. So the next time I met with her I asked her what she wanted to do in the session, to which she replied that she wanted to go on a treasure hunt. For two solid months we went on treasure hunts weekly and found jewels and gold and all other kinds of precious items until one day, she simply said, "you know that my mama tried to kill my daddy?" Our moment of change had arrived. Now, I'm certainly not advocating that you take your adult client on treasure hunts in the parking lot. However, I am saying that allowing a motivated client to take his or her time in disclosing some of the most devastating and traumatic moments of their life will take you fostering an environment in which they feel safe enough to do so.

Third, a professional counselor has the responsibility to provide a therapeutic experience based on authenticity and truth. It is not worth the time to try and pretend to be something you are not. Your clients will smell you out a mile away. Living the life that your clients have and experiencing those experiences has made them experts in many things, the least of which is to possess the ability to sense their environment and the people within it. It is a survival skill long since developed in most cases due to abuse and neglect whether from childhood, a spouse or lover or by having to live on the streets. Our clients are true experts when it comes to who to trust, who to manipulate and who to lie to. They possess a unique quality very similar to that of a chameleon in that they can become who they need to in order to have their needs or desires met. To possess that ability to change on a moment's notice, takes someone who is truly in tuned with human behavior. I once worked with clients who were court-ordered to see me for a particular compulsive behavior disorder. In specializing with this population, I worked as long as three years with some people and oh the stories and excuses I heard. Being a young therapist at the time, I tried more subtle gestures such as reacting to the obvious lie disapprovingly or simply trying to ignore their statement. One day I had heard enough and said to my client, "I want you to know that I know you are lying, so let's just cut the crap" to which I immediately wished I could have retracted the statement. I had been trained better than that and I was embarrassed by my outburst. Before I could apologize my client stated he was just seeing how far I would let him go. It turned out to be the most therapeutic thing I could have done. My client knew, or at least had a reasonable suspicion, that I knew he was lying. However, he was

content not to address real issues when the make-believe ones could fill our sessions. While I would not recommend on any regularity such crass conversation, I would challenge the counselor not to expect the client to travel down a road (of truth) that the counselor is unwilling to travel themselves.

The fourth responsibility of the professional counselor is to be fully present and engaged in the client session regardless of life's circumstances. There are few things that bother us more than engaging someone in conversation only to receive half-hearted "uh, hums" in return. This pet peeve of mine is so large that I will actually begin making up outrageous things just to see if the person I am talking to will catch it. Now, if this is annoying during a casual dinner party or conversation on the phone, imagine how a client must feel who is attempting to disclose or convey events or emotions that perhaps they have never told anyone before and their counselor is thinking about "life" outside the session. A professional counselor knows how to successfully table their personal circumstances and focus solely on their client. They also know that if they cannot, they should reschedule the session for a time in which they can.

Fifth, a counselor has the responsibility to offer hope to the patient beyond their present circumstances. Perhaps some of you reading this will not agree thinking something to the effect of, "How do you offer to the hopeless?" My response would be, "They're in your office aren't they?" I have come to believe that the truly hopeless will not seek and maintain the services of a counselor. The truly hopeless suffer oftentimes in silence. We will not be able to help them because we will not know who they are in the first place. However, you will know and be able to help those that seek treatment. Even the most resistant client can be said to have made progress if they stay engaged in treatment and attend their counseling appointments. Our job is to recognize and reinforce what they are doing well in the midst of difficult times with the belief that in doing so we make it more likely they will continue this in the future. This type of interaction with your client will allow for them to realize they have strengths that can be employed to solve their own problems with the outcome being that hope is developed.

The sixth responsibility of the professional counselor is to respect the patient and know that his or her choices and decisions are just that, his or hers. This is a tough one for some. We chose this line of work to make a difference and there are few things more disappointing than working with a client that continues to make poor choices for their lives. Our instinct is to continue trying and trying until we arrive at the point that we are emotionally reactive against the patient. As counselors, we should never place ourselves in a position in which we are working harder than our clients. In doing so, we enable them to ourselves and can actually do more harm than good. We must know when to let go knowing that we have done our jobs and we cannot be responsible for something for which we have no control.

The seventh responsibility of a counselor is to maintain a professional identity even when those around them falter. This is an especially important one to emphasize. Throughout my career working in private psychiatric hospitals, non-profit agencies and now treatment centers, I have had the distinct pleasure of working with some truly brilliant professionals. These people are intrinsically motivated towards excellence and have high moral standards. Then there are those that seem to be content with cutting corners, providing sub-par services and generally are

difficult to be around. In my trainings I currently conduct with the more than 140 counselors in my department, I offer instruction on many topics. However, no topic is covered with more passion than this one. My advice to them is simple: if ever you feel that you cannot provide the highest level of quality in patient care, then leave. This is not meant to be harsh, just honest. Most patients voluntarily seek treatment and ask that we help them move on from their present life of chaos, pain and trauma. Not being fully invested and committed to offer the highest standards in patient care should never be an option.

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