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Frontline Ethics: Issues in Mental Health and Substance Abuse Counseling

with Peggy Keilholz, ACSW, CASAC

Center for Prevention, Outreach, and Professional Education

Summary

Ethical Issues and dilemmas challenge the practitioner. What are the guiding principles that inform ethical decision-making? How do the codes of ethics under which clinicians practice fit with the guiding principles? This program focuses on the use of the guiding principles, the codes of ethics, and practice applications.

Presenter

Peggy Keilholz, ACSW, CASAC, is a Licensed Clinical Social Worker and a Certified Advanced Substance Abuse Counselor here in Missouri. She is a member of the Academy of Certified Social Workers, a Clinical member of American Association for Marriage and Family Therapy and an AAMFT approved supervisor. In addition to maintaining a private practice in individual, couples, and family therapy, Peggy teaches part time in the Family Therapy Specialization at the George Warren Brown School of Social Work at Washington University in St. Louis. She is the past President of the St. Louis Association for Marriage and Family Therapy. From 2005 to 2007 she served as Ethics Chair for the Missouri Association for Marriage and Family Therapy. During her years in practice Peggy has worked with numerous individuals and families coping with alcoholism and drug addiction and chronic mental and physical conditions. She presented numerous workshops on Social Work Ethics. Peggy has received her Bachelor of Arts in Biology from Fontbonne College, a Master of Arts in Religion and Education from St. Louis University and a Master of Social Work from Washington University in St. Louis.

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References

Family Therapists' Ethical Decision-Making Processes in Two Duty-to-Warn Situations, by Ellen Burkemper. www3.interscience.wiley.com/journal/118915150/abstract?CRETRY=1&SRETRY=0

Kitchener, K.S. (1985) Ethical Principles and decisions in student affairs. In H.J. Canon and R.D. Brown (Eds), Applied Ethics in Student Services (pp 17-29), Josey-Bass

www.socialworkers.org

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Glossary

Autonomy - independence or freedom; control over and/or input into treatment decisions

Beneficence - doing good

Ethical Dilemma - two or more good reasons to make two or more reasonable decisions

Ethics - the discipline that deals with what is good and bad and with moral duty and obligation; one of the branches of philosophy; "moral philosophy"

Fidelity - to act faithfully to a set of principles, guidelines or practices

Justice - ensuring equal access to service; removal of barriers to treatment

Non-maleficence - to do no harm

Transcript

T: Thom Pancella **PK: Peggy Kielholz**

Thom Pancella: Hello and welcome to this MIMHTraining.com presentation called "Frontline Ethics: Issues in Mental and Substance Abuse Counseling" I'm Thom Pancella with the Missouri Institute of Mental Health, thank you for joining us today. We're joined by Peggy Kielholz who is a Licensed Clinical Social Worker and a Certified Advanced Substance Abuse Counselor here in Missouri. She is a member of the Academy of Certified Social Workers, a Clinical member of American Association for Marriage and Family Therapy and an AAMFT approved supervisor. In addition to maintaining a private practice in individual, couples, and family therapy, Peggy teaches part time in the Family Therapy Specialization at the George Warren Brown School of Social Work here at Washington University in St. Louis. She is the past President of the St. Louis Association for Marriage and Family Therapy. From 2005 to 2007 she served as Ethics Chair for the Missouri Association for Marriage and Family Therapy. During her years in practice Peggy has worked with numerous individuals and families coping with alcoholism and drug addiction and chronic mental and physical conditions. She presented numerous workshops on Social Work Ethics. Peggy has received her Bachelor of Arts in Biology from Fontbonne College, a Master of Arts in Religion and Education from St. Louis University and a Master of Social Work from Washington University in St. Louis. Peggy, thanks for joining us today.

Peggy Kielholz: I'm very happy to be here, Thom.

TP: It's always good to start with some foundation, so why don't you tell us what is Ethics?

PK: Well, very simply, if you go to the dictionary and look it up you find out that this is the discipline that deals with what is good and bad and with moral duty and obligation. It's one of the branches of philosophy and it sometimes go by another name, "moral philosophy".

TP: Why is there just a great interest in ethics and ethics education right now?

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PK: I think the current circumstances in which our country finds itself is a result of not applying ethics there in the business world. So, if you look at the literature, ethics is discussed in many, many areas and the interest particularly here in Missouri has been spurred by the state committee that licenses clinical social workers requiring that every license renewal period the clinical social workers have at least 3 clock hours in social work ethics. So, it's a good thing to have but oftentimes something that people don't want to spend a lot of time talking about. I think because people are conscientious a discussion of ethics usually gets them anxious. So, they would rather not talk about it and yet it's very important to talk about because it's so easy for people to get into trouble before they know it in the area of ethics. And so typically in the professions one of the major areas that we have found over the years where people are in trouble ethically is in the area of having sexual intimacy with clients. I'm sure that every professional has heard somewhere in their training not to do that; and yet it ends up being a very common ethical violation. Now some others have become more common as clinical social workers have sought third party reimbursement from insurance companies or Medicare and Medicaid providers; people also get into trouble by misrepresenting what they have done with a client or whether or not they've even had sessions--and that constitutes fraud so that becomes another area of ethical difficulty for people.

TP: So what is an ethical dilemma?

PK: An ethical dilemma, and here I like Ellen Burkemper's definition, Ellen is an Assistant Professor at Saint Louis University and teaches social work ethics. She defines an ethical dilemma as two or more good reasons to make two or more reasonable decisions. So there's some way in which the ethical principles of a profession are in conflict with one another. Other authors add to Ellen's definition that in that process of coming to make--choosing between those two reasonable decisions; one of the ethical principles is compromised in the process. So, that is what constitutes an ethical dilemma, I have something in front of me and I've got two or more different ways to go and I have two or more good reasons for going

Transcript

any of those directions.

TP: I think that examples are always very powerful; can you give us some examples?

PK: Let's just take a very simple one. Let's say that I'm working for an agency; let's say a counseling agency and a client in scheduling a session, the very first one, asks that there be no record kept. Now, there are a couple of ethical principles--issues here; first of all, we recognize that clients have autonomy, that's the ability of a free person to make free decisions. That's usually framed in social work terms as the client's right to self determination. So in this example we could say well… the client has the right in his or her self determination to say that "I don't want a record kept." However, we go to other parts of code of ethics--and for the social workers that is the NASW Code of Ethics-National Association of Social Workers--and it clearly says we should keep records. So, see there's the dilemma. And further more if we look at the state regulations that govern the practice of clinical social work here in Missouri it says "we will keep records." So the dilemma there would be how to honor the clients request for nothing and the obligations that I have towards the organization that I work for, or even myself in private practice, to keep a record.

TP: So, how would you go about resolving something like that, then?

PK: Well, I like to follow the work of Karen Kitchener and she wrote principally for the clinical psychologist but I think she really outlined very well the different--what I would call the process of ethical reasoning. Because that is what we are really talking about here is the process. In a process there are many factors to consider. And she begins with what she would call the intuitive level. Most of us have an idea of what intuition is, but she breaks that out into four areas: 1. Just looking at the facts of situation. So whatever has been presented to me I just look at the facts. So here is a client who has asked not to have a record kept. I work in an organization; the law says this, the regulations says this, the code of ethics say this, those are the facts. Then, I have my own ordinary moral sense. and so when

Transcript

I hear somebody say something like that I probably have an initial reaction to it, and my ordinary moral sense might tell me that doesn't sound like a good idea or why is this person asking for that. Then I have my knee jerk reaction, my initial response to it and then my own use of myself--what have been my experiences in this particular area? Is that a positive or negative thing that somebody would even ask that there be no record kept at all? So I'm going to be looking at all of those… but this is just the beginning. So we would take it to the next step, which is what Kitchener calls a "critical evaluative level" and that level she articulates 5 meta ethical principles. Now, these are found in the literature and what we mean by "meta ethical principle" is that if I look at the codes of ethics of the various professions; social work, substance abuse counseling, clinical psychology, counselors and so on; these are principles that I'm going to find in all of those codes of ethics they are not unique to one code. Basically those are 5 principles: autonomy, non maleficence, beneficence, fidelity and justice. Look at any code of ethics and you are going to find those 5 Meta ethical principles in there. So in this case we have the client asking that nothing be kept so that the person would have absolute confidentiality and privilege with the worker. That would come under the ethical principle of autonomy. The next one is non maleficence, and that means to do no harm. Now it is possible that either in my experience or that client's experience the fact that somebody had a record may have done harm to that client. A typical example of that, is a lot of times a social worker or substance abuse counselor, marriage and family therapist has seen a couple for couples' counseling and the marriage or relationship didn't continue and there is a divorce and now it becomes contentious and the legal system asks for those records. Generally, that is why people don't want a record; because something has happened in the legal process which burned them. Well, that would come under that principle of non maleficence, which is to do no harm; however, I also have to look at what harm might come, let's say, to myself or to my agency if I didn't keep a record. Worst case scenario would be one that happened and was reported on the national level by AAMFT and that was a therapist who kept no records but the client kept a journal and as things unfolded that therapy went south, we might say, and the client ended up making a complaint. Well who had the record? The therapist had none; the client had the record having kept a journal and made an entry after every ses

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sion. So that principle we have to find out it is just not the client being harmed, it is who else might be harmed in that process. Beneficence speaks to my doing good and it's a good thing to have a record. I think to myself what would it be like if my mechanic didn't keep a record? It's hard to keep track of what I'm doing with somebody if I don't have some notes that indicate that this is what happened the last time, this is how the client appears to be doing better or may be not doing so well, and this is the plan for the next time; so that's part of that. But beneficence also includes my looking at evidence-based practice or empirically supported treatments so that what I'm doing I'm sure is having some benefit to the client. Fidelity means I'm faithful. There it might be difficult to see how fidelity applies to whether I keep a record or not--that would apply more in say let's say that I definitely keep records in that practice of fidelity I'm going to keep them a certain length of time and I'm going to keep them safe and so that nobody else has access to them and also protect the client's information. So my fidelity is to the client and that I do what I say I'm going to do and that just because somebody says that want my record doesn't mean that I'm just going to turn it over. I'm very conservative in that area, I really fight very hard not to do that, especially if it would be harmful or damaging to the client. The last principle is justice and that has to with access to services, the balanced treatment of people and so on. If you are thinking in all of those areas and we're just barely started in our process.

TP: You have talked a lot more about process than content; why are you focused more on process than content?

PK: I think that I focus more on process because when I have a process in place I can tackle anything. It's kind of like the similar idea to the saying of "if I give you a fish you have food for a day. If I teach you how to fish you have food for lifetime." If I'm only talking about content I'm really limited to whatever that particular content is. If I have a process, no matter what I'm faced with, I will be able to work my way through that process.

TP: So what other consideration enter into this process?

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PK: Well, the next level would be to look at--in the process of making this decision to whom am I responsible? I think our first reaction is to say "well to the client" and that's true. Obviously we do have a responsibility to the client; however, it doesn't stop there. If that were the only responsibility we probably wouldn't have so many difficulties. For example, I also have a responsibility to an organization that I work for. Most organizations--particularly those that work in the mental health field--have some kind of accreditation. There are either accredited by the Joint Committee on Health Care Organizations or the group that accredits rehabilitation facilities and so those agencies have to meet certain criteria in doing that. Again to take the example of the record, the organization has an expectation that the people who work for them are going to keep adequate and accurate records, that's an obligation to the organization. That's part of risk management. We really never know when the work with a client is going to end up in a direction that nobody intended it to do, and if there is no evidence of what's been done and not only am I as an individual clinician in difficulty but the organization would be--they would have nothing to be able to present to show this is what we did. Typically organizations would be faced with this if, let's say, a client committed suicide, or went out and harmed other people and the family or somebody else would turn back to the organization and said "you had this person in treatment, why didn't you do something?" Well the organization would be able to look at the record or present it and say, "this is what we did. We did this, and this, and this." I also have an obligation to myself. I also want to be interested if we are just looking at the clinical record in terms of the risk management toward me. I want to be able to show if my work was called into question what I had actually done and my efforts on behalf of a client. I also have an obligation to my family that whatever I do in my work with other people also doesn't lead to any harm to them. And I have a obligation to society. So all of these also enter in to the process of ethical reasoning; and we're still not finished.

What comes next? When do we finally get to the Professional Codes of Ethics? Well, they're next. So at some point in this process I'm actually going to open up the Code of Ethics and to look at it to see what does it have to say about this particular area? In addition to that, I'm going to be looking at the state laws and

Transcript

regulations. We come into--this as probably a much more common area of an ethical dilemma and social workers are faced with this I assume also substances abuse counselors are and they might end up in different places in this process. It has to do with the whole area of reporting child abuse and neglect. That's an ethical dilemma, because--and you can see in this process social workers are clearly mandated reporters of that. Suppose I have a client who says to me, "if you make that phone call I'm never coming back and further more I'm taking my child with me." So, there the person would be balancing all of those factors in coming to a reasoned decision. Actually people might come to a different decision about that assuming risk on either side. If I make the call I may risk the safety of the child; because they'll pull out of therapy and treatment; if I don't make the call I risk the safety of the child because now there is no third party intervening which could be helpful. Actually over the years we have found out that it's better to err on the side of the safety of the child than whether or not the client stays in treatment.

TP: You mentioned the NASW Code of Ethics, you mentioned Meta Ethical Principles that kind of cross codes of ethics and then you mentioned diving into them. How many are there?

PK: Well, every profession has their own code of ethics and just to kind of give you an idea in preparing for the workshops that I have done I take a look at them; of course we have the National Association of Social Workers. Here in Missouri those of us who are certified substance abuse counselors, when we get our renewal in the mail, part of the packet is a code of ethics that we sign. Now, that code of ethics is very simple--it's 13 statements on a 8 ½ x 11 page--and that code says, "I subscribe to these things," but that still embodies those same meta ethical principles that we just talked about. It is just shorter and very brief. We go back in NASW history there was time when the NASW code of ethics looked like that--it was 1 8 ½ x 11 sheet with about 12 or 13 statements on it. So generally the professions--as the profession exists longer and longer the codes become more complex as they have more experience. So, the clinical psychologists have a code of ethics, the American Counseling Association has a code, and then there some separate organizations for example the National Association of Black Social

Transcript

Workers has its own code of ethics. There are many out there and when --if you are somebody like myself where I have basically three codes of ethics that I subscribe to: the NASW code of ethics, the AAMFT code of ethics for marriage and family therapists; and the substance abuse one; I would be looking at all three of those in my process of coming to a decision. So how do I decide which one to follow? Well the rule of thumb is you follow the one that's most strict. See, that's the way to go. A lot of times for me as a social worker it's the NASW code of ethics that's the most strict.

TP: Do you ever find that they are in conflict with one another?

PK: Not particularly. At least that has not been my experience. I think things may become more of a conflict--for example, for substance abuse counselors and the codes of ethics because it has to do with the federal regulations that govern people in treatment for substance abuse and I wish--I'm not as well versed in that as I would like to be but that's more likely where the conflict is to come in because there is some things that cannot be disclosed otherwise it so discourages people from seeking treatment that they wouldn't do that. Let me give you an example, it's not necessarily a conflict but where the NASW code of ethics and the AAMFT code of ethics differ is in the area of having sexual contact with a former client. The AAMFT code of ethics says that I could after 2 years after the last treatment contact that I could enter into sexual relationship with a client. The NASW code of ethics is silent on that. The assumption being that you don't ever do that. If you did even the AAMFT code of ethics it's on the therapist's end to be able to articulate why that's not harmful to somebody. But in social work we take the approach that if you had been my client and I had been working with you for some time and we end, I want the door to be open so that you can come back in the future; but if we get into another kind of relationship then that's not going to be possible.

TP: Early on you talked about the possibility of coming to different reasoned conclusions given the same set of facts. How is that dealt with at the professional level, then, if you're faced with having to--if you are faced with kind of an ethical

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charge. How is it dealt with "well I went through this process and here is the conclusion that I came to," but somebody else says "this is the conclusion that you should have come to!"

PK: Well, basically what I'm responsible for is my process. I have to be able to articulate how I came to the conclusion that I came to even if somebody else disagrees with it. Now whether or not that leads to legal liability--that's a legal question; but all of the professions also have their own committees that deal with ethical complaints and that's usually the first place where a complaint would be handled is at either the state level or the national level by the organization. There I would want to be able to articulate "well this is what I did." Now an important element of coming to a reasoned decision involves having a process. In other words, I can go through and I can say "well, I've looked at this intuitive aspects, I looked at the meta ethical principles, I looked at the obligations, the code, the laws of the state and so forth and this is the conclusion I come to." But usually I would not find that enough. What's important to me is to have consultation. I want to be able to talk with somebody about what I'm thinking. Because very often getting my thoughts out there and hearing them out loud helps me to maybe reason this differently. So, and I like to have consultation be routine not kind of catch as catch can. By routine I mean for example on a weekly or on an every-other-week basis or a monthly basis. I can also turn to what are called decision screens. In the workshop that I do that builds on the first one that I did this year we get more into the use of such decision screens and those delve more deeply usually into the values that people hold and how those values play out in terms of application of the code of ethics. Then there is the opportunity for special consultation. The NASW, for example, has a number that members can call and receive a consultation on ethics. So all of those things going together can help me to come to a reasoned decision; I have had—I've used that over the years.

TP: You kind of touched on what I was going to ask about resources for people who have questions about these decisions. What about after a decision is made and somebody is backtracking and saying "I've made a decision, I've implemented something but now I'm not sure if I did the right thing?"

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PK: Well, I've actually had that happen where I did something and I thought later about it and I was fairly confident of what I had done but then had decided that probably wasn't such a good idea, but I couldn't do anything about what I had already done. What I could do is learn from that experience and not repeat that in the future and also not repeat whatever that was with a particular client. This involved something cross-culturally and also a relationship that involved somebody that I knew in another context. Based on the consultation that I did it seemed like a good idea to respect the persons culture--which is another part of the code of ethics, is the whole area of cultural competence, at least for social workers. The choice there seemed to be between is this person going to receive service at all? Or, another words, no service? Or service delivered by somebody that the person knew and trusted? Later on thinking about that, and also looking at the state regulations, which specifically prohibit those kinds of dual relationships, when the person asked me again in the future about doing that, I declined; and explained the ethics behind it and why that would not be a good idea.

TP: Are there other resources that people can get hooked up with ?

PK: Sure. First of all, it helps to be a member of your professional organization; because if you're not a member you're kind of floating out there. You do not have access to the resources; for example, calling the state office of NASW here in Missouri or the National office has an 800 number and certain hours and you can also visit the website; but if you're not a member you can't--you don't have access to that. I very much encourage people to become members of their professional organizations; not only for that reason--that you have the resources for consultation but the codes of ethics are not static documents. They are living documents. If I'm not a member of the --my professional organization--I don't have any say in what goes in to that code of ethics. They change periodically; there were some amendments made just this year to the NASW code of ethics in the areas of discrimination. I have happened to look at the American Counseling Association's code of ethics and they're most recent one was adopted in 2005. It had a lot to say in there about the use of the modern means of communicatio-- e-mail, electronic

communications, those kinds of things. So, it's through the professional organizations that the codes of ethics are revised and adapted to meet the changing circumstances. They reflect the different thinking that people might have. So those are some of the things that are resources out there. In order to access them you have to be a member.

TP: Do you have any final thoughts that you would like to share our audience?

PK: Well, I hope that people will find ethics intriguing and interesting rather than frightening. See whether or not I ever read a code of ethics or engage in any ethical process--any ethical reasoning process--I'm practicing according to some ethic. I just haven't articulated it. That's a dangerous place to be, one of the—an author writing for the marriage and family therapists put together what he called a "ethics at risk test" and one of the first questions was "have you ever had a course in ethics, particularly as it relates to your profession?" If you haven't then you are already at risk. I know from the workshops that I have done that sometimes people will say that if they got nothing else out of the workshop they learned that the need to read the code of ethics at least once a year. And I'm delighted if that is what they got out of it then I'm very pleased; because that is the first place that you have to start if you don't know what it says then how can you practice ethically?

TP: I appreciate your time and expertise, Peggy. Thanks for joining us!

PK: You're welcome.

TP: Thank you for joining us today.

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Missouri Institute of Mental Health, we're always looking for suggestions on topics or speakers that you'd like to see in this or any other format. If you have any suggestions whatsoever, please drop us a line at feedback@MIMHTraining.com. Again, we appreciate your time; thank you for joining us. And thanks for joining us.

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