THE ETHICS OF TREATING EATING DISORDERS ON A COLLEGE CAMPUS

Presented by:
Marcuetta Sims, PhD
Kennesaw State University
msims55@Kennesaw.edu
 Topics to be covered

• Prevalence of Eating Disorders on College Campuses
  • Stats
  • Challenges

• Overview of Important Ethics Codes Related to Treating Eating Disorders:
  • Competency
  • Beneficence and Nonmaleficence
  • Fidelity and Responsibility
  • Integrity
  • Respect for People’s Rights
  • Informed Consent
  • Confidentiality
TOPICS TO BE COVERED

• Diagnosing Eating Disorders
• Assessing for the presence of an Eating Disorder
• Providing an accurate diagnosis. Knowing limits of competency
• Explaining diagnosis to clients and discussing the implications of this diagnosis
TOPICS TO BE COVERED

• Ethical Decision Making in treating eating Disorders Using Clinical Case Studies
  • Steps in Ethical Decision Making
  • 4 Bin Approach
  • Standard of Care
  • Level of Care
TOPICS TO BE COVERED

• Treating Eating Disorders
  • Developing a Treatment Team
• Ethical considerations when developing and utilizing a treatment team approach
• Ethics of Collaborating, Consultation, and Referrals
• The HEAL Team at KSU
OBJECTIVES

Develop an Eating Disorder treatment team to meet the needs of their campus.

Describe the available levels of care for students with eating disorders and utilize this information to refer students appropriately.

Identify the most relevant ethical considerations when making decisions about treating eating disorders on a college campus.

Develop an Eating Disorder treatment team to meet the needs of their campus.
PREVALENCE OF EATING DISORDERS ON COLLEGE CAMPUSES

• National surveys estimate that **20 million women** and **10 million men** in America will have an eating disorder at some point in their lives.

• Prevalence estimates of current EDs among college students range from **8%** to **17%**.

• In a recent national survey of college students, **20% of respondents** said they suspected that they had suffered from an ED at some point in their lives.

• In the American College Health Association’s National College Health Assessment (ACHA-NCHA), **3% of females** and **0.4% of males** reported ever **receiving a diagnosis of anorexia**; **2% of females** and **0.2% of males** reported **a previous diagnosis of bulimia**; and **4% of females** and **1% of males** reported vomiting or taking laxatives to lose weight in the previous 30 days.
• Young people between the ages of 15 and 24 with anorexia have 10 times the risk of dying compared to their same-aged peers.

• Males represent 25% of individuals with anorexia nervosa, and they are at a higher risk of dying, in part because they are often diagnosed later since many people assume males don’t have eating disorders.

• It is estimated that clinical eating disorders affect 10 to 20% of female university students and 4 to 10% of male university students (Hoerr et al, 2002).
ATHLETES

• One study found that 35% of female and 10% of male college athletes were at risk for anorexia nervosa and 58% of female and 38% of male college athletes were at risk for bulimia nervosa.

• The prevalence of eating disorders in college athletes is higher among dancers and the most elite college athletes, particularly those involved with sports that emphasize a lean physique or weight restriction (e.g., figure skating, wrestling, rowing).
CHALLENGES

Client
- Typically not the presenting concern
- [The Eating Disorder] More resistant to treat
- Need more resources, but often have less access or opportunity (i.e. classes, insurance)

Clinician
- Biases
- The Righting Reflex
- Lack of training, feelings of incompetence

Institution
- Limited sessions
- Limited on campus resources
- Lack of ability to collaborate
OVERVIEW OF IMPORTANT ETHICS CODES RELATED TO TREATING EATING DISORDERS
COMPETENCE
C. Counselor Responsibility and Integrity

1. Competence The maintenance of high standards of professional competence is a responsibility shared by all mental health counselors in the best interests of the client, the public, and the profession. Mental health counselors:

   • a) Recognize the boundaries of their particular competencies and the limitations of their expertise.
   • b) Provide only those services and use only those techniques for which they are qualified by education, training, or experience.
   • c) Maintain knowledge of relevant scientific and professional information related to the services rendered, and recognizes the need for on-going education.
   • d) Represent accurately their competence, education, training, and experience including licenses and certifications.
   • e) Perform their duties, as teaching professionals, based on careful preparation in order that their instruction is accurate, up-to-date and educational.
   • f) Recognize the importance of continuing education and remain open to new counseling approaches and procedures documented by peer-reviewed scientific and professional literature.
• g) Recognize the important need to be competent in regard to cultural diversity and are sensitive to the diversity of varying populations as well as to changes in cultural expectations and values over time.
• i) Have a responsibility to maintain high standards of professional conduct at all times.
• j) Take appropriate steps to rectify ethical issues with colleagues by using procedures developed by employers and/or state licensure boards.
• k) Have a responsibility to empower clients, when appropriate, especially/particularly clients with disabilities.
• l) Are aware of the intimacy of the counseling relationship, maintain a healthy respect for the integrity of the client, and avoid engaging in activities that seek to meet the mental health counselor's personal needs at the expense of the client.
• m) Will actively attempt to understand the diverse cultural backgrounds of the clients with whom they work. This includes learning how the mental health counselor's own cultural/ ethical/racial/religious identities impact their own values and beliefs about the counseling process.
C.2. Professional Responsibility

• C.2.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. Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population.

• C.2.d. **Monitor Effectiveness:** Counselors continually monitor their effectiveness as professionals and take steps to improve when necessary. Counselors take reasonable steps to seek peer supervision to evaluate their efficacy as counselors.
COMPETENCE (APA)

2.01 Boundaries of Competence

- (a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.
• (c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

• (d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.
• APA Ethics Code

• 2.03 Maintaining Competence
  Psychologists undertake ongoing efforts to develop and maintain their competence.

• ACA (2015) Ethics Code

• C.2.f. Continuing Education Counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. Counselors maintain their competence in the skills they use, are open to new procedures, and remain informed regarding best practices for working with diverse populations.
COMPETENCE (NASW)

• **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.

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.
STANDARD III

• PROFESSIONAL COMPETENCE AND INTEGRITY
  • Marriage and family therapists maintain high standards of professional competence and integrity.

• 3.1 Maintenance of Competency.
  • Marriage and family therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, and/or supervised experience.

• 3.2 Knowledge of Regulatory Standards.
  • Marriage and family therapists pursue appropriate consultation and training to ensure adequate knowledge of and adherence to applicable laws, ethics, and professional standards.

• 3.6 Development of New Skills.
  • While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, and/or supervised experience.

• 3.10 Scope of Competence.
  • Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies.
COMPETENCE

Diagnosing
D. Assessment and Diagnosis

1. Selection and Administration

Mental health counselors utilize educational, psychological, diagnostic, career assessment instruments (herein referenced as “tests”), interviews, and other assessment techniques and diagnostic tools in the counseling process for the purpose of determining the client’s particular needs in the context of his/her situation.

a) Mental health counselors choose assessment methods that are reliable, valid, and appropriate based on the age, gender, race, ability, and other client characteristics. If tests must be used in the absence of information regarding the aforementioned factors, the limitations of generalizability should be duly noted.

b) In selecting assessment tools, mental health counselors justify the logic of their choices in relation to the client’s needs and the clinical context in which the assessment occurs.
2. Interpretation and Reporting

- Mental health counselors respect the rights and dignity of the client in assessment, interpretation, and diagnosis of mental disorders and make every effort to assure that the client receives the appropriate treatment.
  - a) Mental health counselors base diagnoses and other assessment summaries on multiple sources of data whenever possible.
  - b) Mental health counselors are careful not to draw conclusions unless empirical evidence is present.
  - c) Mental health counselors consider multicultural factors (including but not limited to gender, race, religion, age, ability, culture, class, ethnicity, sexual orientation) in test interpretation, in diagnosis, and in the formulation of prognosis and treatment recommendations.
  - g) To the extent possible, mental health counselors provide test results in a neutral and nonjudgmental manner.
E.5. Diagnosis of Mental Disorders

• **E.5.a. Proper Diagnosis**
  • Counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interviews) used to determine client care (e.g., locus of treatment, type of treatment, recommended follow-up) are carefully selected and appropriately used.

• **E.5.b. Cultural Sensitivity**
  • Counselors recognize that culture affects the manner in which clients’ problems are defined and experienced. Clients' socioeconomic and cultural experiences are considered when diagnosing mental disorders.

• **E.5.d. Refraining From Diagnosis**
  • Counselors may refrain from making and/or reporting a diagnosis if they believe that it would cause harm to the client or others. Counselors carefully consider both the positive and negative implications of a diagnosis.
9.02 Use of Assessments

• (a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

• (b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

• (c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.
9.10 Explaining Assessment Results

- Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, pre-employment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.
DIAGNOSING EATING DISORDERS

- Screening (SCOFF, Eat26, CCAPS- Eating Concerns)
- Assessment (Extended IC: Eating Disorder)
- Diagnosis
- Discussing Diagnosis with Client and the implications
• Principle A: Beneficence and Nonmaleficence

• Maximize Good, Minimize Harm

• Psychologists strive to **benefit those with whom they work and take care to do no harm**. In their professional actions, psychologists seek to **safeguard the welfare and rights of those with whom they interact professionally and other affected persons**. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that **avoids or minimizes harm**.

• It is important to recognize that in some cases, in rightly practiced psychology, **individuals may be harmed without being wronged**.
  • i.e. Disclosing confidential information to protect a client/student from self-harm or harming others may have moral priority over protecting that individuals' privacy rights.
A.4.a. Avoiding Harm

• Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm.

LMFT

• Marriage and family therapists advance the welfare of families and individuals and make reasonable efforts to find the appropriate balance between conflicting goals within the family system.
PRINCIPLE B: FIDELITY & RESPONSIBILITY (APA)

• Fidelity= Faithfulness

• Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct.

• Promise Keeping, Responsibility to obtain and maintain high standards of competence AND to be concerned about the ethical compliance of their colleagues.

• Consultation
FIDELITY AND RESPONSIBILITY

• NASW- Standard I Social Worker’s Ethical Responsibilities to Clients
• AMCHA- Standard I, Commitment to Clients, Standard II, Commitment to Colleagues, Standard III, Commitment to the profession.
• ACA- Section C- Professional Responsibility
• LMFT- Standard I Responsibility to clients.
Mental health counselors value objectivity and integrity in their commitment to understanding human behavior, and they maintain the highest standards in providing mental health counseling services.

- a) The primary responsibility of mental health counselors is to respect client autonomy, dignity and promote client welfare.
PRINCIPLE C: INTEGRITY (APA)

• Honest communication, Truth Telling, promise keeping, and accuracy

• Psychologists seek to promote **accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology**. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

• Refraining from making professional commitments that can not be met
• **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.
PRINCIPLE D: JUSTICE (APA)

• Psychologists recognize that **fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists.** Psychologists exercise reasonable judgment and take precautions to ensure that their **potential biases, the boundaries of their competence, and the limitations of their expertise** do not lead to or condone unjust practices.

• Strive to provide fair, equitable, and appropriate access to treatment

• **Be aware of and guard against their own biases and the prejudices** of others that may condone or lead to unjust practices.

• **Select procedures and services that meet the needs** of those with whom they work, recognizing that existing social and economic inequities may require different but comparable scientific and professional techniques.
• **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.
• 1.05 Cultural Awareness 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, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability.

(d) Social workers who provide electronic social work services should be aware of cultural and socioeconomic differences among clients and how they may use electronic technology. Social workers should assess cultural, environmental, economic, mental or physical ability, linguistic, and other issues that may affect the delivery or use of these services.
NON-DISCRIMINATION (AMHCA)

• Counselor Responsibility and Integrity

• 2. Non-discrimination
  • a) Mental health counselors do not condone or engage in any discrimination based on ability, age, color, culture, disability, ethnic group, gender, gender identity, race, religion, national origin, political beliefs, sexual orientation, marital status, or socioeconomic status.
  
  • c) Mental health counselors have a responsibility to educate themselves about their own biases toward those of different races, creeds, identities, orientations, cultures, and physical and mental abilities; and then to seek consultation, supervision and or counseling in order to prevent those biases interfering with the counseling process.
STANDARD 1: RESPONSIBILITY TO CLIENTS (LMFT)

1.1 Non-Discrimination.

- Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity or relationship status.
A.4. IMPOSING VALUES (ACA)

• A.4.b. Personal Values
  • Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor’s values are inconsistent with the client’s goals or are discriminatory in nature.
Other Roles

• 2. Advocate
  
  • Mental health counselors may serve as advocates at the individual, institutional, and/or societal level in an effort to foster sociopolitical change that meets the needs of the client or the community.
  
  • a) Mental health counselors are aware of and make every effort to avoid pitfalls of advocacy including conflicts of interest, inappropriate relationships and other negative consequences. Mental health counselors remain sensitive to the potential personal and cultural impact on clients of their advocacy efforts.
  
  • b) Mental health counselors may encourage clients to challenge familial, institutional, and societal obstacles to their growth and development and they may advocate on the clients’ behalf. Mental health counselors remain aware of the potential dangers of becoming overly involved as an advocate.
  
  • c) Mental health counselors may only speak on their behalf and are clear, cautious, and authorized to speak on the behalf of any counseling organization. d) Mental health counselors endeavor to speak factually and discern facts from opinions.
A.7.a. Advocacy

- When appropriate, counselors advocate at individual, group, institutional, and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients
PRINCIPLE E: RESPECT FOR PEOPLE’S RIGHTS AND DIGNITY

• Psychologists **respect the dignity and worth** of all people, and the rights of individuals to **privacy, confidentiality, and self-determination**. Psychologists are aware of and respect **cultural, individual, and role differences**, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to **eliminate the effect on their work of biases based on those factors**, and they **do not knowingly participate in or condone activities of others based upon such prejudices**.

• **Duty to protect the rights of individuals to determine what and with whom personal information will be shared.**
DIGNITY AND WORTH OF A PERSON (NASW)

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.

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.
1.8 Client Autonomy in Decision Making.

Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions. Therapists clearly advise clients that clients have the responsibility to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, and visitation.
A.1.a. Primary Responsibility

- The primary responsibility of counselors is to respect the dignity and promote the welfare of clients.
7. In all mental health services, wherever and however they are delivered, clients have the right to be treated with dignity, consideration and respect at all times.

Clients have the right:

• a) To expect quality service provided by concerned, trained, professional and competent staff.

• b) To expect complete confidentiality within the limits of both Federal and state law, and to be informed about the legal exceptions to confidentiality; and to expect that no information will be released without the client’s knowledge and written consent.

• d) To a clear statement of the purposes, goals, techniques, rules limitations, and all other pertinent information that may affect the ongoing mental health counseling relationship.

• e) To appropriate information regarding the mental health counselor’s education, training, skills, license and practice limitations and to request and receive referrals to other clinicians when appropriate.

• f) To full, knowledgeable, and responsible participation in the ongoing treatment plan to the maximum extent feasible.
CLIENT'S RIGHTS (AMHCA)

• g) To obtain information about their case record and to have this information explained clearly and directly.
• h) To request information and/or consultation regarding the conduct and progress of their therapy.
• i) To refuse any recommended services, techniques or approaches and to be advised of the consequences of this action.
• j) To a safe environment for counseling free of emotional, physical, or sexual abuse.
• k) To a client grievance procedure, including requests for consultation and/or mediation; and to file a complaint with the mental health counselor's supervisor (where relevant), and/or the appropriate credentialing body.
• l) To a clearly defined ending process, and to discontinue therapy at any time.
INFORMED CONSENT
INFORMED CONSENT

• Seen by many as the primary means of protecting the self-governing and privacy rights of those with whom psychologists work.

• Autonomy based view of professional and scientific ethics
INFORMED CONSENT (APA)

• (a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code.

• (b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

• (d) Psychologists appropriately document written or oral consent, permission, and assent.
10.01 Informed Consent to Therapy

(a) When obtaining informed consent to therapy psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers.

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.
INFORMED CONSENT IN THE COUNSELING RELATIONSHIP (ACA)

• A.2.a. Informed Consent
  • Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to review in writing and verbally with clients the rights and responsibilities of both counselors and clients. Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship.
INFORMED CONSENT (NASW)

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.
INFORMED CONSENT (AMHCA)

I.A. Primary Responsibility

• A.1.b) Mental health counselors are **clear with clients about the parameters of the counseling relationship**. In a professional disclosure statement, they provide information about expectations and responsibilities of both counselor and client in the counseling process, their professional orientation and values regarding the counseling process, emergency procedures, supervision (as applicable) and business practices. Information is also provided regarding client rights and contact information for the state counseling licensure authority.
INFORMED CONSENT (AMHCA)

B. 2. Informed Consent

• Clients have the right to know and understand what is expected, how the information divulged will be used, and the freedom to choose whether, and with whom, they will enter into a counseling relationship.
  • a) Mental health counselors provide information that allows clients to make an informed choice when selecting a provider. Such information includes but is not limited to: counselor credentials, issues of confidentiality, the use of tests and inventories, diagnosis, reports, billing, and therapeutic process. **Restrictions that limit clients’ autonomy are fully explained.**
  • b) Informed Consent includes the mental health counselor’s professional disclosure statement and client bill of rights.
  • d) **Informed consent is ongoing and needs to be reassessed throughout the counseling relationship.**
1.2 Informed Consent.

- Marriage and family therapists obtain appropriate informed consent to therapy or related procedures and use language that is reasonably understandable to clients. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client:
  - (a) has the capacity to consent;
  - (b) has been adequately informed of significant information concerning treatment processes and procedures;
  - (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist;
  - (d) has freely and without undue influence expressed consent; and
  - (e) has provided consent that is appropriately documented.
CONFIDENTIALITY

Ethics of deciding when to Breach it.
• 4.01 Maintaining Confidentiality
Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.
4.02 Discussing the Limits of Confidentiality

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship
   • (1) the relevant limits of confidentiality and
   • (2) the foreseeable uses of the information generated through their psychological activities.

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.
3.08 Disclosures

(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.
1.07 Privacy and Confidentiality

(a) Social workers should respect clients' right to privacy.

(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 others. 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.
PRIVACY AND CONFIDENTIALITY

• (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.

• (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 client's 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.

• (n) Social workers should develop and disclose policies and procedures for notifying clients of any breach of confidential information in a timely manner.
• 2. Confidentiality
  • Mental health counselors have a primary obligation to safeguard information about individuals obtained in the course of practice, teaching, or research. Personal information is communicated to others only with the person’s consent, preferably written, or in those circumstances, as dictated by state laws. Disclosure of counseling information is restricted to what is necessary, relevant and verifiable.
CONFIDENTIALITY (AMHCA)

• a) Confidentiality is a right granted to all clients of mental health counseling services. From the onset of the counseling relationship, mental health counselors inform clients of these rights including legal limitations and exceptions.

• c) The release of information without consent of the client may only take place under the most extreme circumstances: the protection of life (suicidality or homicidality), child abuse, and/or abuse of incompetent persons and elder abuse. Above all, mental health counselors are required to comply with state and federal statutes concerning mandated reporting.
CONFIDENTIALITY (AMHCA)

• k) The primary client owns the rights to confidentiality; however, in the case where primary clients are minors or are adults who have been legally determined to be incompetent, parents and guardians have legal access to client information. Where appropriate, a parent(s) or guardian(s) may be included in the counseling process; however, mental health counselors must take measures to safeguard client confidentiality within legal limits.

• n) Mental health counselors may justify disclosing information to identifiable third parties if clients disclose that they have a communicable or life threatening illness. However, prior to disclosing such information, mental health counselors must confirm the diagnosis with a medical provider. The intent of clients to inform a third party about their illness and to engage in possible behaviors that could be harmful to an identifiable third party must be assessed as part of the process of determining whether a disclosure should be made to identifiable third parties.
B.1. RESPECTING CLIENTS RIGHTS

(ACA)

• B.1.a. Multicultural/Diversity Considerations
  • Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared.

• B.1.b. Respect for Privacy
  • Counselors respect the privacy of prospective and current clients. Counselors request private information from clients only when it is beneficial to the counseling process.

• B.1.c. Respect for Confidentiality
  • Counselors protect the confidential information of prospective and current clients. Counselors disclose information only with appropriate consent or with sound legal or ethical justification.

• B.1.d. Explanation of Limitations
  • At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify situations in which confidentiality must be breached.
B.2. EXCEPTIONS (ACA)

• B.2.a. Serious and Foreseeable Harm and Legal Requirements
  • The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception.
Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.

• **2.1 Disclosing Limits of Confidentiality.**
  • Marriage and family therapists disclose to clients and other interested parties at the outset of services the nature of confidentiality and possible limitations of the clients' right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures.
ETHICAL DECISION MAKING IN TREATING EATING DISORDERS
STEPS IN ETHICAL DECISION MAKING

1. Develop and Sustain a professional commitment to doing what is right
2. Ensure that you have a sufficient understanding of your Ethics Codes, General Principles, Standards, and Aspirational Core Values.
3. Gather additional facts (4-Bin approach)
4. Generate alternative paths and evaluate each based on additional facts (the 4 Bins)
5. Select and Implement a plan of action
6. To the extent possible, monitor and evaluate the effectiveness of the course of action
7. Modify and continue to evaluate the ethical plan if necessary.
4- BIN APPROACH

Clinical
Quality of Clinical Care

Ethical
Making decision that are doing the “right” thing

Risk Management
Malpractice/Board Complaints Exposure to liability

Legal
Considering laws, statues, and ordinances that are relevant
HOW TO WORK IN THE BINS

• We may often disagree on the most clinically appropriate course of treatment, but that needs to be clearly separated from a discussion about whether a course of action is unethical.

• Ethics is also often confused with liability risk; we may do things for ethical reasons that increase liability exposure.

• “Differentiation precedes integration”
4 BIN APPROACH

• What questions are in the bin?
• Whether the situation requires a certain bin to receive priority over the other bins?
• How possible tensions among the bins may be resolved?
• Where can the appropriate expertise can be found to answer questions outside the consultant’s expertise?
• What is in the best treatment or assessment interests of the individual with whom the psychologist is working?

• Is it better to provide some treatment that is insufficient or no treatment at all?

• Insight of a clinician
• How does a particular course of action increase or decrease the psychologist’s exposure to liability?
  • Assessing lethality/Suicide risk
  • Duty to protect
  • Risk of student dying (i.e. having a heart attack, fainting while dizzy, etc.)
  • Is this a situation that can be considered self-harm, does it reach the threshold of breaching confidentiality?
• Insurance/Malpractice Carrier
• Refers to the clinician’s responsibility to protect clients’ (or an identified 3rd party’s welfare when a clinician knows that a client poses and imminent risk of danger towards him or herself, or an identified third party.

• No law that clarifies the duty, that we may or may not have

• Thus, no clear guidance on how to execute the duty

• No immunity when trying to fulfill the duty
ETHICAL BIN

• What is the most ethical thing (the “right”) thing to do?

• Insight of licensing board’s ethics office
LEGAL BIN

• Related to federal laws (including regulations and the laws and regulations of a particularly jurisdiction

• Insight of an attorney

• Questions to be asked: Are there federal laws (including regulations) and the laws and regulations of the particular jurisdiction, whether it is a state, province or territory?
STANDARD OF CARE

• Outlines behaviors that are to be reasonably expected from a given set of issues, presenting concerns, diagnoses in treatment.
  • i.e. if a therapist in this same situation would have come to a similar conclusion or responded in a similar way.

• Designed for both protection of the client and the therapist.

• Provides guidelines for good decision making.

• Allows clients to make an informed decision and evaluation of their treatment and provides therapists with a foundation to stand on and justify their decisions regarding treatment- i.e. refusal to treat someone who needs a higher level of care than a center can provide.
STANDARD OF CARE

- Reasonable: Did you act in a way that in the professional judgements of other clinicians given the knowledge that you had or that you should have had at the time?

- It is your duty to not only know everything you DO know about your clients, but you will also be held against everything that you SHOULD know about your client.

- The outcome does not determine whether the standard of care was met, however, the questions of whether all factors were taken into consideration and the best decision was made is more important.

- So DOCUMENT! DOCUMENT! DOCUMENT!
LEVELS OF CARE

• Level 1 - Outpatient (College Counseling Centers)
• Level 2 - Intensive Outpatient
• Level 3 - Partial Hospitalization
• Level 4 - Residential Treatment Center
• Level 5 - Inpatient Hospitalization
TREATING EATING DISORDERS ON A COLLEGE CAMPUS
WHY HAVE A TREATMENT TEAM?

• A treatment team is THE recommended model of care
• Built in consultation
• Increases the ability to make ethical decisions
• Coordination of Care
• Assessment at the appropriate level
• Ongoing progress monitoring
TREATING EATING DISORDERS

• Developing a Treatment Team - Collaboration with Other Professionals
  • Physician (primary care physician, pediatrician, cardiologist, etc.)
  • Psychotherapist
  • Dietitian
  • Psychiatrist
  • Additional therapists as required (yoga therapist, art therapist, etc.)
  • Case manager at your insurance company (if needed)
COOPERATION WITH OTHER PROFESSIONALS

• 3.09 Cooperation with Other Professionals (APA)
  • When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately

• 2.03 Interdisciplinary Collaboration (NASW)
  • (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.
II. Commitment to Other Professionals

A. Relationship with Colleagues Mental health counselors act with due regard for the needs and feelings of their colleagues in counseling and other professions. Mental health counselors respect the rights and obligations of the institutions or organizations with which they associate.

1. Mental health counselors understand how related professions complement their work and make full use of other professional, technical, and administrative resources that best serve the interests of clients.

2. Mental health counselors treat professional colleagues with the same dignity and respect afforded to clients. Professional discourse should be free of personal attacks.

3. Mental health counselors respect the viability, reputation, and proprietary rights of organizations that they serve.
B.3.b. Interdisciplinary Teams

• When services provided to the client involve participation by an interdisciplinary or treatment team, the client will be informed of the team's existence and composition, information being shared, and the purposes of sharing such information.
B. Clinical Consultation

- Mental health counselors may offer or seek clinical consultation from another mental health professional. In clinical consulting mental health counselors provide critical and supportive feedback. Clinical consultation does not imply hierarchy or responsibility for client outcome.
4.06 Consultations

• When consulting with colleagues,
  • (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and
  • (2) they disclose information only to the extent necessary to achieve the purposes of the consultation.
CONSULTATION (NASW)

• (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.

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

• B.7. Case Consultation
  • B.7.a. Respect for Privacy Information shared in a consulting relationship is discussed for professional purposes only. Written and oral reports present only data germane to the purposes of the consultation, and every effort is made to protect client identity and to avoid undue invasion of privacy.
  • B.7.b. Disclosure of Confidential Information When consulting with colleagues, counselors do not disclose confidential information that reasonably could lead to the identification of a client or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided. They disclose information only to the extent necessary to achieve the purposes of the consultation.
• **2.7 Confidentiality in Consultations.**
  • Marriage and family therapists, when consulting with colleagues or referral sources, do not share confidential information that could reasonably lead to the identification of a client, research participant, supervisee, or other person with whom they have a confidential relationship unless they have obtained the prior written consent of the client, research participant, supervisee, or other person with whom they have a confidential relationship. Information may be shared only to the extent necessary to achieve the purposes of the consultation.
C.2.e. Consultations on Ethical Obligations

• Counselors take reasonable steps to consult with other counselors, the ACA Ethics and Professional Standards Department, or related professionals when they have questions regarding their ethical obligations or professional practice.
TREATING EATING DISORDERS

• Training
• Screeners and Assessment
• Diagnosing
• Communicating Diagnosis to client
• Determining appropriate level of care
  • Consultation
• Appropriate Interventions Based on LOC
• Referrals as needed
10.10 Terminating Therapy

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.
• 2.01 (b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

• 2.02 Providing Services in Emergencies
In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.
• 1.10 Referrals.
  • Marriage and family therapists respectfully assist persons in obtaining appropriate therapeutic services if the therapist is unable or unwilling to provide professional help.

• 1.11 Non-Abandonment.
  • Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of treatment.
1.16 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 other services are 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.
1.17 Termination of Services

- (a) Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests.

- (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.

- (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.
A.11. Termination and Referral

• A.11.a. Competence Within Termination and Referral
  • If counselors lack the competence to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors discontinue the relationship.

• A.11.c. Appropriate Termination
  • Counselors terminate a counseling relationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, or is being harmed by continued counseling. Counselors may terminate counseling when in jeopardy of harm by the client or by another person with whom the client has a relationship, or when clients do not pay fees as agreed upon. Counselors provide pre-termination counseling and recommend other service providers when necessary.

• A.11.d. Appropriate Transfer of Services
  • When counselors transfer or refer clients to other practitioners, they ensure that appropriate clinical and administrative processes are completed and open communication is maintained with both clients and practitioners.

• A.12. Abandonment and Client Neglect
  • 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, illness, and following termination.
TERMINATION AND REFERRAL (AMHCA)

• Mental health counselors do not abandon or neglect their clients in counseling.
  • a) Assistance is given in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacation and following termination.
  • b) Mental health counselors terminate a counseling relationship when it is reasonably clear that the client is no longer benefiting, when services are no longer required, when counseling no longer serves the needs and/or interests of the client, or when agency or institution limits do not allow provision of further counseling services.
  • c) Mental health counselors may terminate a counseling relationship when clients do not pay fees charged or when insurance denies treatment. In such cases, appropriate referrals are offered to the clients.
  • d) If mental health counselors determine that services are not beneficial to the client, they avoid entering or terminate immediately the counseling relationship. In such situations, appropriate referrals are made. If clients decline the suggested referral, mental health counselors discontinue the relationship.
TERMINATION AND REFERRAL (AMHCA)

• e) When mental health counselors refer clients to other professionals, they will be collaborative.

• f) Mental health counselors take steps to secure a safety plan if clients are at risk of being harmed or are suicidal. If necessary, they refer to appropriate resources, and contact appropriate support.
HEAL TEAM AT KSU

- Case Manager (Social Worker)
- Psychiatrist
- Treating Clinician(s) from various disciplines
- Dietician
- AOD Counselor
HEAL TEAM ED ASSESSMENT FLOW SHEET

• During Initial Consultation...
  • If CCAPS Eating Concerns area is 80 or higher, student identifies “Eating/Food” as reason for visit, or if student discloses any questionable disordered eating behaviors/attitudes, complete ED Questionnaire data form and attach to IC note
    • If student answers “Yes” to three or more questions from ED Questionnaire, Schedule IC: Extended Eating Disorder Assessment appointment

• After Initial Consultation...
  • Communicate with Eating Disorder Coordinator / Case Manager to notify of student
  • Review Eating Disorder Assessment to prepare for Extended Assessment, if needed
HEAL TEAM ED ASSESSMENT FLOW SHEET

• During Extended Assessment...
• Use Eating Disorder Assessment to guide Extended Assessment
  • If student meets criteria for an eating disorder:
  • Complete a Release of Information form for the following:
  • HEAL ROI
  • KSU WellStar Health Clinic (use the WellStar ROI)
  • Any treatment facilities the student has previously attended (using the treatment center’s ROI)
• Make the following appointments while in session:
  • Medical Work Up Appointment with KSU WellStar
  • Initial Nutrition Assessment with KSU Nutrition Services
• After Extended Assessment…
• Consult with Eating Disorder Coordinator/Case Manager to address any concerns (assessment, possible scope of care issues, etc.)
• Flag student with “ED Referral” flag; include date and “Referred by _____” in flag comment
• Complete HEAL Team Medical Work Up Referral Form
• Fax HEAL Team Medical Work Up Referral Form and WellStar ROI to KSU Health Clinic
• Provide ROIs for Case Manager to request records from previous treatment facilities
• Case Manager will schedule Psychiatry Initial Assessment upon receiving medical records, as needed
• HEAL Team will consult regarding appropriate level of care
REFERENCES


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REFERENCES


• The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.