Florida Laws and Rules

Introduction

This course was designed to meet the requirements of a Florida Laws and Rules course for Florida clinicians. This training will provide a review of ethical guidelines, laws, and ethical decision-making pertinent to Florida clinicians and will focus on many of the issues specific to Florida's underserved populations. The course provides information about and review changes to the laws and rules contained in Chapters 456 and 491, F.S., and Rule Title 64B4, F.A.C.

According to 2010 census data, the population of Florida is quite culturally diverse. It is also an aging population with an overall median age of 40.9. While it is not possible to estimate what percentage of this population has engaged mental health services, attention to providing quality mental health services has been an ongoing need. In 2004, the Florida Commission on Mental Health Services and Substance Abuse released the findings of a report that provided a wakeup call for mental health. The report concluded that Floridians with severe mental illnesses were particularly under-served by the mental health system, with less than 25 percent receiving services, that aging adults with serious mental disorders were the least well serviced in Florida's public mental health system, and that mental illness is extremely prevalent among the state’s adult and juvenile incarcerated population. Another startling finding was that the annual suicide rate in Florida—14.3 per 100,000 persons—is higher than the national average. In 2002, 2,332 Floridians died by suicide, making it the 9th leading cause of death in the state. 206 of those deaths were in individuals between the ages of 10 and 24 years.

These statistics provide a frame of reference for many of the ethical considerations required of Florida clinicians. Although many practitioners do not work with the specific groups listed in the report, many of the competencies needed to provide services to the populations listed above transcend the issue of client base, and are helpful for all clients.

While it is important to be familiar with the Florida needs related to mental health treatment, mental health professionals must also be familiar with the ethical guidelines for their specific professions and are encouraged to review these as well. Highlights from the various ethical codes will be covered in this training manual. Case studies and “Questions to Consider,” will also be used to illustrate this material. Participants in this training are encouraged to reflect on the questions contained prior to each section and before reviewing the material within the segment. A key part of learning and reflection is to develop sound ethical judgment. Some guidelines for this are listed below:

- Familiarize yourself thoroughly with established standards
- Be sensitive to ethical problems as they arise, and take into account the complexity of these issues
- Remember that ethical decision-making is an evolutionary process that requires you to be continually open and self-critical
While this document provides a comprehensive overview, additional resources that may prove helpful in delving deeper into ethical issues and scenarios includes Knapp & VandeCreek, (2012) and Welfel, (2012).

Educational Objectives

1. Discuss established ethical and legal requirements as stated in ethical codes and in Chapter 456 (General Provisions)
2. Be sensitive to ethical problems as they arise, including the complexity of these issues
3. Discuss the issue of competence and the steps a provider should take to maintain competence, including important competencies
4. Define multicultural competence and list some considerations in working with Latino families
5. Define confidentiality, and discuss informed consent and limits of confidentiality (including Baker act and Chapter 90.503: Psychotherapist-Patient Privilege)
6. List the legal requirements for mandated reporting of child and elder abuse
7. Discuss the dynamics of dual relationships
8. Discuss issues related to sexual relationships with clients including harm to therapist and client (law stated in Chapter 456, General Provisions)
9. Outline steps clinicians can take in responding to suicidal risk
10. Discuss recognizing medical conditions that share common symptoms with mental health illnesses
11. Discuss ethical issues related to the “business” of mental health
How Do Ethical Problems Occur?

**Questions to consider:**
Why are ethics important?
How do ethical problems occur?

Mental health professionals have a responsibility to the clients they serve. Although the scope of services may vary, the fundamental need to protect our clients’ interests does not. Ethical dilemmas occur frequently; ethical problems also occur but can be reduced through vigilance on the part of the provider and knowledge of ethical and legal codes.

The following is a list of some common reasons that ethical problems occur. As you will note by reading the list, some of these things are in the providers’ control and others are not.

**How do ethical problems occur?**
- People are human and make mistakes
- Clients misreport
- Inexperience
- Inadequate agency policies
- Guidelines not adequate for situation
- Ethics in conflict with law

By keeping these reasons in mind it is easier for the practitioner to avoid ethical pitfalls. The intersection between ethics and the law is a topic of particular interest. As such, the following sections of this document will consider ethical and legal issues related to mental health practice.

Ethics vs. Law

**Questions to consider:**
Are ethical standards and legal standards always consistent?
If they are not, what is the best way to handle this?

Many ethical issues faced by mental health professionals involve legal issues. Ethical decisions in social work, counseling and marriage and family therapy that involve legal issues do not *always* involve ethical dilemmas. In many cases such decisions are compatible with both legal and ethical standards.

However, other situations are more difficult ethical dilemmas, particularly when clinicians’ decisions are compatible with legal standards but not consistent with prevailing ethical standards or vice versa. In reading the following training material, such
Achieving and Maintaining Competence

Questions to consider:
Why is competence so critical for mental health professionals?
How do mental health professionals achieve and maintain competence?
Are there ever times when it is okay to practice outside the scope of one's competence?

Case Study

Melanie Walters, a licensed MFT, has been working with John and Mary. She has seen the couple in counseling for 6 months, and is supporting them in managing Mary's depression. Melanie receives a phone call from John, expressing concerns that his wife has started engaging in eating disordered behavior, including purging. Melanie is not familiar with treating bulimia, but feels that since she has already been treating the couple and that many of their communication problems are improving, the eating disorder does not need to be the focus of treatment. Mary's symptoms continue to increase in frequency, although Melanie is not aware of this. At work one day, Mary experiences severe vertigo. She consults with her primary care physician and learns that Mary's blood panels are abnormal. Melanie feels badly about this, but rationalizes that Mary has not made her aware that her symptoms have worsened. Had she known she would have referred Mary to a specialist (or would she?)

The above case study focuses on the issue of professional competence. Mental health providers cannot be expected to be “experts” in all psychological disorders or in treating all populations. Professional competence is at the heart of professional practice. It is so important that NASW considers it one of the core values of their profession. The concept of professional competence, however, is not unique to social work, but is a key factor in the ethical codes and professional training of all mental health professions. Epstein and Hundert (2002) define competence as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served” (p. 226).

Competence is explicitly mentioned in all professional codes of ethics. The AAMFT Code, for example, lists several areas of professional competence. These include:

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, or supervised experience.

3.2 Knowledge of Regulatory Standards. Marriage and family therapists
maintain adequate knowledge of and adhere to applicable laws, ethics, and professional standards.

3.3 Seek Assistance. Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment.

The issue of attaining and maintaining professional competence has been the focus of a number of authors (e.g., Welfel, 2012; Knapp and VandeCreek, 2012; Pope and Vasquez, 2007; Roberts et al., 2005.) It is also mentioned in all professional codes.

While there are many areas that mental health clinicians need to be fully competent in, some areas of particular interest to Florida clinicians are:

- Competence in treating serious mental illness (e.g., bipolar)
- Competence in assessing suicidal risk
- Competence in preventing medical errors
- Multicultural competence
- Competence in working with aging/vulnerable populations

For further resources on the topic of professional competence please see (e.g., Elman et al., 2005; Pope and Vasquez, 2007; Roberts et al., 2005.) For information on assessing suicidal risk, please see Klott & Jongsma (2004), working with the elderly, please see Knight (2004), and serious mental illness, please see Rudnick (2011).

Impaired Professionals

In addition to competence issues related to knowledge and skills, Florida statute 491.009 (Discipline) outlines another competence issue: lack of competence due to the professional’s illness or addiction. According to the statute: “Being unable to practice the profession for which he or she is licensed, registered, or certified under this chapter with reasonable skill or competence as a result of any mental or physical condition or by reason of illness; drunkenness; or excessive use of drugs, narcotics, chemicals, or any other substance” can result in loss of license.

Cultural Competence

Questions to consider:
What is “cultural competence?”
How do you assess whether you are culturally competent?
Are there circumstances in which a provider should refuse to provide services?
What are these circumstances?

Case Study
Gerald Siran, a licensed MFT, received a phone call from a couple seeking family counseling due to problems with the 14-year-old son. In a brief phone conversation, Gerald learned that the couple was from Laos, and that their son was the first generation to be raised in the United States. The mother, who had initiated the phone contact at the request of the school guidance counselor, expressed disappointment in their son, who had not been getting the grades (As) that the family expected. Gerald, who felt out of his depths due to a lack of knowledge about Laotian culture, referred the family to a colleague, who had worked with other Asian families. Has Gerald responded to the request for services ethically? Legally?

The idea of competence also encompasses the need for mental health professionals to be culturally competent treatment providers. Legal and ethical mandates for mental health professionals stress the need for these professionals to respect and promote the welfare of individuals and families. With the amazing diversity of Florida’s population, special attention to non-discriminatory practices is needed.

What is cultural competence? Saldana (2001) describes three important components in developing cultural competence: knowledge, professional skills, and personal attributes. The knowledge component consists of knowledge of the client’s culture, communication styles, and help seeking behaviors. Professional skills include application of specific techniques that will prove effective with diverse populations, the ability to discuss racial and ethnic issues, and the ability to use resources on behalf of minority clients. Perhaps the most important of these components are the personal attributes of the counselor, which includes a willingness to work with diverse populations and the ability to communicate genuine warmth and empathy.

Cultural competence is an area specifically mentioned in professional ethical codes. The NASW Code of Ethics, for example, states that social workers should:

- Understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.
- 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.
- Obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability.

Some Considerations for Latino Clients

In 2007, the total U.S. Latino population surpassed 45 million, or 15 percent of the U.S. population. According to the 2005 census, 18% of Floridians are of Latino descent, the second highest Latino population in the East coast outside of New York. Traditionally, Latinos have not been not well served in the mental health system.
Why is this the case? While there are a number of considerations, the language barrier is a primary issue. While most Latinos living in the U.S. do speak some English, 60 percent of Latino adults speak primarily Spanish at home. There are also socioeconomic disparities and differences in the way that Latinos seek mental healthcare. Many Latinos rely on folk medicine and traditional healers. Common folk illnesses related to mental health include *mal de ojo* (the "evil eye"), *susto* (fright illness), and *nervios* (vulnerability to stressful experiences) (Kaiser Permanente, 2001).

Mental health providers are often confused by cultural differences in the way Latino clients relate in therapy. Some important concepts include:

- **Simpatia**—politeness and the avoidance of hostile confrontation
- **Personalismo**—the value of warm personal interaction
- **Respeto**—the importance of showing respect to authority figures, including health care providers
- **Familismo**—collective loyalty to extended family and commitment to family obligation (more family-centered decision making model)

While these general guidelines are helpful, some sources for further information are: Jaes & Falicov (2000), Saldana, (2001), and Santiago-Rivera et al. (2002).

**Informed Consent**

**Questions to consider:**
How would you define “informed consent?”
Why is informed consent important? Therapeutically? Ethically?
Are there ever times when informed consent is unnecessary?

One important issue for mental health professionals is that of informed consent. Informed consent involves providing clients with information necessary to make educated decisions about treatment. The process of “informed consent” is an opportunity for the therapist and client to make sure they understand their shared venture. Knapp and VandeCreek (2012) term informed consent “empowered collaboration.” Informed consent is a process of communication and clarification. Professional codes of ethics are generally very similar in the way that they approach the informed consent process. The Florida Medical Consent Law (766.103), which primarily applies to medical professionals, states that informed consent should be obtained in writing, prior to administering medical services.

Providing clients with the information they need to become active participants in the therapy relationship begins with the initial session and continues throughout counseling. It is challenging to balance giving clients too much information and too little. Informed consent promotes the active cooperation of clients. Clients sometimes don’t realize they have rights and don’t think about their responsibilities in solving their
problems. They seek the expertise of a counselor without realizing that the success of
the therapy relationship depends largely on their own investment in the process.

The following case helps to illustrate the importance of the informed consent
process:

Anna is a 36-year-old morbidly obese female. Anna has been obese most of her
life, and has consulted with a surgeon regarding gastric bypass surgery. The surgeon
evaluates Anna, and feels that a gastric bypass would be an appropriate option for her.
He asks Anna to have a series of tests, including a psychological evaluation. The
evaluator feels that Anna needs more counseling prior to undergoing weight loss
surgery, and that the primary focus of this counseling should be in developing coping
skills and decreasing binging behavior. Anna is told to seek the services of a counselor
skilled in treating eating disorders. This counselor could send the surgeon a note when
he or she feels that Anna has the appropriate coping skills to manage the binging.

Anna contacts her insurance company and receives a list of eating disorder
specialists. She contacts Sarah Jeffers, a social worker with 15 years of experience in
treating eating disorders. In her initial session with Sarah, Anna explains why she is
seeking treatment for her binging. Anna clearly states that her ultimate objective is to
have gastric bypass surgery. She also provides Sarah with a copy of her psychological
evaluation.

Sarah and Anna meet for nine months. Both agree that Anna has made good
progress on her binging, but recognize that her weight has not changed. Anna asks
when Sarah believes that she will be ready to continue with the surgery process. Sarah
replies that she does not believe in gastric bypass and surgery and would not be willing
to support her in this and will not provide Anna with a letter for her surgeon.

In the case study, Sarah did not accurately represent her position on weight loss
surgery or provide Anna with information that would have allowed her to seek alternate
services.

Professional codes of ethics provide that clients have the right to be presented
with enough information to make informed choices about entering and continuing the
therapy relationship. The AAMFT Ethical Code, for example, is explicit in defining the
informed consent process. It states: “Marriage and family therapists obtain appropriate
informed consent to therapy or related procedures as early as feasible in the therapeutic
relationship, and use language that is reasonably understandable to clients. 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.”

Informed consent should include the following factors:
- Goals of therapy/psychotherapy services
- Risks and benefits of therapy
- Approximate length of the process
- Alternatives to therapy
- Fees and services, including processes if bills are not paid
- Qualifications and background of the counselor
- Treatment procedures, including emergency procedures
- Third party disclosures
- Choices between paying with and without insurance
- Limits of confidentiality

If the provider needs to be HIPAA compliant (transmission of information to third parties) the informed consent process must also include specific information about access to PHI (protected health information).

Confidentiality

Questions to consider:
Have you ever needed to break confidentiality? Why?
Why is confidentiality so important?
Are there times in which maintaining confidentiality proves to be limiting?
Would you like to see additional exceptions to confidentiality mandates?

Case Study

John, a 16-year-old high school junior has been in treatment with clinical social worker Sandra Connell for the past year. She has become increasingly concerned by his depression, and has noted some signs that tell her that he is considering suicide. Sandra asks that they have a family session with John’s parents to discuss the situation. She reminds John that it is a legal and ethical mandate that she get John help given the seriousness of the situation. John is very resistant and angrily storms out of the office when Sandra tells him that she will be contacting his parents. Did she handle this situation well from a therapeutic standpoint? Did Sandra handle the situation well from an ethical standpoint?

This section of the training material will outline a key aspect of mental health treatment: confidentiality. Seasoned clinicians are well aware that confidentiality in therapeutic relationships is not an absolute. There are times when client welfare dictates that the clinician break confidentiality, such as in the case of a client considering suicide or in a situation in which a client is being abused.

Confidentiality is a therapeutic, legal and an ethical issue. Confidentiality refers to the nature of information shared in therapy sessions as well as contents of a patient’s medical records. Although many of the factors related to confidentiality are familiar to
mental health providers, it is central to the practice of mental health professionals (Bond, 2011, Crowell, & Levi, 2012, Knapp & VandeCreek, 2012).

Confidentiality is also a leading cause of ethical complaints. Pope and Vasquez’s (2007) study of ethics complaints found that failing to protect client confidentiality was the fourth most frequent basis of disciplinary action. Kenneth Pope’s (2003) review of malpractice claims also found breach of confidentiality to be a leading cause of litigation. This is particularly concerning as confidentiality is central to developing a trusting and productive therapeutic relationship.

Mandates related to confidentiality are found in the ethical codes of all professions. The NASW Code of Ethics, for example, states: “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 mental health professionals keep information confidential does not apply when disclosure is necessary to prevent “serious, foreseeable, and imminent harm” to a client or other identifiable person. In these instances, professionals 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. This is open to some degree of discretion on the part of the treatment professional. In the case, for example, Sandra could disclose her concerns to John’s parents, and seek their help in arranging for hospitalization, but could choose not to provide them with specifics of information shared in therapy such as the stressors that have resulted in John’s suicidal ideation.

Thus, one of the primary considerations in looking at confidentiality is maintaining the privacy of client disclosures that are shared in therapy. Many clients are unaware of the degree of confidentiality that they can expect, and it is important to let them know that although it is not permissible for a mental health professional to share their disclosures with third parties without the client’s written consent (verbal consent can be given in emergency situations only), there are exceptions to this rule. It is the mental health professional’s responsibility to define the degree of confidentiality that can be promised. Generally speaking, it may be helpful to have clients sign a written statement that includes information about limits to confidentiality. A client should understand in advance the circumstances under which the therapist is allowed to disclose information (see Informed Consent). Knapp and VandeCreek (2012) also urge that clinicians using technologies such as Internet, Skype, and emails inform clients about the limits of confidentiality through these means of communication.

According to Florida Law (491.0147) any communication between any person licensed or certified under this chapter and her or his patient or client shall be confidential. This may be waived under the following conditions:

(1) When the person licensed or certified under this chapter is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by the patient or client, in which case the waiver shall be limited to
that action.

(2) When the patient or client agrees to the waiver, in writing, or, when more than one person in a family is receiving therapy, when each family member agrees to the waiver, in writing.

(3) When, in the clinical judgment of the person licensed or certified under this chapter, there is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society and the person licensed or certified under this chapter communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities. There shall be no liability on the part of, and no cause of action of any nature shall arise against, a person licensed or certified under this chapter for the disclosure of otherwise confidential communications.

Involuntary Commitment (Baker Act)

Case Study

Vicky is a social worker who is seeing Roberta Parkins, a 70-year-old widowed woman. Roberta’s husband recently passed away. Since that time, Vicky has become increasingly concerned that Roberta has not been taking care of herself. She has lost a significant amount of weight, and often comes to sessions disheveled. As Roberta decompensates, Vicky becomes more and more alarmed. After a no-show for an appointment, and an alarming phone call in which Vicky fears that Roberta may harm herself, she contacts the Department of Children and Families. When asked to provide Roberta’s medical record to the examining psychiatrist, she does so.

Another limit to confidentiality under Florida law concerns situations in which a patient may require involuntary hospitalization. The Florida Mental Health Act of 1971 (known as the "Baker Act") Florida Statute 394.451 (2009 rev.) allows for involuntary examination of an individual, when there is evidence that the person:

- Has a mental illness
- Is a harm to self, harm to others, or self neglectful

A patient may not be held in a receiving facility for involuntary examination longer than 72 hours.

Florida statute 394.4655 allows clinicians to release clinical records “for the purpose of determining whether a person meets the criteria for involuntary outpatient placement or for preparing the proposed treatment plan pursuant to hospitalization.” The record may be released to “the state attorney, the public defender or the patient’s private legal counsel, the court, and to the appropriate mental health professionals.”
Mandated Reporting

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<th>Questions to consider:</th>
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<td>Do you always report suspected cases of child/elder abuse? Why or why not?</td>
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<td>Why is mandated reporting necessary?</td>
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<td>Are any professional or ethical difficulties that arise from the need to be a mandated reporter?</td>
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Case Study

Vicki, a social worker in private practice sees Eric, an 8-year-old boy for the first time. His parents described “hyperactive” behavior and a propensity to get into trouble, some classic symptoms of ADHD. The evaluation today was at the request of the school, which had also noted the difficulties expressed by Eric’s parents. Vicki first meets with the family, noting that Eric actually appears quite withdrawn. There was little eye contact between Eric and his parents and at times he appeared to physically shrink away from his mother. Vicki does not see any evidence of hyperactive behavior, but she does recognize that sometimes this is not evident on first meeting a child. Vicki does note several bruises on Eric’s arms and legs, which Eric’s mother states are a result of rough play. They also state that Eric has been known to lie, and that he has done so in the past with school authorities. Eric’s parents reluctantly agree to Vicki spending time alone with Eric. In meeting individually with Eric, he makes reference to “hitting” and “screaming.” Suspicious, but uncertain what she was seeing, Vicki decides to assess the case further. She was later alerted by a local hospital that Eric had been admitted due to multiple fractures.

Gina is a social worker and has just started consulting with a geriatric day program. The group facilitator calls Gina to express concerns about Adele, a 68-year-old woman who has a dementing process. The program has noted that she becomes fearful and agitated when leaving for home at the end of the day. They have attempted to express their concerns with Adele’s son, Ronnie, but he has not returned their calls. They have not seen any signs of bruises, and Adele is well-nourished.

As these cases illustrate, child and elder abuse is a special area of concern for mental health professionals. The first child abuse and reporting law was enacted in California in 1963. This law pertained only to physicians, and covered the reporting of physical abuse. Since this time, the definition of mandated reporters has expanded, and includes mental health professionals. Current mandated reporting laws also expand the definition of the reportable types of abuse. Mandated reporters are defined as “professionals who, in the ordinary course of their work and because they have regular contact with children or other identified vulnerable populations (such as the elderly), are required to report suspicions of physical, sexual or other types of abuse.” The Florida Abuse Hotline will accept a report when a) There is reasonable cause to suspect that a child b) who can be located in Florida, or is temporarily out of the state but expected to return in the
immediate future, c) has been harmed or is believed to be threatened with harm d) from a person responsible for the care of the child.

Florida statute 39.201 ([http://www.flsenate.gov/Laws/Statutes/2012/39.201](http://www.flsenate.gov/Laws/Statutes/2012/39.201)) uses the "reasonable suspicion" rule. This simply says that although a clinician may not have concrete evidence of abuse, if the clinician’s training and experience causes them to believe that abuse is occurring, they must report this abuse. As mandated reporters, mental health professionals are immune from criminal or civil action in the case of a good faith report.

Types of reportable abuse are:

- abuse, abandonment or neglect by a parent, legal custodian, caregiver, or other person responsible for the child’s welfare
- abuse by an adult other than a caregiver
- sexual abuse by a caregiver or juvenile sexual offender

Florida law also requires mental health professionals to report abuse of “vulnerable adults.” These rules are covered by Florida statute 4114.1034 ([http://www.flsenate.gov/Laws/Statutes/2011/415.1034](http://www.flsenate.gov/Laws/Statutes/2011/415.1034)). This mandate covers: a) Any vulnerable adult who is a resident of Florida or currently located in Florida b) who is believed to have been abused or neglected by a caregiver in Florida, or c) suffering from the ill effects of neglect by self and is need of service, or d) exploited by any person who stands in a position of trust or confidence, or any person who knows or should know that a vulnerable adult lacks capacity to consent and who obtains or uses, or endeavors to obtain or use, their funds, assets or property. A vulnerable adult is defined as “persons 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging. (s. 415.102(27)), F.S.)

Penalties for those who suspect a child is being abused but fail to report it have been increased from a misdemeanor to a felony. Financial penalties also have increased.

Mandated reporters should call the Florida Abuse Hotline at 1-800-962-2873 (TDD 1-800-453-5145). If a child is in immediate danger, call 911.

**Recognizing Child Abuse and Neglect**

The following signs of child abuse and neglect are provided by the Child Welfare Information Gateway (2007):

**Signs of Physical Abuse**
Consider the possibility of neglect when the child has:
- Unexplained burns, bites, bruises, broken bones, or black eyes
- Fading bruises or other marks noticeable after an absence from school
• Fears of caretakers

Signs of Neglect
Consider the possibility of neglect when the child:
• Is frequently absent from school
• Begs or steals food or money
• Lacks needed medical or dental care, immunizations, or glasses
• Is consistently dirty and has severe body odor
• Lacks sufficient clothing for the weather
• Abuses alcohol or other drugs
• States that there is no one at home to provide care

Signs of Sexual Abuse
Consider the possibility of sexual abuse when the child:
• Has difficulty walking or sitting
• Suddenly refuses to change for gym or to participate in physical activities
• Reports nightmares or bedwetting
• Experiences a sudden change in appetite
• Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
• Becomes pregnant or contracts a venereal disease, particularly if under age 14
• Runs away

Recognizing Elder Abuse and Neglect

Signs of Elder Abuse
There are signs of abuse, neglect or exploitation that might alert mental health professionals to the possibility of problems. Although it is important not to take any of these signs as a “definite,” they should certainly be taken seriously. There is also the difficulty that some of these things may not be signs of abuse, but of client report skewed by declining mental state. Here are some common indicators of elder abuse (Hazeldon, 2010; Helpguide.org, 2010):

• Sudden change in behavior such as decreased grooming, staring vacantly, fear, agitation or anxiety, unexplained crying

• Discrepancies between a person’s standard of living and his/her financial assets, or a depletion of assets without adequate explanation..

• Withdrawn, apathetic, fearful, or anxious behavior.

• Malnourishment, poor overall hygiene, over-sedation, lack of healthcare appliances such as dentures or glasses.

5. Physical injuries, bruises, etc.

6. Reports of urinary tract infection, vaginal or anal bleeding
It is frequently very difficult to detect abuse. Typically, abusive behavior occurs in private and the victim may be unwilling or unable to describe the attacks. When reports are made, they are frequently not believed.

**Duty to Protect (Tarasoff)**

**Questions to consider:**
- What is your “Duty to Protect”?
- Do you believe that the “Duty to Protect” is beneficial? Why or Why not?
- What information should you consider in making a report?
- Do you agree that “Duty to Protect/Warn” should be permissive rather than mandatory?

On October 27, 1969 Tatiana Tarasoff was killed by Prosenjit Poddar, who was an exchange student at the University of California at Berkley. Poddar had pursued a romantic relationship with Tarasoff, however, she rejected his advances. Poddar sought treatment at the school’s mental health facility and was assigned to a psychologist who diagnosed him with paranoid schizophrenia. Poddar spoke about his anger at Tarasoff and his plans to murder her. The psychologist attempted to initiate commitment procedures without success, and although Poddar was questioned by police he was released after agreeing to stay away from Tarasoff. Two months later, Poddar murdered Tarasoff.

Tarasoff’s parents sued the university, the therapist, and the police for negligence. The case went to the California Supreme Court who found that the defendants were negligent in not notifying Tarasoff that she had been the subject of a homicidal threat. Specifically, the court ruled that the therapist is liable if (1) they should have known about the dangerousness based on accepted professional standards of conduct, and (2) they failed to exercise reasonable care in warning the potential victim.

The Supreme Court of California held that mental health professionals have a duty to protect individuals who are being threatened with harm by a patient. The original 1974 decision mandated warning the threatened individual, but a 1976 rehearing of the case by the California Supreme Court called for a “duty to protect” the intended victim. The professional may carry out the duty in several ways, including notifying police, warning the intended victim, and/or taking other reasonable steps to protect the threatened individual.

Opinions about duty to protect laws vary. The American Psychological Association, for example, has advocated allowing mental health workers to exercise professional judgment regarding the duty to warn and not to unnecessarily expand “dangerous patient” exceptions. The biggest criticisms of duty to protect laws is that they may discourage people from seeking help or fully disclosing their intentions; or that providers may be reluctant to treat potentially violent patients because they fear liability for failure to properly fulfill the duty to warn.
Florida laws do not require that clinicians warn but are “permissive” laws that allow clinicians break confidentiality in order to warn victims, but do not require it. According to Florida statute 394.4615, which pertains to clinical records “Information from a clinical record may be released under the Mental Health Act when the patient has declared an intention to harm other persons. If such a declaration is made, an administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient. Any facility or private mental health practitioner who acts in good faith in releasing information under this section are not subject to criminal or civil liability.”

Statute 491.0147 further states that “Any communications between psychotherapists or counselors and patients are confidential but may be waived when in the clinical judgment of the professional there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society. The professional may communicate information to the potential victim, appropriate family member, or law enforcement or other appropriate authorities. The professional is immune from liability for disclosure under this section.”

For further information, please see Soulier, Maislen & Beck (2010), Fox (2010) and Werth et al. (2008).

Multiple or Non-Sexual Dual Relationships

Questions to consider:
Have you ever encountered the possibility of entering a dual/multiple relationship?
Are all multiple relationships harmful?
Why may some dual relationships be harmful to clients?

The term “boundaries” refers to a set of rules of the professional relationships that set mental health professionals apart from other relationships. Boundaries clarify behaviors that are appropriate in psychotherapy, provide limits and structure, and prevent harm to patients (Knapp and VandeCreek, 2012).

Our ethical codes and state laws are aware of potential conflicts of interest in relationships with clients. There are a number of potential areas that could present potential conflicts of interests, but some of the most commonly occurring ones involve sexual relationships and non-sexual dual relationships. Sexual relationships are extremely harmful and will be discussed in the next section, but it is also important to review issues related to multiple/non-sexual dual relationships.

Standard 1.06C of the NASW ethical code states “Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple
relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries."

Some examples of dual/multiple relationships include:

- Counseling a friend, family member or someone known to the therapist
- Providing individual therapy to two members of the same household
- Providing simultaneous individual and group therapy
- Entering a business relationship with a client

Possible “warning signs” of inappropriate behavior and misuse of power:

- Entering a social relationship with a client
- Hiring a patient to do work for the therapist
- Bartering goods or services to pay for therapy.
- Supporting the patient’s isolation from social support systems
- Increasing dependency on the therapist.

If we compare the first and second lists, it is clear that some multiple relationships are extremely problematic and others are not at all problematic. For example, many therapists see clients in both individual and group therapy. Some relationships, however, are both avoidable and potentially problematic. Consider the follow case:

Case Study

Geri, clinical social worker in private practice, receives a call from Mary, an old college friend. Mary has recently discovered that her daughter, Kim, has been cutting herself, and Mary is very concerned. Kim has refused all treatment, but says she is willing to talk with Geri, whom she knows and trusts. Geri is not entirely comfortable with this, but feels that the potential benefits of treating Kim would outweigh any of the issues related to dual relationships. Geri sets up a consultation, and will reassess her stand following the meeting with Kim. Did Geri make the right decision? Why or why not?

There are many potential issues with Geri’s agreement to see Kim, even for only an assessment. Pope and Vasquez (1991) discuss the difficulties inherent in dual relationships. On the whole, dual relationships jeopardize professional judgment, clients’ welfare, and the process of therapy. Pope and Vasquez make the following points:

1. Dual relationships erode and distort the professional nature of the therapeutic relationship, which is secured within a reliable set of boundaries upon which both therapist and client depend
2. Dual relationships create conflicts of interest and thus compromise the disinterest necessary for sound professional judgment. Management of transference and countertransference becomes impossible
3. There is unequal footing between therapist and client, making a truly
egalitarian relationship impossible
4. The nature of therapy would change
5. This could affect future needs of the client. In particular, the therapist could be compelled (by court order) to provide testimony on the client’s diagnosis, treatment or prognosis

Consequences to the Therapist of Boundary Violations

In addition to consequences to clients, boundary violations effect therapists as well. Fry (2008) describes the following consequences to therapists:

a) Less personal time with family and friends
b) Less job satisfaction
c) Co-worker frustrations

Fry also lists “extreme” consequences of boundary violations:

a) Loss of job/license
b) Loss of professional identity
c) Loss of peers
d) Loss of professional relationships

Sexual Relationships with Clients

Questions to consider:
Have you ever encountered a situation in which a client reported having a sexual relationship with a former therapist? How did you handle this situation? Why do you believe it is harmful for a therapist and a client to engage in sexual intimacies?

Sexual contact of any kind between a therapist and a patient is unethical and illegal in the state of Florida. According to Florida statute 456.063 sexual misconduct is defined as “misconduct in the practice of a health care profession means violation of the professional relationship through which the health care practitioner uses such relationship to engage or attempt to engage the patient or client, or an immediate family member, guardian, or representative of the patient or client in, or to induce or attempt to induce such person to engage in, verbal or physical sexual activity outside the scope of the professional practice of such health care profession. Sexual misconduct in the practice of a health care profession is prohibited.” Sexual misconduct results in the revocation of their professional license. Statute 456.063 also states that no Board will admit to practice a candidate whose license has been revoked or surrendered in a different jurisdiction due to sexual misconduct. In addition to being illegal, sexual misconduct results in harm to the client.
Janine is a 36-year-old client seeking services from Carol Porter, LPC. Janine presents with symptoms of post-traumatic stress, including recurrent dreams, depression, and thoughts of self-harm. Janine is a survivor of multiple traumas, including abuse by a former therapist.

Despite ethical and legal mandates, estimates of sexual relationships between therapists and clients place these in the range of .9-3.6 percent for male therapists and .2-.5 percent for female therapists. The most important predictor of whether a client will become sexually involved with a therapist is prior sexual involvement on the part of the therapist (Pope & Vasquez, 1991). Interestingly there is also evidence that sexual attraction to clients is a common occurrence with 82 percent of therapists reporting that this has occurred for them at some point in their treatment (Pope & Vasquez, 1991).

Kenneth Pope (see references) a mental health ethicist who writes about many topics but has a particular interest in the area of sexual intimacies between therapists and clients recently conducted a national survey of 1,320 mental health professionals. He looked specifically at sexual relationships that had occurred between therapist and client following termination of treatment. He found that half the respondents reported assessing or treating at least one patient who had been sexually intimate with a prior therapist; a total of 958 sexual intimacy cases were reported. Most cases involved female patients. He also assessed perceptions of harm arising as a result of these intimacies and found that harm occurred in at least 80% of the instances in which therapists engaged in sex with a patient after termination.

**Warning Signs of Sexual Inappropriateness:**

- Telling sexual jokes or stories
- “Making eyes at” or giving seductive looks to the patient
- Discussing the therapist’s sex life or relationships excessively
- Sitting too close, initiating hugging, holding the patient or lying next to the patient
- “Special” treatment by a therapist, such as inviting a patient to lunch, dinner or other social activities
- Changing any of the office’s business practices (for example, scheduling late appointments so no one is around, having sessions away from the office, etc.)
- Confiding in a patient (for example, about the therapist’s love life, work problems, etc.)
- Relying on a patient for personal and emotional support
- Giving or receiving significant gifts

**Consequences to the Therapist of Sexual Boundary Violations**

Certainly therapists are human and do make mistakes. Sexual boundary violations are extremely detrimental professionally. Sexual intimacy with clients is a cause for revocation of licensure.

**Consequences to the Patient of Sexual Boundary Violations**
It is well established that sexual boundary violations harm the patient. Simon (1995) describes the types of harm that may occur. In addition to direct causation such as relapse or worsening of symptoms, there are more indirect consequences such as loss of trust and damage to self-esteem.

These consequences include:

- Disengagement from services
- Depression
- Shame, fear or rage
- Guilt and self-blame
- Isolation and emptiness
- Emotional lability
- Self-harm behaviors

Clearly these negative aspects of sexual boundary violations are important. It is key that mental health providers maintain a strong therapeutic frame and consider the possible consequences of their actions. Should they have any questions they may consult with colleagues or supervisors.

Responding to Suicide Risk

**Questions to consider:**

Have you ever been in a situation in which a client expressed suicidal ideation? How did you respond?

Why is it important not to minimize risk?

What is the most challenging aspect of responding to risk?

An important area of competence for clinicians is responding to a client who is having a suicidal crisis. While this is something that most clinicians have faced, it is difficult none-the-less. Given the statistics quoted in the introduction and which find that suicide is the 9th leading cause of death in Florida, a review of the issues involved in responding to suicidal crisis is certainly pertinent.

**Case Study**

John Gonzales is working with a patient, Sharon Peterson. Sharon is a “difficult” client and often engages in behaviors that John considers attention-seeking, and indicative of borderline personality disorder. Recently she expressed to John that she is feeling more depressed and thinks she will be dead by the end of the week. Sharon further states that she has “plenty of medication saved up to do the job right.” Despite the fact that Sharon has never made such a comment before, John makes the decision not to engage in her “borderline manipulation.” He is shocked when he receives a call from Sharon’s husband indicating that she is in intensive care and may not recover following
an overdose.

While there are no absolutes in assessment of and intervention for clients who are suicidal, one of the most important things that therapists can do is to educate themselves about risk factors and potential indicators. According to Pope and Vasquez (2011) these include:

- Direct verbal warning. This is one of the most useful indicators. If a client expresses suicidal ideation, it is always important to take the warning seriously. As demonstrated in the case study, clients with more serious psychological disorders are sometimes not taken seriously when expressing suicidal risk. According to Soloff et al. (2000) this is a mistake; People with Borderline Personality Disorder are more likely to complete suicide than individuals with any other psychiatric disorder. Between 8 and 10 percent of people with Borderline Personality Disorder will complete suicide.

- Indirect Statements/Behavioral warning signs. Not every person who is feeling suicidal will make a direct verbal statement. There are often, however, behavioral warning signs. Some common ones include giving away possessions, cancelling future plans or making indirect statements about "going away soon."

- Plan. The presence of a plan, particularly a concrete, specific plan, increases the risk. It is always important to ask the client for specifics of a plan. This does not "put ideas in someone's head."

- Past attempts. Clients who have made past attempts at suicide are significantly more likely to succeed with a subsequent attempt.

- Depression and other clinical disorders. While not all clients who commit suicide appear to be depressed, the presence of depressive symptoms increases suicidal risk. Vuorilehto MS, Melartin TK & Isometsa (2006) cite studies that found a large percentage of completed suicides to be about twenty times greater among depressed individuals than for the general population. The presence of other clinical disorders including alcoholism, schizophrenia and bipolar disorder also increase risk.

- Use of Alcohol. Intoxication was also a noted factor in suicide and suicide attempts. Between one-fourth and one-third of all suicides are associated with alcohol as a contributing factor. While a client may not be considered an alcoholic, or even a problem drinker, assessment of alcohol use is critical, particularly with the presence of other indications.

- Stressful events/Bereavement. A range of stressful events increase risk for suicide. This includes significant losses and deaths of loved ones, as well as serious physical illnesses and symptoms.
• Perceived burdensomeness/Lack of a sense of belonging. Joiner's review of the research and his own studies led him to conclude being considered a burden and a lack of sense of connectedness/belonging to others are two factors that are risk factors for death by suicide.

Pope and Vasquez (2011) list 10 factors to reduce suicide risk:

1) Screen all clients for suicidal risk during initial contact and remain alert to this issue throughout the therapy
2) Work with the suicidal client to arrange an environment that will not offer easy access to the instruments the client might use to commit suicide (in cases where risk is severe, this would involve inpatient hospitalization)
3) Work with the client to create an actively supportive environment (family/friends)
4) While not denying or minimizing the client's problems and desire to die, also recognize and work with the client's strengths and desire to live
5) Make every effort to communicate and justify realistic hope. Hopelessness is a big part of suicide attempts
6) Explore any fantasies the client may have regarding suicide. This will also help to assess presence of a plan
7) Make sure communications are clear and evaluate the probable impact of any interventions
8) When considering hospitalization as an option, explore the drawbacks as fully as the benefits, the probable long-term and the immediate effects of this intervention. Other options can include partial hospitalization, intensive outpatient or more frequent sessions
9) Be sensitive to negative reactions to the client's behavior. While it is sometimes hard to hear about suicidal thoughts, reacting negatively does not help
10) Communicate caring

For further information on assessing and responding to suicidal risk, please see Pope and Vasquez (2011) and Klott & Jongsma (2004).

Failure to Detect Medical Conditions

Another area of competence needed by Florida mental health professionals is training on medical errors. While the scope of this document precludes a full discussion, one of the frequently cited medical errors is a clinician’s “failure to diagnose medical illness when psychological symptoms are associated with this condition.” These disorders are typified by the presence of mental symptoms that are the consequences of an underlying medical condition (Chaung, 2006). Despite the inclusion of these criteria in the DSM, study of medical illness is not covered in many psychology, counseling or social work programs.

In his definitive text, *When Psychological Problems Mask Medical Disorders: A*
Guide for Psychotherapists, Morrison (1999) lists 60 medical illnesses that may result in psychological symptoms. Such symptoms include, but are not limited to, depression, anxiety, dementia, perceptual changes (e.g., hallucinations), depersonalization, personality changes, and emotional lability. These symptoms may also be the result of a mental disorder. Another author to discuss this issue is Hersen (2004).

Morrison (1999) suggests that clinicians screen for possible medical illness during the initial assessment and beyond, but notes that it may be difficult for mental health clinicians to diagnose physical illnesses. Symptoms of disease may be gradual at first and many clients have consulted medical doctors, and testing has been inconclusive. Morrison (1999) notes that it is easier to detect a medical issue in an existing client that presents with a personality or behavior change, as clinicians can compare these symptoms to a prior baseline. He also suggests that clinicians remain vigilant when clients discuss new physical symptoms, symptoms that don’t fit the working diagnosis or when a client has symptoms that don’t resolve despite appropriate treatment. Morrison (1999) cites several “sources of error,” such as clinicians’ tendencies to focus only on what they know best or to seek a “comfortable” diagnosis.

How can mental health professionals screen for medical disorders? In her discussion of mental disorders secondary to general medical conditions, Chaung (2006) provides a helpful list of features that suggest a medical origin to psychiatric symptoms:

- Late onset of initial presentation
- Known underlying medical condition
- Atypical presentation of a specific psychiatric diagnosis
- Absence of personal and family history of psychiatric illnesses
- Illicit substance use
- Medication use
- Treatment resistance or unusual response to treatment
- Sudden onset of mental symptoms
- Abnormal vital signs
- Waxing and waning mental status

Chaung (2006) also provides a comprehensive listing of medical conditions that result in psychological symptoms. She divides these categories that are helpful in thinking about this topic. These include symptoms that are a result of medical and toxic effects (e.g., alcohol or drug related mental symptoms), diseases of the central nervous system (e.g., tumors, multiple sclerosis, normal pressure hydrocephalus), infectious diseases (e.g., HIV, pneumonia), metabolic and endocrine disorders (e.g., thyroid disorder, hypo/hyperglycemia), cardiopulmonary disease (e.g., myocardial infarction, congestive heart failure) and an other category (e.g., systemic lupus, anemia). Chaung goes on to discuss each of the illnesses she identifies.

While it is impossible for clinicians to be familiar with every medical condition that may result in psychological symptoms, and a workup with a medical provider is a good rule of thumb for new clients. Clinicians should consult with medical doctors when
needed to appropriately assess or rule out physical illness.

**Ethics and Business Practice**

Another area of ethics involves the business of mental health practice. Misunderstandings about the nature of mental health services, office policies and fee arrangements can lead to a breach of the therapeutic relationship. A related issue involves the marketing of mental health services. Clinicians should be aware of the relevant sections of their ethical codes. This section will provide a brief overview of some of these concerns.

*Marketing and Advertising*

Clinicians advertise themselves in many different ways: through printed materials, through their business cards, on the Internet, through consumer-oriented and professional publications and through public and professional talks. The key to ethical marketing is in being balanced in what is stated, and ensuring accuracy.

Advertising of mental health services is covered in most professional codes. The NASW code of ethics, for example, includes a section on Public Statements. The introduction to the section reads “Public statements, announcements of services, and promotional activities of clinical social workers serve the purpose of providing sufficient information to aid consumers in making informed judgments and choices. Clinical social workers state accurately, objectively, and without misrepresentation their professional qualifications, affiliations, and functions as well as those of the institutions or organizations with which they or their statements may be associated. In addition, they should correct the misrepresentations of others with respect to these matters.”

Marketing materials should strive to be accurate about a clinician’s credentials. Materials can include:

- highest relevant academic degree from an accredited institution;
- specialized post-graduate training;
- type and level of state certification or license;
- any advanced certifications held;

If a clinician holds a degree in another field, it is important to be clear about the distinction. For example, if a counselor who specializes in health psychology also holds a master’s degree in health education, it is permissible to clearly state that (e.g., Mary Smith, Licensed Professional Counselor, Ed.M., in health education).

Marketing materials that contain statements about fee arrangements should also strive to be accurate. While it is ethical to include statements such as “moderate fees,” this may be unclear to consumers.
Billing and Bill Collection

Billing issues should be discussed with clients from the first contact. Ethically it is important that the fees are "fair, reasonable, and commensurate with the service performed. Consideration should be given to clients' ability to pay." While fee discussions are often distasteful, it is advisable to discuss fees with clients verbally and in writing, including fee amounts, what services are billed, when payment is due, use of credit cards and other pertinent information. Explaining these issues helps patients make and informed decision. The following illustrates some of the difficulties that clinicians encounter.

Case Study

Julie, an art therapist agreed to see Connie. While she had some hesitation about Connie’s ability to pay for services, she agreed to put her on a payment plan. Connie continued to run up a large balance while becoming increasingly dependent on her therapy sessions. Julie found herself becoming resentful of not being paid, especially when she noted Connie’s excesses, such as arriving to each session toting an expensive coffee drink. Julie angrily and abruptly terminated treatment.

While it is not inherently unethical for Julie to terminate therapy due to nonpayment, this is an example where it was not ethical to begin treatment with a client who could not afford services. By continuing this treatment and then abruptly terminating with Connie, she has left herself open to an ethical complaint. Additionally, if clinicians intend to use collection agencies or take legal measures to collect fees from clients who do not pay for services as agreed upon, they first inform clients of intended actions and offer clients the opportunity to make payment (ACA ethical standard A.10.C)

Another common question concerns insurance coverage and determining who the identified patient is. This question can sometimes be challenging. Consider these examples:

Kelly is working with Tina, a married woman struggling with depression. The depression is creating a great deal of strain on the marriage. Kelly sees Tina’s husband for several sessions in order to increase marital support. She bills the insurance company under Tina as the patient.

In this example the therapist was acting appropriately as the treatment was supporting Tina’s recovery and that treatment was rendered in a collateral context.

Regina is working with Cara, a married woman struggling with depression. The depression is creating a great deal of strain on the marriage. Regina sees Cara’s husband for several sessions in order to increase marital support. Because the insurance plan he has through his work has more substantial coverage and reimbursement, Regina bills the session under her husband’s benefit, using the
This example is more problematic. Cara’s husband was not being treated for an adjustment disorder; Cara was being treated for anxiety. This was a collateral visit and fits the criteria for insurance fraud (see Florida statute 817.234) due to misrepresentation of billing information for personal gain.

Another common question is that of reducing fees and/or waiving co-pays. While many clinicians reduce fees for clients with demonstrated financial need, this should be well-documented. Reducing co-pays as a way to set a sliding scale is a practice that has come under increasing scrutiny. This falls under the domain of the Florida Patient Brokering Statute. This statute says that if a clinician intends to waive copayments for a patient, they should inform the insurer upon the submission of its claim of the waiver. The insurer can then take the position that the reimbursement amount paid to the supplier should be reduced by the amount of copayment waived by the supplier.

For further information on the ethics of billing practices, please see Barnett & Walfish (2011) and Mikalac (2005).

**Updates to Florida Laws and Board Rules**

The following are updates to the 2013 Florida Statutes which are relevant to licensed practitioners.

**Continuing Education**

Every third biennium after initial licensure, a licensee must complete three hour of laws and rules continuing education credits.

An easy way to keep up to date on changes to the law and board rules is to sign up for email updates on the board website. You can do this by clicking on the "Resources" tab and look for the Subscribe & Receive Updates via Email! headline.

**Summary**

This training document has outlined many important ethical and legal issues for Florida mental health professionals including responding to common ethical dilemmas, achieving and maintaining competence, informed consent and confidentiality, and sexual and nonsexual dual relationships. Although mental health professionals cannot be experts, it is expectable that they advance the welfare of families and individuals, respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately. Remember the following overall guidelines:
• Familiarize yourself thoroughly with established standards
• Be sensitive to ethical problems as they arise, including the complexity of these issues
• Remember that ethical decision-making is an evolutionary process that requires you to be continually open and self-critical
Appendix

2013 Florida Statutes

Clinical, Counseling, and Psychotherapy Services

491.0057 Dual licensure as a marriage and family therapist.--the department shall license as a marriage and family therapist any person who demonstrates to the board that he or she:

(1) Holds a valid, active license as a psychologist under chapter 490 or as a clinical social worker or mental health counselor under this chapter, or is certified under s. 464.012 as an advanced registered nurse practitioner who has been determined by the Board of Nursing as a specialist in psychiatric mental health.

(2) Has held a valid, active license for at least 3 years.

(3) Has passed the examination provided by the department for marriage and family therapy.

491.009 Discipline.--

(1) When the department or the board finds that an applicant, licensee, provisional licensee, registered Intern, or certificate holder whom it regulates under this chapter has committed any of the acts set forth in subsection (2), it may issue an order imposing one or more of the following penalties:

(a) Denial of an application for licensure, registration, or certification, either temporarily or permanently.

(b) Revocation of an application for licensure, registration, or certification, either temporarily or permanently.

(c) Suspension for a period of up to 5 years or revocation of a license, registration, or certificate, after hearing.

(d) Immediate suspension of a license, registration, or certificate pursuant to S. 120.60(6).

(e) Imposition of an administrative fine not to exceed $1,000 for each count or separate offense.

(f) Issuance of a public reprimand.
(g) Placement of an applicant, licensee, registered intern, or certificate holder on probation for a period of time and subject to such conditions as the board may specify, including, but not limited to, requiring the applicant, licensee, registered intern, or certificate holder to submit to treatment, to attend continuing education courses, to submit to reexamination, or to work under the supervision of a designated licensee or certificate holder.

(h) Restriction of practice.

(2) The following acts of a licensee, provisional licensee, registered intern, certificate holder, or applicant are grounds for which the disciplinary actions listed in subsection (1) may be taken:

(a) Attempting to obtain, obtaining, or renewing a license, registration, or certificate under this chapter by bribery or fraudulent misrepresentation or through an error of the board or the department.

(b) Having a license, registration, or certificate to practice a comparable profession revoked, suspended, or otherwise acted against, including the denial of certification or licensure by another state, territory, or country.

(c) Being convicted or found guilty of, regardless of adjudication, or having entered a plea of nolo contendere to, a crime in any jurisdiction which directly relates to the practice of his or her profession or the ability to practice his or her profession. However, in the case of a plea of nolo contendere, the board shall allow the person who is the subject of the disciplinary proceeding to present evidence in mitigation relevant to the underlying charges and circumstances surrounding the plea.

(d) False, deceptive, or misleading advertising or obtaining a fee or other thing of value on the representation that beneficial results from any treatment will be guaranteed.

(e) Advertising, practicing, or attempting to practice under a name other than one’s own.

(f) Maintaining a professional association with any person who the applicant, licensee, registered intern, or certificate holder knows, or has reason to believe, is in violation of this chapter or of a rule of the department or the board.

(g) Knowingly aiding, assisting, procuring, or advising any nonlicensed, nonregistered, or noncertified person to hold himself or herself out as licensed, registered, or certified under this chapter.

(h) Falling to perform any statutory or legal obligation placed upon a person licensed, registered, or certified under this chapter.
(I) Willfully making or filing a false report or record; failing to file a report or record required by state or federal law; willfully impeding or obstructing the filing of a report or record; or inducing another person to make or file a false report or record or to impede or obstruct the filing of a report or record. Such report or record includes only a report or record which requires the signature of a person licensed, registered, or certified under this chapter.

(0) Paying a kickback, rebate, bonus, or other remuneration for receiving a patient or client, or receiving a kickback, rebate, bonus, or other remuneration for referring a patient or client to another provider of mental health care services or to a provider of health care services or goods; referring a patient or client to oneself for services on a fee-paid basis when those services are already being paid for by some other public or private entity; or entering into a reciprocal referral agreement.

(k) Committing any act upon a patient or client which would constitute sexual battery or which would constitute sexual misconduct as defined pursuant to s. 491.0111.

(l) Making misleading, deceptive, untrue, or fraudulent representations in the practice of any profession licensed, registered, or certified under this chapter.

(m) Soliciting patients or clients personally, or through an agent, through the use of fraud, intimidation, undue influence, or a form of overreaching or vexatious conduct.

(n) Failing to make available to a patient or client, upon written request, copies of tests, reports, or documents in the possession or under the control of the licensee, registered intern, or certificateholder which have been prepared for and paid for by the patient or client.

(o) Failing to respond within 30 days to a written communication from the department or the board concerning any investigation by the department or the board, or failing to make available any relevant records with respect to any investigation about the licensee’s, registered intern’s, or certificateholder’s conduct or background.

(p) Being unable to practice the profession for which he or she is licensed, registered, or certified under this chapter with reasonable skill or competence as a result of any mental or physical condition or by reason of illness; drunkenness; or excessive use of drugs, narcotics, chemicals, or any other substance. In enforcing this paragraph, upon a finding by the secretary, the secretary’s designee, or the board that probable cause exists to believe that the licensee, registered intern, or certificateholder is unable to practice the profession because of the reasons stated in this paragraph, the department shall have the authority to compel a licensee, registered intern, or certificateholder to submit to a mental or physical examination by psychologists, physicians, or other licensees under this chapter, designated by the department or board. If the licensee, registered intern, or certificateholder refuses to comply with such order, the department’s order directing the examination may be enforced by filing a petition for
enforcement in the circuit court in the circuit in which the licensee, registered intern, or certificateholder resides or does business. The licensee, registered intern, or certificateholder against whom the petition is filed shall not be named or identified by initials in any public court records or documents, and the proceedings shall be closed to the public. The department shall be entitled to the summary procedure provided in 51.011. A licensee, registered intern, or certificateholder affected under this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that he or she can resume the competent practice for which he or she is licensed, registered, or certified with reasonable skill and safety to patients.

(q) Violating provisions of this chapter, or of part II of chapter 456, or any rules adopted pursuant thereto.

(r) Performing any treatment or prescribing any therapy which, by the prevailing standards of the mental health professions in the community, would constitute experimentation on human subjects, without first obtaining full, informed, and written consent.

(s) Failing to meet the minimum standards of performance in professional activities when measured against generally prevailing peer performance, including the undertaking of activities for which the licensee, registered intern, or certificate holder is not qualified by training or experience.

(t) Delegating professional responsibilities to a person whom the licensee, registered intern, or certificate holder knows or has reason to know is not qualified by training or experience to perform such responsibilities.

(u) Violating a rule relating to the regulation of the profession or a lawful order of the department or the board previously entered in a disciplinary hearing.

(v) Failure of the licensee, registered intern, or certificate holder to maintain in confidence a communication made by a patient or client in the context of such services, except as provided in 491.0147.

(w) Making public statements which are derived from test data, client contacts, or behavioral research and which identify or damage research subjects or clients.

491.0149 Display of license; use of professional title on promotional materials

-(1)(a) A person licensed under this chapter as a clinical social worker, marriage and family therapist, or mental health counselor, or certified as a master social worker shall conspicuously display the valid license issued by the department or a true copy thereof at each location at which the licensee practices his or her profession.
(b) 1. A licensed clinical social worker shall include the words "licensed clinical social worker" or the letters "LCSW" on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the licensee.

2. A licensed marriage and family therapist shall include the words “licensed marriage and family therapist” or the letters “LMFT” on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the licensee.

3. A licensed mental health counselor shall include the words “licensed mental health counselor” or the letters “LMHC” on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the licensee.

(2)(a) A person registered under this chapter as a clinical social worker intern, marriage and family therapist intern, or mental health counselor intern shall conspicuously display the valid registration issued by the department or a true copy thereof at each location at which the registered intern is completing the experience requirements.

(b) A registered clinical social worker intern shall include the words “registered clinical social worker intern,” a registered marriage and family therapist intern shall include the words “registered marriage and family therapist intern,” and a registered mental health counselor intern shall include the words “registered mental health counselor intern” on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the registered intern.

(3)(a) A person provisionally licensed under this chapter as a provisional clinical social worker licensee, provisional marriage and family therapist licensee, or provisional mental health counselor licensee shall conspicuously display the valid provisional license issued by the department or a true copy thereof at each location at which the provisional licensee is providing services.

(b) A provisional clinical social worker licensee shall include the words “provisional clinical social worker licensee,” a provisional marriage and family therapist licensee shall include the words “provisional marriage and family therapist licensee,” and a provisional mental health counselor licensee shall include the words “provisional mental health counselor licensee” on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the provisional licensee.

491.0111 Sexual misconduct. Sexual misconduct by any person licensed or certified under this chapter, in the practice of her or his profession, is prohibited. Sexual misconduct shall be defined by rule.

491.0112 Sexual misconduct by a psychotherapist; penalties

(1) Any psychotherapist who commits sexual misconduct with a client, or former client
when the professional relationship was terminated primarily for the purpose of engaging in sexual contact, commits a felony of the third degree, punishable as provided in s. 775.082 or s. 775.082; however, a second or subsequent offense is a felony of the second degree, punishable as provided in s. 775.082 s. 775.083 s. 775.084.

(2) Any psychotherapist who violates subsection (1) by means of therapeutic deception commits a felony of the second degree punishable as provided in s. 775.082 s. 775.083 s. 775.084.

(3) The giving of consent by the client to any such act shall not be a defense to these offenses.

(4) For the purposes of this section:

(a) The term “psychotherapist” means any person licensed pursuant to chapter 458, chapter 459, chapter 464, chapter 490, or chapter 491, or any other person who provides or purports to provide treatment, diagnosis, assessment, evaluation, or counseling of mental or emotional illness, symptom, or condition.

(b) “Therapeutic deception” means a representation to the client that sexual contact by the psychotherapist is consistent with or part of the treatment of the client.

(c) “Sexual misconduct” means the oral, anal, or vaginal penetration of another by, or contact with, the sexual organ of another or the anal or vaginal penetration of another by any object.

(d) “Client” means a person to whom the services of a psychotherapist are provided.
References

APA Online. Patient Protections: The Core of the Privacy Rule. 

American Association Of Marriage And Family Therapy Code of Ethics Retrieved January 6, 2012 from 

A Citizen’s Guide to Reporting Elder Abuse and Neglect Retrieved January 6, 2012 from 
www.ag.ca.gov/bmfea/pdfs/citizens_guide.pdf

Access to and amendment of health records Retrieved May 21, 2009 from 
http://www.disabilityrightsca.org/pubs/511201.htm


Overview of HIPAA – General Information http://www.cms.hhs.gov/hipaaGenInfo/


