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Ethical Concerns When Working with Children and Adolescents

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Introduction

Behavioral health professionals support individuals across the lifespan from all different backgrounds. Case managers might have teenagers who immigrated from another country and who speak very little English on their caseloads as well as also having infants from a wealthy family to oversee. Any professional who enters into behavioral health or mental health in some way should be prepared to support children and adolescents as well as their families.

Working with children and minors has a variety of ethical responsibilities that behavioral health professionals must adhere to because of the high vulnerability of minors. Behavioral health professionals are often the gatekeepers to important services for the health and safety of minors. Because of this, these professionals must always be leading with strong ethical values and practices.

Section 1: How Behavioral health professionals support children and adolescents in their work

Introduction

There are dozens of roles that behavioral health professionals assume where they support and work with children and adolescents. Those roles and professional guidelines will determine the kind of services and treatments provided, and each individual may adhere to a different set of responsibilities and requirements when caring for minors. Regardless of the specific role, care providers have an ethical responsibility to protect the wellbeing and support the needs of the minor child.

This section of the course will review a variety of different roles in behavioral health where professionals work with minor children.

Child Psychologist and Psychiatrist

Psychologists who specialize in working with children will support the psychological, behavioral, social, and emotional needs of children in their practices (Cherry, 2021). They may work in a variety of settings including schools, private practices, hospitals, and research settings. They are responsible for assessing, diagnosing, and treating mental

disorders that children experience (Cherry, 2021). Child psychiatrists have similar responsibilities when treating children, but they may prescribe medication as part of the treatment plan to help children who are struggling. While child psychologists follow the The American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct, child psychiatrists have a specific set of ethical principles for working with young clients.

The American Academy of Child and Adolescent Psychiatry outlines the following ethical principles for Child Psychiatrists (2021):

Principle 1: Developmental Perspective

“This is an aspect of ethics unique to our profession, emphasizing the obligation to understand the developmental context of children and adolescents when providing clinical care, conducting research studies or making consultation recommendations. All aspects of development should be considered and optimal development should always be facilitated.”

Principle 2: Promoting the Welfare of Children and Adolescents

“This focuses on the obligation to promote the optimal wellbeing, functioning and development of youth, both as individuals and as a group. This commitment should be prioritized over familial or societal pressures. The actions of the child and adolescent psychiatrist should be based on solid scientific knowledge, including properly conducted research, clinical experience and sound judgment, and an understanding of the significant relationships between the child, adults, and agencies. In situations in which the practitioner has obligations to entities other than the child or adolescent, these responsibilities should be clear to all. The welfare and needs of the child should be paramount.”

Principle 3: Minimizing Harmful Effects

“This focuses on the importance of "do no harm". Practitioners should strive to avoid any and all actions that may be detrimental to the optimal development of children and adolescents. They should also strive to minimize the harmful impact of the behaviors of others on children at the individual, family, local community, and societal levels. The vulnerability of youth and their families should never be exploited for personal gain. Relationships outside of professional interactions should be carefully considered

prioritizing the responsibility to prevent any adverse impact on patient care. Some types of relationships, such as sexual interactions with current or former patients are never appropriate."

Principle 4: Assent and Consent

"This focuses on respecting the rights of patients and caregivers to make their own informed decisions without pressure. Youth under the age of 18 years should be involved in the decision making about their care and assent should be obtained. Guardians must always consent to treatment except in emergencies. Practitioners should always provide full communication about all relevant issues for informed decisions to be made. Particular care should be taken when youth and guardians disagree."

Principle 5: Confidentiality

"This focuses on the patient's right to have information kept private and confidential. Practitioners should inform children and adolescents about confidentiality and any known limits to their confidentiality at the beginning of the treatment relationship. Patients and their families should always be told, preferably in advance, about possible disclosures of information, such as the reporting of abuse. Release of information to outside parties must involve the guardian's consent and the patient's assent as capable."

Principle 6: Third Party Influence

"This focuses on issues related to the influences of outside entities. Practitioners should always place the welfare of the patient above competing interests. Monitoring to keep professional judgments and opinions regarding the interests of children and adolescents above improper influence by competing interests is paramount. Child and adolescent psychiatrists should fully disclose and describe all possible conflicts to all involved parties."

Principle 7: Research Activities

"This focuses on the value of research with emphasis on the importance of minimizing risk. While scientific advancement of the field is essential, the priority of researchers must be to protect the child or adolescent from risks. The safety and well being of the participating youth is always paramount. The level of risk should always be fully disclosed. A child should never be forced to participate against their will and assent

should always be obtained; Children and adolescents always have the right to rescind assent and parents and guardians always have the right to rescind consent. Research should always be conducted in accordance with all ethical standards. All investigator and organizational conflicts of interest should be clear and thoroughly discussed."

Principle 8: Advocacy and Equity

"This focuses on the importance of the availability of competent mental health care for all children, adolescents and families. Practitioners should support efforts to improve access to care for all children. Practitioners should also attempt to minimize youth's exposure to injustice. Research risk should not be borne disproportionately by vulnerable groups and its benefits should be shared equally."

Principle 9: Professional Rewards

"This focuses on issues relevant to the tangible and intangible reinforcements of aspects of CAP practice. Practitioners should be aware of the possible influence of rewards on their judgments and actions. Child and adolescent psychiatrists should not exploit their influence or relationships for improper personal aggrandizement. The pursuit of personal rewards must not interfere with or negatively impact youth, families or communities. When such rewards compromise the integrity of the child and adolescent psychiatrist the public trust in the CAP profession is damaged."

Principle 10: Legal Considerations

"This focuses on the importance of understanding the local, state and federal laws that impact CAP practice. For example, in some circumstances, adolescents manage consent and confidentiality, not their parents or guardians. However, legal standards do not replace ethical ones. Practitioners should be knowledgeable in both areas, striving to integrate them effectively in practice."

School Psychologists

School psychologists are essential for supporting children who may not otherwise be referred to treatment. Children in need of support are often identified in the classroom by their teachers and treated at school when they can be. This is cost-effective and accessible for many families who might otherwise be unable to access services for their children. School Psychologists are responsible for supporting children in being successful

in school, managing their emotions, and learning to effectively socialize with their peers (Cherry, 2021). These professionals work in schools, partner with families, provide support to administrators, and work with counselors to ensure that the health needs of students are being met. They are responsible for counseling, diagnosing learning problems, creating positive learning environments, designing behavioral interventions, and referring to other necessary services outside of the classroom (Cherry, 2021).

The National Association of School Psychologists states the following ethical principles of School Psychologist professionals (2020):

Broad theme 1: Respecting the Dignity and Rights of all Persons

"School psychologists engage only in professional practices that maintain the dignity of all with whom they work. In their words and actions, school psychologists demonstrate respect for the autonomy of persons and their right to self-determination, respect for privacy, and a commitment to just, equitable, and fair treatment of all persons."

Broad theme 2: Professional Competence and Responsibility

"Beneficence, or responsible caring, means that the school psychologist acts to benefit others. To do this, school psychologists must practice within the boundaries of their competence, use scientific knowledge from psychology and education to help clients and others make informed choices, and accept responsibility for their work."

Broad theme 3: Honesty and Integrity in Professional Relationships

"To foster and maintain trust, school psychologists must be faithful to the truth and adhere to their professional promises. School psychologists demonstrate integrity in professional relationships."

Broad theme 4: Responsibility to Schools, Families, Communities, the Professional, and Society

"School psychologists promote healthy school, family, and community environments. They assume a proactive role in identifying social injustices that affect children and youth and schools, and they strive to reform systems-level patterns of injustice. School psychologists who participate in public discussion forums, both in person and by electronic means, adhere to ethical responsibilities regarding respecting the dignity of all persons and maintaining public trust in the profession. School psychologists also

maintain the public trust by respecting laws and encouraging ethical conduct. School psychologists advance professional excellence by mentoring less experienced practitioners and contributing to the school psychology knowledge base."

Developmental Psychologists

Developmental psychologists are another group of professionals who often support young people during the growth and development process (Cherry, 2021). Developmental psychologists conduct research about how language is acquired and used, how reasoning develops, and how attachment impacts relationships. They work with minor children to identify if they have developmental delays and support families in seeking treatment and services to promote the highest level of functioning possible for that child (Cherry, 2021). Because this group of professionals often works with individuals by conducting research, it is vital that they adhere to strong ethical considerations.

The Society of Research in Child Development outlines the following ethical responsibilities of Developmental Scientists (2021):

Competence

With regards to science: "Research benefits are maximized, and research harms minimized when investigators have acquired the training, experience, knowledge, and continued involvement in life-long learning to ensure they are designing and conducting studies consistent with the highest standards of scientific and ethical competence. Cultural and linguistic competence and the competencies necessary to understand the developmental needs of persons, families, and peoples with distinct characteristics and within different contexts is required to ensure population-valid and appropriate recruitment procedures, measure selection, implementation, data collection and interpretation, and dissemination procedures across and within diverse populations."

With regards to population competence: " Investigators recognize the diversities of populations they seek to serve and investigate, and develop essential competencies to minimize harm and best serve them. Members must develop and maintain competence through involvement and consultation with members of the group under investigation, continued review of the literature, and by continual updating of designs and procedures."

With regards to interpersonal competence: “Developmental scientists recognize that to enhance benefits and reduce potential harm, competent caring is critical to implement effective study and ethical practices and requires the ability to establish interpersonal relationships and rapport with participants, families, communities, and professionals with whom they work. This requires adequate self-knowledge of how one’s identity, values, experiences, culture, and social context may influence the selection of a research topic, research design, and interpretation of a study. Developmental scientists work to eliminate the harmful effect that personal and professional biases can have on participants and their communities, and they do not knowingly participate in or condone the activities of others based upon such prejudices. As interdisciplinary and international research with children continues to become more common, investigators will need to obtain the competencies necessary for productive professional collaborations that protect children’s rights, and that enhance research benefits and minimize research harms.”

With regards to staff competence: “Developmental scientists ensure the competent performance of research staff through appropriate selection criteria and training tailored to the population of children under study and the staff member’s current skill level. Supervision includes training staff in appropriate anticipated and unanticipated ethical procedures and practices and overseeing that all research activities are performed competently and according to approved protocols.”

Informed consent

With regards to child procedures: “Investigators respect the developing autonomy of children through the design and conduct of informed consent and assent procedures tailored to their cognitive, emotional, and social maturity. In longitudinal studies, investigators consider developmentally appropriate modifications in consent information and consent procedures. While a child’s assent is not legally binding, a minor’s objection to participation in research should be ethically binding unless the intervention holds out a prospect of direct benefit that is important to the health or well-being of the child and is available only in the context of research.”

With regards to parent/guardian consent: “Developmental scientists conducting research with minor children make adequate provisions for soliciting the permission of each child’s parent/guardian. Researchers familiarize themselves with relevant cultural and legal definitions of guardianship and recognize cultural contexts in which community or tribal permission may be a required component of the consent process. Written

documentation of assent and parent/guardian permission is not required when it is developmentally inappropriate or when identification would risk a participant's, parent's/guardian's, family member's, or other's safety. Child welfare concerns should always be a first priority. For example, those children who are wards of the state and their parents and guardians may require additional consideration and advocates."

With regards to volunteering: "Developmental scientists respect the self-determination rights of participants of all ages to voluntarily choose whether or not to participate in research. Informed consent procedures clearly communicate protections against adverse consequences of declining or withdrawing from participation. Participants are also informed about policies for whether data collected from participants who withdraw will (or will not) be included in data analyses."

Equity

With regards to context: "Developmental scientists are both aware of and respectful of individual, cultural, and contextual differences and consider these factors when working with members of diverse groups and communities. Members make every effort to acknowledge, mitigate, and eliminate the effect of biases based on group and individual characteristics and they do not knowingly participate in or condone activities of others based upon such prejudices."

With regards to development: "Developmental scientists have a responsibility to understand current inequities in developmental outcomes and/or inequities in access to resources and services that promote positive development. In doing so, their research aims to counteract or dismantle the structures and systems that cause inequity and ensure that their work does not exacerbate these inequities in research, practice, or policy."

With regards to recruitment: "Developmental scientists conduct research recruitment equitably, neither privileged nor disadvantaged certain individuals or communities. Within the target population of a study, no individuals should be categorically excluded or included for demographic, personal, social, or other characteristics without sufficient scientific justification. Special efforts should be made to recruit hard to reach populations who may not respond to more traditional recruitment procedures."

With regards to compensation: "To ensure equitable participation in research, developmental scientists avoid inadequate or excessive financial and other inducements or compensation for research recruitment that would either inequitably discourage or

coerce participation of economically insecure or other populations. When recruitment involves subordinates such as students doing course work with the researcher, patients recruited in health care settings, or persons otherwise vulnerable to exploitation or coercion, developmental scientists take steps to avoid the influence of multiple relationships and to protect individuals from adverse consequences (real or perceived) of declining participation."

Integrity

With regards to standards: "Developmental scientists ensure their work meets the highest scientific standards for the responsible conduct of research design, analysis, interpretation, and dissemination and that all methods and procedures are reported fully and honestly. Investigators also recognize the potential social impact of their findings on communities and make every effort to obtain community input on the aims, design, and interpretation of data and to ensure that the results of their research is disseminated to participants and the communities they represent."

With regards to independent ethics: "Protecting the rights and welfare of research participants requires ongoing efforts by investigators to eliminate the effect of biases on the design and implementation of ethical procedures. This requires obtaining independent review by submitting accurate information regarding ethical protocols to institutional review boards or other ethics review panels. Investigators conduct the research in accordance with the approved research protocol."

With regards to data: "Developmental scientists are aware of and institute special confidentiality protections required as new technologies for data collection and storage continue to emerge. Particular attention should be paid to research involving geospatial profiling, automated decision-making, data mining, big-data analytics, and genomics as data breaches that may pose higher social, financial, health, legal, and political risks to participants."

With regards to debriefing: "As soon as feasible, investigators provide an opportunity for participants to obtain additional information about the purpose, nature, results, and dissemination of the research. This may occur immediately following an individual's participation or at study completion. Debriefing procedures are described during informed consent. When they become aware, investigators take steps to correct or minimize any post-study misconceptions or harms. Investigators are also sensitive to the personal and social impact of their findings and ensure as appropriate that debriefing

includes information on the implications both risk and resilience of persons and communities."

With regards to deception: "Deception is the intentional provision of false, misleading, or withheld information to purposely mislead research participants. Developmental scientists may consider including deception in the design of a study if disclosing its real purpose would lead participants to modify their behavior, thereby distorting the research objective and if no non-deceptive alternative procedures are feasible. Investigators do not implement deceptive methods if the conditions can be reasonably expected to cause physical pain or emotional distress. Deception is explained to the participant at the end of the study, except in situations in which there is reason to believe that the research participants will be negatively affected by the disclosure."

With regards to transparency: "Developmental scientists ensure the transparency of their work through clear, accurate, and complete reporting of all components of research. Transparency includes, but is not limited to: reporting the aims of and related study hypotheses; participant characteristics, how participants were identified, recruited, and screened, and inclusion and exclusion criteria; research design and procedures; measures, apparatus, equipment, or instruments employed; analytic plans and procedures, including what transformations in measures or observations occurred; and material and financial resources supporting the research, and when appropriate, conflicts of interest."

With regards to data sharing: "Developmental scientists openly share scientific resources, such as methods, measures, and data in order to further scientific advances. Scientific openness ranges from provision of materials to other scientists to the depositing of scientific data in data sharing repositories. Minimizing harm to participants through the protection of their privacy and confidentiality takes precedence over sharing of data. Embracing transparency and openness, does not require that researchers must share all of their information without restrictions. Data sharing obligations need to be based on considerations of reasonable time periods for data analysis and dissemination, investigator financial or other burdens. This standard does not preclude the need to protect researchers from professional harm that can occur when requests for scientific transparency and openness veer into attacks on the integrity of researchers themselves or result in significant, new, or unfunded burdens that limit progress in scholarship."

Risks and benefits

With regards to balancing risks and benefits: “In designing their studies, developmental scientists identify and minimize potential risks and maximize potential benefits to participants and communities with whom they work. When research does not provide the possibility of direct benefits, the degree of risk to which participants are exposed should never exceed that determined by the prospective scientific, educational, or humanitarian value of the problem to be addressed by the research. Special protections against research risks are required for vulnerable participants, including infants and young children and others who may not have the consent capacity required to understand the risk or make a reasoned decision regarding participation.”

With regards to disclosure: “Developmental scientists protect the confidentiality of all participants and ensure that the extent and limits of such protections are clear during assent, informed consent, and guardian permission procedures. There are instances in which disclosure of confidential information is necessary to protect the participant or others from harm. Developmental scientists develop appropriate disclosure procedures in advance, tailored to the research topic and content of data they will collect, and ensure that the specific nature of situations in which confidential information will be disclosed is clearly communicated during informed consent and at the time a disclosure may need to be made.”

With regards to assessment: “During the course of the research, researchers in charge must be prepared to terminate the research at any stage they have probable cause to believe that a continuation of the research is likely to result in physical, psychological, or social injury or disability to participants.”

Counselors

Professionals who counsel are responsible for working with youth in a variety of settings: at school, in clinics, in hospitals, and inpatient facilities (Cherry, 2021). These professionals support youth to cope with personal issues, process traumas, learn strategies for effectively interacting with others, and find success at school (Cherry, 2021).

The Family Institute at Northwestern University identifies the following professional code of ethics for counselors (2021):

The Counseling Relationship

"Counselors must:

- Work hard to create and sustain a relationship with their clients based on trust.
- Obtain informed consent from clients entering a counseling relationship.
- Respect a client's confidentiality and privacy.
- Explain to clients what the counseling relationship entails (which could include fees, group work, and termination).
- Be cognizant of the client's culture, values, and beliefs."

Confidentiality and Privacy

"Counselors must:

- Communicate the concept of confidentiality with their clients on an ongoing basis and do so in a culturally sensitive way.
- Inform clients about the limitations of confidentiality regarding what situations information must be disclosed (e.g., to protect clients or others from harm).
- Discuss if and how information may be shared with others.
- Understand legal and ethical issues involved in working with clients who cannot provide informed consent (such as minors or clients with impairment).
- Maintain and store records in an approved way."

Professional Responsibility

"Counselors must:

- Adhere to the ACA Code of Ethics.
- Practice within one's boundaries of competence.
- Participate in associations that help improve the profession.
- Practice counseling based on scientific foundations.

- Be mindful when advertising and talking with the media.
- Engage in self-care activities so they can work at their highest capacity."

Relationships with Colleagues, Employees, and Employers

"Counselors must:

- Develop relationships with colleagues from other disciplines and be respectful of those who have different theoretical approaches.
- Provide consultation services within areas of competence.
- Provide appropriate consultation referrals when requested or necessary."

Evaluation, Assessment, and Interpretation

"Counselors must:

- Understand the use of assessments as an important part of information gathering and to assist in conducting clients' treatment and evaluation.
- Use educational, mental health, forensic, and career assessments (among others) on which they are trained and have had comprehensive supervised experience administering and interpreting.
- Diagnose clients and interpret assessments accurately and in a culturally sensitive manner."

Supervision, Training, and Teaching

"Counseling supervisors must:

- Be trained in supervision methods and techniques before they offer supervision services.
- Be responsible for monitoring supervisees' clients' welfare and supervisees' performance and development through a variety of supervision modalities, such as regular meetings and live supervision.
- Inform supervisees of their clients' rights and inform clients with information regarding the supervision process and its limitation on confidentiality.

- Be aware of and address the role of multiculturalism and diversity in the supervisory relationship.
- Endorse supervisees that they deem qualified and sufficiently able to perform duties in the areas of certification, licensure, employment, or completion of an academic or training program."

"Counselor educators must:

- Be knowledgeable regarding the ethical, legal, and everyday aspects of the profession including how diversity impacts groups and individuals.
- Inform students of their ethical responsibilities and standards as professionals and as students.
- Provide ongoing feedback, evaluation, and act as gatekeepers to the profession.
- Promote the use of techniques, procedures, and modalities that are grounded in theory and have scientific foundations.
- Develop clear policies and provide direct assistance regarding field placement."

"Counseling students must:

- Be aware of their responsibility to follow the ACA Code of Ethics and applicable laws.
- Understand the implications of taking a break from counseling others when impaired.
- Disclose their status as supervisees before beginning counseling others."

Research and Publication

"Counselors must:

- Conduct research that is aligned with ethical principles, federal and state laws, host institutional regulations, and scientific standards of governing research.
- Adhere to confidentiality in their research.
- Be responsible for participants' welfare throughout the research process.

- Inform individuals of their rights as research participants through informed consent.
- Plan, conduct, and report research accurately."

Distance Counseling, Technology, and Social Media

"Counselors must:

- Be knowledgeable about the laws governing distance counseling and social media.
- Only utilize distance counseling after gaining competence through training and supervised experience in this specialty area.
- Inform clients about the limits of confidentiality and potential Internet interruptions due to the nature of technology.
- Understand the benefits and drawbacks related to distance counseling
- Utilize a professional presence if they choose to use social media platforms
- Avoid disclosing confidential information through social media.
- Utilize informed consent to explain the boundaries of social media."

Resolving Ethical Issues

"Counselors must:

- Behave in an ethical and legal manner and recognize when there is a conflict between ethics codes and laws.
- Utilize and document an ethical decision-making process when faced with an ethical dilemma.
- Hold other counselors to similar standards of professional conduct.
- Resolve ethical dilemmas with direct and open communication to all parties involved.
- Seek consultation when necessary.

- Become familiar with the ACA Policy of Procedures for Processing Complains of Ethical Violations and use it as a reference."

Social Workers

Social Workers support children and families in a variety of roles and responsibilities (Cherry, 2021). Social workers help kids by identifying behavioral problems and providing resources and treatments for them, protecting vulnerable clients, acting as advocates for children, helping single parents, arranging foster care and adoptions, and counseling children (Cherry, 2021).

The National Association of Social Workers identifies the following ethical principles that social workers must adhere to (2021):

Service

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

Social Justice

"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."

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."

Importance of Human Relationships

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

Integrity

"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 should take measures to care for themselves professionally and personally. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated."

Competence

"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."

Art Therapist

Children are highly creative and often process the world through art and experience. Because of this, art therapists are incredibly important behavioral health professionals. Professionals in art therapy provide psychotherapy by using art and creative processes (Cherry, 2021). These professionals often work with children who have developmental delays, anxiety, or have experienced trauma (Cherry, 2021).

The American Art Therapy Association identifies the following ethical responsibilities of art therapists (2017):

Autonomy

“Art therapists respect clients’ right to make their own choices regarding life direction, treatment goals, and options. Art therapists assist clients by helping them to make informed choices, which further their life goals and affirm others rights to autonomy, as well.”

Nonmaleficence

“Art therapists strive to conduct themselves and their practice in such a way as to cause no harm to individuals, families, groups and communities.”

Beneficence

“Art therapists promote wellbeing by helping individuals, families, groups and communities to improve their circumstances. Art therapists enhance welfare by identifying practices that actively benefit others.”

Fidelity

“Art therapists accept their role and responsibility to act with integrity toward clients, colleagues and members of their community. Art therapists maintain honesty in their dealings, accuracy in their relationships, faithfulness to their promises and truthfulness in their work.”

Justice

“Art therapists commit to treating all persons with fairness. Art therapists ensure that clients have equal access to services.”

Creativity

“Art therapists cultivate imagination for furthering understanding of self, others and the world. Art therapists support creative processes for decision-making and problem solving, as well as, meaning-making and healing.”

Conclusion

Regardless of the position the behavioral health professional holds, there are many ethical considerations when working with clients. This is especially true with working with minor children because of their high level of vulnerability. Behavioral health professionals are responsible for adhering to ethical practices and boundaries to protect children. Boundaries ensure that the therapeutic relationship is upheld and the child is safe both physically and emotionally.

While maintaining boundaries is critical in behavioral health relationships, boundaries may be crossed in some situations if it will help the client. These instances are referred to as beneficial boundary crossings according to Zur (2018). Examples of such boundary crossing opportunities are as follows (Zur, 2018):

1. Walking with or being outside of the typical therapeutic session in an open space is helpful to a patient with fear of leaving a space. For example, when working with a child with agoraphobia
2. Playing games or exchanging small gifts with children promotes their success in treatment through motivation
3. Attending a dinner or meal with a patient who has an eating disorder
4. Self-disclosure for the purpose of modeling and/or increasing therapeutic alliance
5. Utilizing rituals that are culturally relevant to the patient, even though the therapist would not usually do so
6. Bartering services for patients who work in poor communities or are unable to financially afford services
7. Going on home visits for patients who are bedridden or dying

Even when there are beneficial reasons to work around a boundary, it is essential that behavioral health professionals very seriously consider such strategies before they engage in them.

Section 2: Confidentiality and privacy in the treatment of children and adolescents

Introduction

Minor children are often afraid of their peers, parents, friends, and teachers learning about their struggles. This is not surprising in a society where most people want to fit in and be embraced and accepted in their peer groups. When individuals stand out, as a result of any kind of dissimilarity, they may be ostracized or treated differently. This is most minor children's nightmare: being different. Mental health issues or behavioral health challenges are often thought of as characteristics that "others" a person or makes that individual atypical. Because of these fears and the reality of being ostracized by those around them, it is even more important for children and adolescents that their privacy is maintained in behavioral health relationships. If they feel they can trust their providers to adhere to the confidentiality laws, children are far more likely to engage in treatment.

Because of this, it is ethically required that behavioral health professionals understand the confidentiality and privacy laws in behavioral health treatment for minor children, both federally and at the individual state level where the provider practices.

Confidentiality

Confidentiality is a legal and ethical requirement in behavioral healthcare. All professionals are responsible for adhering to privacy laws, including HIPAA, which stands for the Health Insurance Portability and Accountability Act that was enacted in 1996 (U.S. Department of Health and Human Services, 2021). Health plans, health care providers, health care clearinghouses, and business associates are responsible for adhering to HIPAA and other patient privacy laws (U.S. Department of Health and Human Services, 2021).

The following information is protected under HIPAA (U.S. Department of Health and Human Services, 2021):

1. Information that health care professionals put into a patient's medical record
2. Conversations that patients have with their health care professionals

3. Information in the health professional's computer system about the patient
4. Billing information about the patient
5. Most other information about the patient

Information is protected through the following (U.S. Department of Health and Human Services, 2021):

1. By having covered entities place safeguards to accessing health care information
2. By ensuring that covered entities limit the use or access of healthcare information and ensuring they access the minimum amount of information necessary to effectively support the patient
3. Ensuring that covered entities have programs for training employees and business associates about how to interact with and access private health information

Some might assume that because children are minors, their parents can access all of their healthcare information. This simply is not true. Parents or guardians are referred to as "personal representatives" of minor children (The Compliancy Group, 2021). Personal representatives are authorized to exercise the HIPAA rights of the individual they represent based on state law (The Compliancy Group, 2021).

Parents are almost always the personal representatives of their minor children except in the following cases (The Compliancy Group, 2021):

1. When state law does not require consent of a parent for the child to access a particular health care service. For example, many states allow minor children to access mental health treatment without the consent of a parent and therefore the parent would not be able to access the private health information related to that mental health treatment
2. When another person, aside from the parent, is authorized to consent to services for the minor. For example, when a court appoints another adult to make healthcare decisions for the minor child
3. When a parent agrees to a confidential relationship between the minor child and the professional treating the child (The Compliancy Group, 2021)

State specific information

Each state will determine the following information about minor mental health (U.S. Department of Health and Human Services, n.d):

1. The age of majority - the age when an individual is considered an adult
2. What types of health care services a minor child can consent to without parental consent
3. What types of health care services someone other than a parent can consent to for a minor child
4. Whether the state the child lives in requires health care providers to give parents access to information about their minor children's health
5. Whether the state the child lives in prohibits health care providers from sharing information about children's health with their parents
6. Who has the legal authority to consent to health care services for the minor child or make healthcare decisions for the minor child

The following table shows the decision-making authority for various types of behavioral health treatments by state (Kerwin, Kirby, Speziali, Duggan, Mellitz, Versek, & McNamara, 2016):

State	Inpatient drug treatment	Outpatient drug treatment	Inpatient mental health treatment	Outpatient mental health treatment
Alabama	Minor child	Minor child	Minor child	Minor child
Alaska	No specific law	No specific law	No specific law	No specific law
Arizona	Either (≥12)	Either (≥12)	Parent	Parent
Arkansas	No Specific Law	No Specific Law	No Specific Law	No Specific Law
California	Either (≥12)	Either (≥12)	Minor child (≥12)	Minor child (≥ 12)
Colorado	Minor child	Minor child	Minor child (≥15)	Minor child (≥ 15)
Connecticut	Either	Either	Either(≥14)	Minor child

Delaware	Parent	Either (≥14)	Parent	Parent
DC	Minor child	Minor child	Parent	Minor child
Florida	Either	Minor child	Parent	Minor child (≥ 13)
Georgia	Either (≥12) b	Minor child	Parent	Either (≥ 12)
Hawaii	Minor child	Minor child	Parent	Minor child
Idaho	Either	Either	Either (≥14) a	Either
Illinois	Minor child (≥12)	Minor child (≥12)	Either (≥ 16) a	Minor child (≥ 12)
Indiana	Minor child	Minor child	Minor child	Minor child
Iowa	Either	Either	Minor/Both	Minor child
Kansas	Minor child	Minor child	Either (≥14)	Either (≥ 14)
Kentucky	Either	Minor child	Minor child (≥ 16)	Minor child (≥ 16)
Louisiana	Minor child	Minor child	Minor child	Minor child
Maine	Both b	Minor child	Minor child	Minor child
Maryland	Either	Minor child	Either (≥ 16)	Either (≥ 16)
Massachusetts	Minor child (≥ 12)	Minor child (≥ 12)	Either (≥ 16)	Either (≥ 16)
Michigan	Either (≥ 14) f	Either (≥ 14)	Either (≥ 14)	Minor (≥ 14)
Minnesota	Minor child (≥ 16)	Minor child (≥ 16)	Minor child (≥ 16)	Minor child (≥ 16)
Mississippi	Parent	Minor child (≥ 15)	Parent	No Specific Law
Missouri	Either	Either	Parent	Parent
Montana	Minor child	Minor child	Either (≥ 16)	Either (≥ 16)
Nebraska	Either	Either	Either	Either
Nevada	Minor child	Minor child	Parent	Parent
New Hampshire	Minor child (≥ 12)	Minor child (≥ 12)	Either	Either

New Jersey	Minor child	Minor child	Parent	Parent
New Mexico	Minor child (≥ 14)	Minor child (≥ 14)	Minor child (≥ 14)	Minor child (≥ 14)
New York	Either	Either	Either (≥ 16)	Either
North Carolina	Parent	Minor child	Parent	Minor child
North Dakota	Minor child (≥ 14)	Minor child (≥ 14)	Parent	Parent
Ohio	Minor child	Minor child	Parent	Minor child (≥ 14)
Oklahoma	Minor child (≥ 16)	Minor child	Minor child (≥ 16)	No Specific Law
Oregon	Minor child	Minor child (≥ 14)	Parent	Minor child (≥ 14)
Pennsylvania	Either	Either	Either (≥ 14)	Either (≥ 14)
Rhode Island	Either	Either	Both	Both
South Carolina	Minor child (≥ 16)	Minor child (≥ 16)	Minor child (≥ 16)	Minor child(≥ 16)
South Dakota	Either	Either	Both (≥ 16)	Both (≥ 16)
Tennessee	Either (≥ 16)	Either(≥ 16)	Minor child (≥ 16)	Minor child (≥ 16)
Texas	Either (≥ 16)	Either (≥ 16)	Either (≥ 16)	No Specific Law
Utah	Parent	Parent	No Specific Law	No Specific Law
Vermont	Minor child (≥ 12)	Minor child (≥ 12)	Minor child (≥ 14)	Minor child (≥ 14)
Virginia	Both (≥ 14)	Minor child	Both (≥ 14)	Minor child
Washington	Parent	Minor child (≥ 13)	Minor child (≥ 13)	Minor child (≥ 13)
West Virginia	Minor child	Minor child	Both (≥ 12)	Both (≥ 12)
Wisconsin	Parent	Either (≥ 12) b	Both (≥ 14) g	Both (≥ 14)
Wyoming	No specific law	No specific law	No specific law	No specific law

Confidential treatment notes and documentation

Children who can consent to their own services are able to protect their confidentiality (U.S. Department of Health and Human Services, n.d). Therefore, based on the information above, unless minor children grant consent for their parents to access information about their medical history, their parents cannot access their files (U.S. Department of Health and Human Services, n.d).

It is important to note that unless requested even minors and their parents cannot simply view notes from psychological treatment sessions (Mental Health America Inc, 2021). Individuals and their parents may be able to request access to such records but the ability to receive them is based on the discretion of the mental health provider (Mental Health America Inc., 2021).

Psychotherapy notes are referred to as the following based on the HIPAA standard: notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session starts and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date (Stanger, 2020).

Psychotherapy notes are maintained separately from the minor child or adult person's medical record and therefore cannot simply be accessed, even by other medical professionals who might be able to view the patient's chart (Stanger, 2020). Privacy laws state the following about psychotherapy notes: "With few exceptions, the Privacy Rule requires a covered entity to obtain a patient's authorization before disclosure of psychotherapy notes for any reason, including disclosure for treatment purposes to a health care provider other than the originator of the notes. See 45 CFR 164.508(a)(2). A notable exception exists for disclosures required by other law, such as for mandatory reporting of abuse, and mandatory "duty to warn" situations regarding threats of serious and imminent harm made by the patient (State laws vary as to whether such a warning is mandatory or permissible) (Stanger, 2020).

Access to psychotherapy notes requests can be denied (Stanger, 2020). Privacy law states that these notes are not the right of a parent or even the patient to simply access: "The Privacy Rule distinguishes between mental health information in a mental health

professional's private notes and that contained in the medical record. It does not provide a right of access to psychotherapy notes.... Psychotherapy notes are primarily for personal use by the treating professional and generally are not disclosed for other purposes. Thus, the Privacy Rule includes an exception to an individual's (or personal representative's) right of access for psychotherapy notes" (Stanger, 2020).

Conclusion

Access to private health information and ensuring that the appropriate individual gives consent to services is not an easy task where minors and adolescents are concerned. The medical team members and clinicians supporting a patient must be well educated in the services and laws specific to the state where they are licensed and practicing.

Clinicians must be prepared to have clear boundary-setting conversations with parents who might feel entitled to consenting for specific services and reading the chart notes about their child's services.

Section 3: Ensuring competent care for children and adolescents

Introduction

Ensuring competent care must be the highest priority for all clinicians working with children and adolescents in behavioral health. Competent care may look different based on culture, location, and other demographic factors, however, it is the responsibility of clinicians to ensure they are practicing as competently as possible. Such care enhances clinicians' ethical responsibilities not only by ensuring competence, but also by promoting autonomy, encouraging social justice and professional responsibility, and by respecting the dignity and rights of the individuals in their care.

Evidenced-based care

One of the most important ways to ensure that competent care for children is being provided is by offering them services that are evidence-based and well supported. Implementing evidence-based practices is essential because it helps children stay safe (Annie E. Casey Foundation, 2018). Programs and services that are not evidence-based

will be less effective in maintaining the outcomes that children, their families, and their providers are seeking (Annie E. Casey Foundation, 2018). From a macro-level perspective, the following must occur to build evidence-based practices in child welfare and children's mental health (Annie E. Casey Foundation, 2018):

1. Engaging - youth and families should be engaged by professionals as stakeholders from the beginning in order to determine the best evidence-based services for youth
2. Assessing - agencies must assess their programs and goals based on what individuals and families are saying
3. Clarifying - stakeholders participating in building evidence-based programs should have a clear understanding of their roles and responsibilities in the process
4. Selecting - agencies and clinicians must select the practices that will be the most supportive and helpful in achieving client and family goals
5. Aligning - policies and procedures must be built around evidence-based practices for them to be the most effective in agencies
6. Generating - buy-in must be achieved by clinicians from families and partners in implementing the evidence-based practices
7. Identifying - the skills and requirements for clinicians to deliver evidence-based practices must be considered. Referrals to programs may be made, for example
8. Supporting - decision making must be supported via data and research

Implementing teams

Children's behavioral health services are often offered in team settings such as wraparound care. Wraparound services are a way of delivering comprehensive behavioral health services that put the child and family at the center of the work and various helping professionals on a team around them (National Wraparound Initiative, 2021). Wraparound services focus on the children and families and their goals, rather than on the goals of the multiple providers involved in their care. Wraparound teams often have better communication and understanding of individuals and their needs because they are all at the table together communicating about them (National Wraparound Initiative, 2021).

Wraparound services have the following benefits (National Wraparound Initiative, 2021):

1. More affordable services for individuals and families and money saved for systems
2. Supports children to stay in the home and not have to go to out-of-home placements as often
3. Improves functioning in school
4. Supports parents and siblings to learn skills and better communicate with the individual in services
5. Improves communication amongst providers who are supporting individuals and families
6. Ensures staff are better trained

When establishing teams, such as wraparound teams, the following must occur to best support individuals and families (Annie E. Casey Foundation, 2018):

1. Families are included in the decision making process and identification of goals for treatment
2. Practices are clearly defined and explained to individuals and families
3. Implementation supports and providers are identified
4. There are tools and mechanisms available to measure progress
5. There are strategies for equity
6. There are interventions in place that will sustain outcomes after goals are met

Teams who are working together to support children should be prepared to do the following (Annie E. Casey Foundation, 2018):

1. Ask what is working for the family
2. Ask what is not working for the family
3. Communicate regularly using a formal process that was established
4. Ensure everyone understands the communication process (access translation as needed and appropriate)

5. Identify gaps and opportunities for new services - send referrals to meet those gaps as able

Cognitive Behavioral Therapy

Cognitive-behavioral therapy is one of the most common therapeutic modalities used with children (Society of Clinical Child and Adolescent Psychology, 2021). Cognitive-behavioral therapy for children is generally a short-term treatment program that typically lasts between six and twenty sessions. It focuses on teaching youth and their parents specific skills when possible. These skills target children's thoughts, emotions, and how they impact their behavior. Cognitive-behavioral therapy is an evidence-based practice that aims to support children in adjusting their thinking patterns to be more effective, which will in turn contribute to more appropriate behavior (Society of Clinical Child and Adolescent Psychology, 2021).

Cognitive-behavioral therapy is most effective in supporting children with anxiety, depression, substance use issues, and post-traumatic stress disorder (Society of Clinical Child and Adolescent Psychology, 2021). In cognitive-behavioral therapy, therapists follow the ethical standard of "enhancing dignity and self-worth" by empowering children to be the experts in their journeys. The following is important in cognitive behavioral therapy (Society of Clinical Child and Adolescent Psychology, 2021):

1. The therapist and the child develop goals for the therapy sessions together
2. Progress is tracked toward goals throughout treatment
3. Therapists explain to children that they are the experts in their lives, while the therapists are there to help children navigate their own expertise
4. Therapists help children realize they are powerful and capable of developing positive thought patterns and resulting behaviors
5. The therapist helps the child take the learnings outside of sessions via homework assignments that are often reviewed in practice
6. Treatment is goal-oriented

Applied Behavior Analysis

This is another form of evidence-based practice that is often used with children receiving behavioral services. It uses principles of learning to teach behavior to children that are socially acceptable and received well in "real-life" settings (Society of Clinical Child and Adolescent Psychology, 2021). This is often delivered in schools to support children in reducing less desirable behaviors and promoting behaviors that help them be effective in school, with their peers, at home, and in the community. Examples of skills include communication, self-management, cognition, and pre-academic skills such as matching and number concepts. This is a common service for children with Autism Spectrum Disorder (Society of Clinical Child and Adolescent Psychology, 2021).

Family therapy

Family therapy is a form of treatment that considers issues to be family-wide and not central to one individual or member (Society of Clinical Child and Adolescent Psychology, 2021). Families are seen as a unit that is connected and integrated. Where one behavior from one member will inherently impact another member and the entire system of the family (Society of Clinical Child and Adolescent Psychology, 2021).

In family therapy, there is not generally one "client" but the goal is to improve patterns of behavior and communication among all family members (Society of Clinical Child and Adolescent Psychology, 2021). In family therapy, individuals avoid blaming and instead focus on improving positively with one another. This type of therapy supports ethical practices of honoring the "Importance of Human Relationships" and "Promoting the Welfare of Children and Adolescents." Family therapy is helpful for families where children are impacted by substance use, obesity, and eating disorders (Society of Clinical Child and Adolescent Psychology, 2021).

Dialectical Behavioral Therapy

Dialectical behavioral therapy is a treatment modality that helps individuals who have acute emotional needs (Society of Clinical Child and Adolescent Psychology, 2021). These are generally teenagers who have strong emotional reactions and difficulties regulating their emotions. They might commonly experience suicidal ideation or planning. This is a treatment program that is very effective in helping children learn to regulate their emotions and therefore interact with others more effectively (Society of Clinical Child

and Adolescent Psychology, 2021). This in turn helps them in the goal of “enhancing dignity and self-worth.”

Dialectical behavioral therapy is based on the following five “problem areas'' for teenagers when being applied to youth (Society of Clinical Child and Adolescent Psychology, 2021). They are as follows (Society of Clinical Child and Adolescent Psychology, 2021):

1. Reduced focus or awareness
2. Impulsivity issues
3. Inability to regulate emotions effectively
4. Interpersonal problems
5. Teen-family challenges (Society of Clinical Child and Adolescent Psychology, 2021)

Dialectical behavioral therapy is a comprehensive program that includes the following (Society of Clinical Child and Adolescent Psychology, 2021):

1. Weekly multi-family skills groups for 24 weeks
2. Weekly individual therapy to reduce individual target behaviors and reach goals
3. Inter-session coaching by phone or text
4. Parenting sessions or family therapy as needed
5. Therapy consultation team where therapists working with individuals consult on cases weekly to ensure adherence to the program is occurring

How to assess for needs

Assessing the needs of children is a requirement for competent care. This is completed via a biopsychosocial assessment and will help clinicians to determine the most effective care services they can provide.

Commonly asked questions during a children’s biopsychosocial assessment include the following (Family Services Society, Inc, 2019):

1. Race/Ethnicity: white; black or African American; Hispanic or Latino; two or more races; native Hawaiian or other pacific islander; Asian; other

2. Gender expression; Male; Female; Male-to-Female/Transgender; Genderqueer, neither exclusively male nor female; Other; Female-to-Male/Transgender; Prefer not to disclose
3. Sexual orientation: Straight or heterosexual; Gay or lesbian or homosexual; Bisexual; Other
4. Current living situation: Own Home; Foster Care; Relative Placement; Emergency Shelter; Group Home; Jail/Juvenile Detention; with legal guardian; pre-adoptive home
5. Who supports the child and the quality of their relationships?
6. Highest level of education and if the child receives any special services at school
7. Legal status and criminal history
8. Employment history
9. Access to resources - what resource, how often, etc.
10. If the child feels emotionally supported
11. How the child's family handles conflict
12. If the child has witnessed or experienced any physical, sexual, or emotional abuse or neglect
13. What daily routines look like for the child
14. Cultural traditions, beliefs, and celebrations that the child participates in
15. Past mental health diagnoses
16. Past mental health treatment history
17. If the clinician believes those diagnoses are correct
18. Completed wellness assessment by the youth (personal inventory)
19. Medication the child takes
20. History of hospitalizations and why
21. Allergies

22. Current health information including conditions
23. Any disabilities
24. Any conditions that impact therapy
25. Substance use history
26. Personal strengths
27. Family strengths
28. Individual hobbies and interests (Family Services Society, Inc, 2019)

How to determine the best therapy to provide

Having a clear process to determine which therapy modality is most effective to use with clients is an essential component to providing competent care. Determining the treatment to utilize occurs after the assessment process and during the treatment planning process (Association for Children's Mental Health, 2021)

Determining what form of therapy to provide will be dependent on a variety of factors and will occur after the assessment helps to determine a clear understanding of the patient's needs. The first factor is diagnosis. For example, specific disorders are best treated by specific therapies. The following shows helpful treatment options for specific disorders (Wright, 2021):

1. Cognitive-behavioral therapy: helpful for patients with anxiety, panic attacks, bipolar disorder, and depression
2. Dialectical behavioral therapy: helpful for patients with difficulty accepting struggles, high self-harm, and suicidal behavior, and for those who have tried other therapies that have not been effective
3. Eye-Movement Desensitization and Reprocessing therapy: for patients who are specifically looking to process traumas
4. Psychoanalysis: helpful for individuals with self-esteem issues

Another factor in determining the best therapy is based on acuity and what the best environment for treatment is (Hillside, 2020). Individuals can receive treatment in an

outpatient session, intensive outpatient setting, and inpatient hospitalization program. They are characterized by the the following (Hillside, 2020):

1. Outpatient care offers support for children who can safely remain living at home, and while they receive support for their specific issues in an outpatient setting, they maintain functioning at home and school otherwise

2. Intensive outpatient care offers structured support to children with more seriou symptoms. They generally cannot function effectively at home and school. It often includes eight to ten hours per week of treatment throughout three to five visits to the treatment center per week. This can occur over a four to six week period of time generally before the patient drops down to general outpatient care

3. A partial hospitalization program offers a step above intensive outpatient care and is helpful for those who are either transitioning from hospitalization or who are at risk for full hospitalization. Patients in this level of care were unable to improve in less restricted environements. Partial hospitalization includes five to seven days of care per week with approximately six hours of treatment

4. Inpatient care is the highest level of care and it is reserved for patients who are at serious risk of harming themselves or others. Individuals live and stay at the property where their hospitalization occurs and have 24/7 support available to them

Communication

Competent care also includes communicating with children and adolescents in a way they understand. This is not simply limited to their specific language spoken, but to the way that they use language to form therapeutic alliances (Bennett, Le, Lindahl, Wharton, & Mak, 2017). Creativity in counseling is important. Not all children may want to engage verbally in therapy. If this is the case, therapists have to be creative in finding a way that communication can be effective. This is a time when art, writing, or music may be very effective. Therapists should also try to expose themselves to age-specific language, humor, and culture to help to relate to and effectively understand the child. The therapist must also be aware of the child's developmental functioning to best engage with the child.

Person-centered care

Competent care must be person-centered. Person-centered care means that the care empowers individuals to take charge of their health and be active recipients of the mental health services that they receive (Guideway Care, 2020).

The following eight key principles help to build effective and ethically responsible person-centered care for children (Guideway Care, 2020):

1. Respect for client care, values, preferences, and needs - this helps to foster a relationship of respect and collaboration and ensure that children are active members in decision making regarding their care
2. Coordination and integration of care - care is integrated so that services reduce client vulnerability
3. Information and education - clients are informed about the services they are receiving to understand their progress and prognosis
4. Comfort - clients feel comfortable where they are receiving care
5. Emotional support - clients receive resources to reduce stress, fear and improve outcomes
6. Involvement of family and friends - individuals who have their preferred people involved in their care have better outcomes. They feel supported in their decision making and have people who know the tools and skills they are learning so they can better implement them outside of the therapeutic relationship and space
7. Access to care - appointments should be streamlined, accessible, and individuals should have their choice of provider when possible
8. Community and transition - individuals are educated about the transition process from intensive care to less-intense treatment services

Strong therapeutic relationship

Competent care is based on a strong therapeutic relationship with clients. Clients who feel safe in therapy will believe in the services they are receiving. That buy-in is important for quality outcomes.

The following strategies help clinicians form strong relationships with their minor clients in therapy (Good Therapy, 2021):

1. Understand that building the therapeutic relationship or alliance will take time to build - the first few sessions will generally be built on small talk and rarely disclosure. This is a time for understanding how therapy works and what to expect

2. Help the client feel welcome by having positive body language and tailoring the space to the needs of the client. This is especially important for children. Bright colors, toys, and other childlike items can be used to make them feel comfortable

3. Practice being nonjudgmental - clinicians should have a goal of never judging their patients as clients, especially since children are intuitive and will likely pick up on those judgments. Therapists should understand that everyone comes to them with a unique life experience that often results in favorable and unfavorable situations. They should believe that everyone can change, improve, and grow and express these beliefs to their clients

4. Manage their own emotions - clinicians cannot have the therapy session be impacted by their own emotional or mental health experience. Tools such as meditation, validation, and mindfulness between sessions can help clinicians show up whole and prepared for therapy

5. Talk with the child about what they want from therapy - every child may have a different reason for attending therapy and have different goals. The clinician should seek to have a strong understanding of those goals

6. Ask questions - clinicians should ask questions that support the client in feeling comfortable to open up about what they need from therapy. This should help clients understand that the clinician is interested in them and invested in their treatment

7. Do not reject clients or make them feel rebuffed - because children are especially vulnerable to feeling rejected, therapists must do everything they can to not leave their young clients feeling rejected in any way, especially when they express their most intimate thoughts, fears, and feelings

8. Refer to other services as necessary - this is helpful for clients who have complex needs. Often children may need additional services, and their therapists should attempt to refer them for all the care they require

9. Being prepared-Effective therapy calls for planning, research, and diligence. Therapists should plan conversations with clients ahead of time and write down some questions in advance, as this will help ensure that therapy follows a productive path

10. Focus on client needs and strengths - focusing on the strengths and needs of clients will help them feel valued and cared for and when help clinicians remember that the clients' needs are most important

Summary

Competent care is person-centered, and it takes place in an environment where the child can lead and feel empowered, and one where there is a strong therapeutic relationship between the child and the provider. Competent care will ensure the strongest outcomes for individuals in behavioral health services and is especially important because of the high vulnerability of children and minors.

Section 4: Respecting autonomy

Introduction

Autonomy, or the ability to think and act for one's self, is important for young people as they form their identities. Childhood and teenage years are marked by constant changes in emotional development, physical development, societal pressure, family pressure, cultural pressure, and other circumstances that often impact the way that children feel about themselves and the world around them. These are inevitably difficult years for many children and adolescents. Because of this, it is helpful for children to be able to feel their autonomy in the therapeutic relationship and during their access to mental health services.

Why autonomy is important in therapy

Autonomy and the ability to choose for one's self what care should look like is an important aspect of therapy. When clients have autonomy in therapy, their therapeutic relationship is improved and they generally achieve better outcomes in treatment (Sutton, 2021). Autonomy enhances motivation, as clients will be motivated to attend

therapy for themselves if they are autonomous. They also will have a desire to grow and change. While this may not always be the case when working with children because of legal and/or developmental factors, therapists should still seek to create autonomy for their patients (Sutton, 2021).

Autonomy and the therapeutic relationship

Teenagers and adolescents in certain states may be forced or required to attend therapy by their parents (Bennett, Le, Lindahl, Wharton, & Mak, 2017). If minor children live in a state where their parents consent to services on their behalf (see table above) and they are required to attend therapy when they do not want to, it can make the child feel a loss of autonomy and personal power. This often leads to a lack of participation and engagement in therapy, therefore reducing the possibility of positive outcomes (Bennett, et al., 2017).

It is important that minor children, regardless of if they consent to their services or not, feel autonomy in the therapeutic relationship (Bennett, et al., 2017). Clinicians should expect to become creative for building autonomy with children, who might not always inherently feel autonomous because they cannot legally make all of their own choices. Clinicians can do so through (Bennett, et al., 2017):

1. Teaching the minor child to see their achievements and successes. This helps children feel a sense of competence and significance in the world - therefore promoting their autonomous sense of self, even if they are dependent on others
2. Teaching the minor child to see their power and the decisions that they can make for themselves every day to have an impact in the world
3. Help children find and integrate into a community where they feel a sense of belonging

Ways to engage clients who are not engaged

Often when minors, as discussed above, are not feeling autonomous in their behavioral health care they will become less engaged in services (Bennett, Le, Lindahl, Wharton, & Mak, 2017). The following activities can help re-engage clients in care (Bennett, et al., 2017):

1. Playing music to engage the child in therapy can be very effective. This is especially true when young clients can choose their favorite type of music. Music can help to inspire children, promote recalling memories, prompt the discussion of feelings, and be a tool to make meaning out of difficult situations. Clinicians can say something such as “I’ve noticed you like to listen to music before and after our sessions. Would you be willing to share the music you listen to with me? It might be helpful for us in getting to know each other. You might also just enjoy spending time in therapy more if we have music playing.”

2. Talk meter activity - this activity helps clients who are struggling to explain how they feel. This can be done by the clinician printing out thermometer images that have not been filled in or colored in. The clinician can offer ideas of subjects to talk about and the client can draw where on the thermometer they feel about discussing that particular topic. The thermometer that is completely drawn will represent a willingness and excitement to talk about that topic and not being drawn in at all represents a complete inability to discuss that particular topic.

3. Creating an environment together - the therapist can invite children to display artwork or move furniture (within reason) that may be helpful for providing comfort during their therapy sessions. Clinicians can also invite them to bring any item to therapy that serves them emotionally as well, such as a blanket, fidget toy, stuffed animal, etc.

4. Build a collage that represents the child’s life - the therapist will bring magazines and art supplies to a session to invite children to create a collage that represents their life so far. Clients will build their collages while giving context to what they are building. This is a helpful and tactile way to engage clients in providing a personal history. The therapist will validate the experiences and celebrate the success of the clients in creating their collages

5. Social media profile - the therapist will invite the child to build a “social media profile.” This is not done online but on a piece of paper that looks like a main social media page. It will have space for children to draw their “profile photo,” an introduction where they can describe how others see them, a space for them to describe how they see themselves, demographic information about them, information about the people who support them, and a space for what the client achieved as part of a year in review (Bennett, et al., 2017)

Deepening engagement

While building engagement in therapy helps the minor client to begin to feel autonomous, therapists must also work to deepen their own engagement with their clients. There are many ways that clinicians can build that deep engagement. The following are helpful examples (Bennett, et al., 2017):

1. Provide support and encouragement to clients even when they do not engage in therapy at all. Examples include the following: “I believe that it is not easy to come here and talk to me - you are brave to show up in this space”; “You are doing a great job here. Keep it up”; “I feel honored to get to know you and watch you grow”

2. The therapist can process the engagement, or lack thereof, with the client. The therapist can say “I’ve noticed you’re having a hard time talking during the session. Is there something that I can do to make you feel more interested in talking?”

3. The therapist can challenge clients to take their reflection deeper. An example of this includes: “You have done such a great job in therapy so far. I am wondering if you’re up for a challenge? I would like to challenge you to dive even deeper into the processing we do to see what your next level of growth looks like. How can I support you to do that?”

4. Ongoing validation to children that therapy is a safe and supportive space can be helpful to deepen engagement

Summary

The greater engagement and the higher autonomous participation that children show in therapy will help to improve their positive outcomes. While creating autonomy in therapy is not always easy, clinicians do have a variety of strategies they can use to build such autonomy as well as to deepen the engagement with their clients after the therapeutic relationship is established.

Section 5: Child abuse reporting

Introduction

One of the more difficult components of being a behavioral health professional is the need to listen for potential incidents that result in mandatory reporting. Individuals who are mandatory reporters often have frequent contact with children and are mandated to report suspected or known maltreatment (Child Welfare Information Gateway, 2019). The following professionals are all mandatory reporters (Child Welfare Information Gateway, 2019):

1. Social workers
2. Teachers, principals, and other school personnel
3. Physicians, nurses, and other healthcare workers
4. Counselors, therapists, and other mental health professionals
5. Child care providers
6. Medical examiners or coroners
7. Law enforcement officers

Child abuse reporting

Child abuse reporting occurs by clinicians when they “suspect or have reason to believe that a child has been abused or neglected” (Child Welfare Information Gateway, 2019). Mandatory reporting requires that if professionals believe there is something reportable that they do so as soon as possible to their state-specific child welfare agency who is responsible for oversight and investigation into child welfare concerns. The following statement provides insight into that reporting: “Mandatory reporters are required to report the facts and circumstances that led them to suspect that a child has been abused or neglected. They do not have the burden of providing proof that abuse or neglect has occurred. Permissive reporters follow the same standards when electing to make a report” (Child Welfare Information Gateway, 2019).

State-specific standards for reporting

According to state laws, the following information shows each state's specific standard for reporting (Child Welfare Information Gateway, 2019)

Alabama

Citation: Ala. Code § 26-14-3

A report must be made when the child is known or suspected of being a victim of abuse or neglect.

Alaska

Citation: Alaska Stat. §§ 47.17.020; 47.17.023

A report must be made when, in the performance of his or her occupational or appointed duties, a reporter has reasonable cause to suspect that a child has suffered harm as a result of abuse or neglect. A person providing—either privately or commercially—film, photo, visual, printed-matter processing, production, or finishing services; or computer installation, repair, or other services; or internet or cellular telephone services; who in the process of providing those services observes a film, photo, picture, computer file, image, or other matter and has reasonable cause to suspect that the film, photo, picture, computer file, image, or other matter visually depicts a child engaged in conduct described in § 11.41.455(a) (sexual exploitation of a minor or child pornography) shall immediately report the observation to the nearest law enforcement agency.

American Samoa

Citation: Ann. Code § 45.2002

A report is required under the following circumstances:

- A reporter has reasonable cause to know or suspect that a child has been subjected to abuse or neglect.
- A reporter has observed the child being subjected to circumstances or conditions that would result in abuse or neglect.

Arizona

Citation: Ann. Code § 12-18-402

A report is required when a person reasonably believes that a minor is or has been the victim of physical injury, abuse, child abuse, a reportable offense, or neglect that appears to have been inflicted on the minor by other than accidental means or that is not explained by the available medical history as being accidental in nature.

A 'reportable offense' means any of the following:

- Any offense listed in chapters 14 and 35.1 of this title or § 13-3506.01
- Surreptitious photographing, videotaping, filming, or digitally recording or viewing a minor pursuant to § 13-3019
- Child sex trafficking pursuant to § 13-3212
- Incest pursuant to § 13-3608
- Unlawful mutilation pursuant to § 13-1214

Arkansas

Citation: Ann. Code § 12-18-402

An individual listed as a mandatory reporter shall immediately notify the child abuse hotline in the following circumstances:

- He or she has reasonable cause to suspect that a child has been subjected to maltreatment, has died as a result of maltreatment, or died suddenly and unexpectedly.
- He or she observes a child being subjected to conditions or circumstances that would reasonably result in maltreatment.

California

Citation: Penal Code §§ 11166; 11165.7

A report is required when the following circumstances apply:

- A mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the reporter knows or reasonably suspects is the victim of abuse or neglect.
- Commercial film and photographic print processors have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child under age 16 engaged in an act of sexual conduct.
- Commercial computer technicians have knowledge of or observe, within the scope of their professional capacity or employment, any representation of information, data, or an image, including, but not limited to, any computer hardware, software, file, floppy disk, data storage medium, CD-ROM, computer-generated equipment, or computer-generated image, that is retrievable in perceivable form and that is intentionally saved, transmitted, or organized on an electronic medium, depicting a child under age 16 engaged in an act of sexual conduct. For the purposes of this article, 'reasonable suspicion' means that it is objectively reasonable for a person to entertain a suspicion based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. 'Reasonable suspicion' does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any 'reasonable suspicion' is sufficient. For the purposes of this article, the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of sexual abuse.

Colorado

Citation: Rev. Stat. § 19-3-304

A report is required when any of the following apply:

- A mandated reporter has reasonable cause to know or suspect child abuse or neglect.
- A reporter has observed a child being subjected to circumstances or conditions that would reasonably result in abuse or neglect.

- Commercial film and photographic print processors have knowledge of or observe any film, photograph, videotape, negative,
  or slide depicting a child engaged in an act of sexual conduct.

Connecticut

Citation: Ann. Code Tit. 16, § 903

A report is required when, in the ordinary course of his or her employment or profession, a reporter has reasonable cause to suspect or believe the following of any child under age 18:

- Has been abused or neglected
- Has had a non accidental physical injury or an injury that is at variance with the history given of the injury
- Is placed at imminent risk of serious harm. Any school employee shall report when, in the ordinary course of his or her employment or profession, he or she has reasonable cause to suspect or believe that any person who is being educated by the technical high school system or a local or regional board of education, other than as part of an adult education program, is a victim of abuse and the perpetrator is a school employee. A mandated reporter's suspicion or belief may be based on factors, including, but not limited to, observations, allegations, facts, or statements by a child, victim, or a third party. Such suspicion or belief does not require certainty or probable cause.

Delaware

Citation: Ann. Code Tit. 16, § 903

A report is required when the reporter knows or in good faith suspects child abuse or neglect.

District of Columbia

Citation: Ann. Code § 4-1321.02

A report is required when any of the following apply:

- A mandated reporter knows or has reasonable cause to suspect that a child known to him or her in his or her professional or official capacity has been or is in immediate danger of being a mentally or physically abused or neglected child.
- A health professional, law enforcement officer, or humane officer, except an undercover officer whose identity or investigation might be jeopardized, has reasonable cause to believe that a child is abused as a result of inadequate care, control, or subsistence in the home environment due to exposure to drug-related activity.
- A mandated reporter knows or has reasonable cause to suspect that a child known to him or her in his or her professional or official capacity has been, or is in immediate danger of being, the victim of sexual abuse or attempted sexual abuse; the child was assisted, supported, caused, encouraged, commanded, enabled, induced, facilitated, or permitted to become a prostitute; the child has an injury caused by a bullet; or the child has an injury caused by a knife or other sharp object that was caused by other than accidental means.
- A licensed health professional who in his or her own professional or official capacity knows that a child under 12 months of age is diagnosed as having a fetal alcohol spectrum disorder.

Florida

Citation: Ann. Stat. § 39.201

A report is required when either of the following apply:

- A person knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected.
- A person knows that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide

Georgia

Citation: Ann. Code §§ 19-7-5; 16-12-100

A report is required when either of the following apply:

- A reporter has reasonable cause to believe that child abuse has occurred.
- A person who processes or produces visual or printed matter has reasonable cause to believe that the visual or printed matter
  submitted for processing or producing depicts a minor engaged in sexually explicit conduct.

Guam

Citation: Ann. Code Tit. 19, § 13201

A report is required when either of the following apply:

- A reporter, who in the course of his or her employment, occupation, or professional practice comes into contact with children, has reason to suspect on the basis of his or her medical, professional, or other training and experience that a child is an abused or neglected child.
- Any commercial film and photographic print processor has knowledge of or observes any film, photograph, videotape,negative, or slide depicting a child under age 18 engaged in an act of sexual conduct.

Hawaii

Citation: Rev. Stat. § 350-1.1

A report is required when, in his or her professional or official capacity, a reporter has reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the reasonably foreseeable future.

Idaho

Citation: Ann. Code § 16-1605

A report is required when either of the following apply:

- A person has reason to believe that a child has been abused, abandoned, or neglected.

- A person observes a child being subjected to conditions or circumstances that would reasonably result in abuse,
  abandonment, or neglect.

Illinois

Citation: Comp. Stat. Ch. 325, § 5/4; Ch. 720, § 5/11-20.2

A report is required when any of the following apply:

- A reporter has reasonable cause to believe that a child known to him or her in his or her professional capacity may be abused or neglected.
- A physician, physician's assistant, registered nurse, licensed practical nurse, medical technician, certified nursing assistant, social worker, or licensed professional counselor of any office, clinic, or any other physical location that provides abortions, abortion referrals, or contraceptives has reasonable cause to believe a child known to him or her in his or her professional or official capacity may be an abused child or a neglected child.
- Commercial film and photographic print processors or computer technicians have knowledge of or observe any film, photograph, videotape, negative, slide, computer hard drive, or any other magnetic or optical media that depicts a child engaged in any actual or simulated sexual conduct.

Indiana

Citation: Ann. Code § 31-33-5-1

In addition to any other duty to report arising under this article, an individual who has reason to believe that a child is a victim of child abuse or neglect shall make a report as required by this article.

Iowa

Citation: Ann. Stat. §§ 232.69; 728.14

A report is required when either of the following apply:

- A reporter, in the scope of his or her professional practice or employment responsibilities, reasonably believes that a child has been abused.

- A commercial film and photographic print processor has knowledge of or observes a visual depiction of a minor engaged in a prohibited sexual act or in the simulation of a prohibited sexual act.

Kansas

Citation: Ann. Stat. § 38-2223

A report is required when a reporter has reason to suspect that a child has been harmed as a result of physical, mental, or emotional abuse or neglect or sexual abuse.

Kentucky

Citation: Rev. Stat. § 620.030

A report is required when a person knows or has reasonable cause to believe that a child is dependent, neglected, or abused.

Louisiana

Citation: Children's Code Art. 609; 610

A report is required when any of the following apply:

- A reporter has cause to believe that a child's physical or mental health or welfare is endangered as a result of abuse or neglect.
- A commercial film or photographic print processor has knowledge of or observes any film, photograph, videotape, negative, or slide depicting a child, whom he or she knows or should know is under age 17, that constitutes child pornography.
- A physician has cause to believe that a newborn was exposed in utero to an unlawfully used controlled dangerous substance, as determined by a toxicology test upon the newborn that may be administered without the consent of the newborn's parents or guardian. Positive test results shall not be admissible in a criminal prosecution.
- A physician observes symptoms of withdrawal in a newborn or other observable and harmful effects in his or her physical appearance or functioning that the physician has cause to believe are due to the chronic or severe use of alcohol by the mother during pregnancy.

Maine

Citation: Rev. Stat. Tit. 22, §§ 4011-A; 4011-B

A report is required when any of the following apply:

- The person knows or has reasonable cause to suspect that a child is or is likely to be abused or neglected or that a suspicious death has occurred.
- A child who is under 6 months of age or otherwise non ambulatory exhibits evidence of the following:
    - Fracture of a bone
    - Substantial bruising or multiple bruises
    - Subdural hematoma
    - Burns
    - Poisoning
    - Injury resulting in substantial bleeding, soft tissue swelling, or impairment of an organ
- A health-care provider involved in the delivery or care of an infant knows or has reasonable cause to suspect that the infant has been born affected by illegal substance use or is demonstrating withdrawal symptoms that have resulted from or have likely resulted from prenatal drug exposure that require medical monitoring or care beyond standard newborn care, whether the prenatal exposure was to legal or illegal drugs, or has fetal alcohol spectrum disorders.

A mandatory reporter shall report to the department if the person knows or has reasonable cause to suspect that a child is not living with the child's family. Although a report may be made at any time, a report must be made immediately if there is reason to suspect that a child has been living with someone other than the child's family for more than 6 months or if there is reason to suspect that a child has been living with someone other than the child's family for more than 12 months pursuant to a power of attorney or other nonjudicial authorization.

Maryland

Citation: Fam. Law §§ 5-704; 5-705

A mandatory reporter is required to report when, acting in a professional capacity, the person has reason to believe that a child has been subjected to abuse or neglect. Other persons shall report when they have reason to believe that a child has been subjected to abuse or neglect.

Massachusetts

Citation: Gen. Laws Ch. 119, § 51A

A mandated reporter must report when, in his or her professional capacity, he or she has reasonable cause to believe that a child is suffering physical or emotional injury resulting from any of the following:

- Abuse inflicted upon the child that causes harm or substantial risk of harm to the child's health or welfare, including sexual abuse
- Neglect, including malnutrition
- Physical dependence upon an addictive drug at birth
- Being a sexually exploited child
- Being a human trafficking victim, as defined by chapter 233, § 20M

Michigan

Citation: Comp. Laws § 722.623

A report is required when a reporter has reasonable cause to suspect child abuse or neglect.

Minnesota

Citation: Ann. Stat. § 626.556, Subd. 3

A report is required when a reporter knows or has reason to believe that a child is being neglected or sexually or physically abused or has been neglected or physically or sexually abused within the preceding 3 years.

Mississippi

Citation: Ann. Code § 43-21-353

A report is required when a person has reasonable cause to suspect that a child is abused or neglected.

Missouri

Citation: Rev. Stat. §§ 210.115; 573.215

A report is required under the following circumstances:

- A reporter has reasonable cause to suspect that a child has been subjected to abuse or neglect.
- A reporter observes a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.
- A film and photographic print processor has knowledge of or observes any film, photograph, videotape, negative, slide, or computer-generated image or picture depicting a child younger than age 18 engaged in an act of sexual conduct.

Montana

Citation: Ann. Code § 41-3-201

A report is required when either of the following apply:

- A reporter knows or has reasonable cause to suspect, as a result of information received in his or her professional or official capacity, that a child is abused or neglected.
- A health-care professional involved in the delivery or care of an infant knows that the infant is affected by a dangerous drug.

Nebraska

Citation: Rev. Stat. § 28-711

A report is required when either of the following apply:

- A reporter has reasonable cause to believe that a child has been subjected to abuse or neglect.

- A reporter observes a child being subjected to conditions or circumstances that reasonably would result in abuse or neglect.

Nevada

Citation: Rev. Stat. § 432B.220

A report is required when any of the following apply:

- A reporter, in his or her professional capacity, knows or has reason to believe that a child is abused or neglected.
- A reporter has reasonable cause to believe that a child has died as a result of abuse or neglect.
- A medical services provider who delivers or provides medical services to a newborn infant, in his or her professional or occupational capacity, knows or has reasonable cause to believe that the newborn infant has been affected by prenatal illegal substance abuse or has withdrawal symptoms resulting from prenatal drug exposure

New Hampshire

Citation: Rev. Stat. § 169-C:29

A report is required when a person has reason to suspect that a child has been abused or neglected.

New Jersey

Citation: Ann. Stat. § 9:6-8.10

A report is required when a person has reasonable cause to believe that a child has been subjected to abuse or neglect.

New Mexico

Citation: Ann. Stat. § 32A-4-3

A report is required when a person knows or has a reasonable suspicion that a child is abused or neglected.

New York

Citation: Soc. Serv. Law § 413

A report is required when the reporter has reasonable cause to suspect that either of the following is true:

- A child coming before him or her in his or her professional or official capacity is an abused or maltreated child.
- The parent, guardian, custodian, or other person legally responsible for the child comes before the reporter and states from
  personal knowledge facts, conditions, or circumstances that, if correct, would render the child an abused or maltreated child.

North Carolina

Citation: Gen. Stat. § 7B-301

A report is required when a reporter has cause to suspect that any juvenile is abused, neglected, or dependent or has died as the result of maltreatment.

North Dakota

Citation: Cent. Code § 50-25.1-03

A report is required when a reporter has knowledge of or reasonable cause to suspect that a child is abused or neglected, if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity. A person who has knowledge of or reasonable cause to suspect that a child is abused or neglected based on images of sexual conduct by a child discovered on a workplace computer shall report the circumstances to the department.

Northern Mariana Islands

Citation: Commonwealth Code Tit. 6, § 5313

A report is required when a mandated reporter comes into contact in a professional capacity with a child who the person knows or has reasonable cause to suspect is abused or neglected.

Ohio

Citation: Rev. Code § 2151.421

A report is required when a mandated person is acting in an official or professional capacity and knows or suspects that a child under age 18 or a person under age 21 with a developmental disability or physical impairment has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child.

Oklahoma

Citation: Ann. Stat. Tit. 10A, § 1-2-101; Tit. 21, § 1021.4

A report is required when any of the following apply:

- Any person has reason to believe that a child under age 18 is a victim of abuse or neglect.
- A physician, surgeon, other health-care professional (including doctors of medicine, licensed osteopathic physicians, residents, and interns), or midwife is involved in the prenatal care of expectant mothers or the delivery or care of infants and an infant tests positive for alcohol or a controlled dangerous substance or is diagnosed with neonatal abstinence syndrome or fetal alcohol spectrum disorder.
- A commercial film and photographic print processor or computer technician has knowledge of or observes any film, photograph, videotape, negative, or slide depicting a child engaged in an act of sexual conduct.

Oregon

Citation: Rev. Stat. § 419B.010

A report is required when any public or private official has reasonable cause to believe that any child with whom the official comes in contact has suffered abuse.

Pennsylvania

Citation: Cons. Stat. Tit. 23, § 6311

A mandated reporter shall make a report of suspected child abuse if he or she has reasonable cause to suspect that a child is a victim of child abuse under any of the following circumstances:

- The mandated reporter comes into contact with the child in the course of employment, occupation, and practice of a profession or through a regularly scheduled program, activity, or service.
- The mandated reporter is directly responsible for the care, supervision, guidance, or training of the child or is affiliated with an agency, institution, organization, school, regularly established church or religious organization, or other entity that is directly responsible for the care, supervision, guidance, or training of the child.
- A person makes a specific disclosure to the mandated reporter that an identifiable child is the victim of child abuse.
- An individual age 14 or older makes a specific disclosure to the mandated reporter that the individual has committed child abuse. Nothing in this section shall require a child to come before the mandated reporter in order for the mandated reporter to make a report of suspected child abuse. Nothing in this section shall require the mandated reporter to identify the person responsible for the child abuse to make a report of suspected child abuse.

Puerto Rico

Citation: Ann. Laws Tit. 8, § 446

A report is required when either of the following apply:

- A person, in his or her professional capacity and in the performance of his or her functions, learns or comes to suspect that a minor is, has been, or is at risk of becoming a victim of abuse.
- A film processor has knowledge of or observes any motion picture, photograph, videotape, negative, or slide that depicts a minor involved in a sexual activity.

Rhode Island

Citation: Gen. Laws §§ 40-11-3(a); 40-11-6

A report is required when the following apply:

- A person has reasonable cause to know or suspect that a child has been abused or neglected.
- The following apply to a physician, nurse practitioner, or other health-care provider:
    - He or she is involved in the delivery or care of infants born with, or identified as being affected by, substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder.
    - He or she has cause to suspect that a child brought to them for treatment is an abused or neglected child.
    - He or she determines that a child younger than age 12 is suffering from any sexually transmitted disease.

South Carolina

Citation: Gen. Laws §§ 40-11-3(a); 40-11-6

A report is required when the following apply:

- A person has reasonable cause to know or suspect that a child has been abused or neglected.
- The following apply to a physician, nurse practitioner, or other health-care provider:
    - He or she is involved in the delivery or care of infants born with, or identified as being affected by, substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder.
    - He or she has cause to suspect that a child brought to them for treatment is an abused or neglected child.
    - He or she determines that a child younger than age 12 is suffering from any sexually transmitted disease.

South Dakota

Citation: Ann. Laws § 26-8A-3

A report is required when a reporter has reasonable cause to suspect that a child has been abused or neglected.

Tennessee

Citation: Ann. Code §§ 37-1-403; 37-1-605

A report is required when any of the following apply:

- A person has knowledge that a child has been harmed by abuse or neglect.
- A person is called upon to render aid to any child who is suffering from an injury that reasonably appears to have been caused by abuse.
- A person knows or has reasonable cause to suspect that a child has been sexually abused.
- A physician diagnoses or treats any sexually transmitted disease in a child age 13 or younger or diagnoses pregnancy in an unemancipated minor. Any school official, personnel, employee, or member of the board of education who is aware of a report or investigation of employee misconduct on the part of any employee of the school system that in any way involves known or alleged child abuse, including, but not limited to, child physical or sexual abuse or neglect, shall immediately upon knowledge of such information notify the Department of Children's Services or law enforcement official of the abuse or alleged abuse.

Texas

Citation: Fam. Code § 261.101

A report is required when a person has cause to believe that a child has been adversely affected by abuse or neglect. In addition, a person or professional shall make a report if the person or professional has cause to believe that an adult was a victim of abuse or neglect as a child and the person or professional determines in good faith that disclosure of the information is necessary to protect the health and safety of another child, an elderly person, or person with a disability.

Utah

Citation: Ann. Code § 62A-4a-403

A report is required when a person has reason to believe that a child has been subjected to abuse or neglect or observes a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.

Vermont

Citation: Ann. Stat. Tit. 33, § 4913

A report is required when a mandated reporter reasonably suspects the abuse or neglect of a child.

Virgin Islands

Citation: Ann. Code Tit. 5, § 2533

A report is required when any of the following apply:

- A reporter has reasonable cause to suspect that a child has been subjected to abuse, sexual abuse, or neglect.
- A reporter observes the child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.

Virginia

Citation: Ann. Code § 63.2-1509

A report is required when, in his or her professional or official capacity, a reporter has reason to suspect that a child is abused or neglected. For purposes of this section, 'reason to suspect that a child is abused or neglected' shall include the following:

- A finding made by a health-care provider within 6 weeks of the birth of a child that the child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure.
- A diagnosis made by a health-care provider within 4 years following a child's birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to maternal abuse of a controlled substance during pregnancy.

- A diagnosis made by a health-care provider within 4 years following a child's birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol. When 'reason to suspect' is based upon this subsection, that fact shall be included in the report along with the facts relied upon by the person making the report.

Washington

Citation: Rev. Code § 26.44.030

A report is required when any of the following apply:

- A reporter has reasonable cause to believe that a child has suffered abuse or neglect.
- Any person, in his or her official supervisory capacity with a nonprofit or for-profit organization, has reasonable cause to believe that a child has suffered abuse or neglect caused by a person over whom he or she regularly exercises supervisory authority.
- Department of Corrections personnel observe offenders or the children with whom the offenders are in contact and, as a result of these observations, have reasonable cause to believe that a child has suffered abuse or neglect.
- Any adult has reasonable cause to believe that a child who resides with him or her has suffered severe abuse.

West Virginia

Citation: Ann. Code § 49-2-803

Any mandatory reporter who has reasonable cause to suspect that a child is neglected or abused or observes the child being subjected to conditions that are likely to result in abuse or neglect, including sexual abuse or sexual assault, shall report the circumstances to the Department of Health and Human Resources. In any case where the reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter shall also immediately report, or cause a report to be made, to the State police and any law enforcement agency having jurisdiction to investigate the complaint.

Wisconsin

Citation: Ann. Stat. § 48.981

A mandatory reporter is required to report when he or she has reasonable cause to suspect that a child seen by him or her in the course of professional duties has been abused or neglected or when he or she has reason to believe that a child seen by him or her in the course of professional duties has been threatened with abuse or neglect and that abuse or neglect of the child will occur.

A health-care provider shall report if he or she has reason to suspect any of the following regarding a child in the provider's care:

- That sexual intercourse or sexual contact occurred or is likely to occur with a caregiver
- That the child suffered or suffers from a mental illness or mental deficiency that rendered or renders the child temporarily or permanently incapable of understanding or evaluating the consequences of his or her actions
- That the child, because of his or her age or immaturity, was or is incapable of understanding the nature or consequences of sexual intercourse or sexual contact
- That the child was unconscious at the time of the act or for any other reason was physically unable to communicate unwillingness to engage in sexual intercourse or sexual contact
- That another participant in the sexual contact or sexual intercourse was or is exploiting the child
- That the provider has any reasonable doubt as to the voluntariness of the child's participation in the sexual contact or sexual intercourse

Wyoming

Citation: Ann. Stat. §§ 14-3-205; 14-3-206

A report is required when any of the following apply:

- A person knows or has reasonable cause to believe or suspect that a child has been abused or neglected.

- A person observes any child being subjected to conditions or circumstances that would reasonably result in abuse or neglect. Effective July 1, 2019: Any physician, physician's assistant, or nurse practitioner who examines a child and finds reasonable cause to believe the child is a victim of child abuse or neglect and has reasonable cause to believe that other children residing in the same home also may be a victim of child abuse or neglect shall report to law enforcement the results of the examination and facts supporting reasonable cause with respect to the other child or children.

Warning signs of abuse and neglect

Clinicians should be prepared to look out for warning signs of abuse and neglect. The following are important signs to look for of physical abuse (Commonwealth of Massachusetts, 2021):

1. Bruising, welts, or burns that cannot be sufficiently explained
2. Clusters of bruises
3. Injuries on the body where bodies do not generally bruise
4. Tears in the tissue of the gums that indicate force-feeding
5. Absence of hair on the scalp
6. Withdrawn behavior
7. Strong fear response
8. Extremely unusual behavior

Clinicians should be prepared to look out for the following warning signs of neglect (Commonwealth of Massachusetts, 2021):

1. Sudden no-shows at school
2. Sudden changes in behavior or school performance
3. Conditions that have not been properly addressed by medical care
4. Learning problems that are not attributed to physical or psychological causes
5. Watchful behavior

6. Constantly preparation for bad things to happen
7. Theft of food or money from others
8. Lack of supervision by adults
9. Dirty clothes or unkempt appearance
10. Lack of appropriate clothing for the weather

Clinicians should be prepared to look out for the following warning signs of sexual abuse (Commonwealth of Massachusetts, 2021):

1. Difficulty walking
2. Difficulty sitting
3. Pain or itching in genital areas
4. Bloody clothing
5. Complaints of stomach aches or headaches
6. Venereal disease
7. Common urinary infections
8. Pregnancy
9. Chronic depression
10. Inappropriate understanding of sex for child's age
11. Promiscuity
12. Running away from home
13. A child is overly concerned for siblings
14. Poor self-esteem
15. Lack of confidence in self
16. Problems with peers
17. An extreme change in weight

18. Suicide attempts or threats
19. Lack of emotional regulation
20. Difficulties at school
21. Unprovoked cruelty to others

Information needed to make a mandatory report

Clinicians will need the following information to make a report to their investigative entity (Darkness to Light, 2017):

1. Name of the child
2. Address where the child resides if possible
3. Age of the child
4. Nature of the abuse or neglect concern
5. Name of the perpetrator and relationship to the child if possible
6. Any other details that might be helpful to offer

Summary

Clinicians and any other mandatory reporters are responsible for noticing any potential signs of abuse and neglect of children. While it is one of the most uncomfortable parts of the job, it is also the most important because clinicians can catch potential situations of abuse and report them to ensure the child is safe. This is something that behavioral health professionals must take very seriously. They must also understand their state-specific laws regarding reporting and what the standards of reporting are.

Section 6: Providing culturally sensitive care

Introduction

Culturally responsive or sensitive care is a requirement of providing ethically responsible care. Culturally sensitive care ensures that the therapist has an understanding of how the background, ethnicity, and cultural beliefs of clients impacts their relationship to therapy and their goals, interventions, and how they establish relationships (Psychology Today, 2021). Examples of demographic information that clinicians should understand to best support their clients include the client's age, beliefs, ethnicity, race, gender, religion, sexual orientation, and socioeconomic status (Psychology Today, 2021).

Benefits of culturally sensitive care

There are many benefits of culturally sensitive care. Some of these are as follows (Psychology Today, 2021):

1. Clients feel seen and heard
2. Clients are better able to connect to their therapist
3. Clients feel accepted for their authentic selves
4. Clients are more likely to achieve their goals
5. Clinicians learn about different cultures

Culturally sensitive clinicians should do the following (Psychology Today, 2021):

1. Communicate an awareness of the culture of their clients
2. Learn the beliefs and practices of their client's culture
3. Seeks to understand how the client goals relate to culture
4. Be comfortable asking about culture and discussing the impact of culture on health
5. Refer to culturally sensitive providers for other services (Psychology Today, 2021)
6. Acknowledge what is occurring in communities and the world such as racism, police brutality, etc. (Jackson, 2020)

7. Do not make any assumptions about others or become stuck in stereotypes about culture and race (Jackson, 2020)

Being a culturally sensitive clinician is a skill that must be honed like any other. Some people, especially those with great privilege, might struggle to understand how to be culturally sensitive providers. The following are barriers to practicing cultural sensitivity (Jackson, 2020):

1. Fear
2. Lack of preparedness for difficult conversations
3. Feelings of inadequacy
4. Being overly polite
5. Stating or believing they are “colorblind”

Why cultural sensitivity matters

Not only is practicing cultural sensitivity ethically required for behavioral health clinicians but it is essential because of the diverse demographics in the United States. The following trends show just how important culturally sensitive care is (Barnett & Bivings, n.d.):

1. In some areas, people of color are the majority of the population
2. Immigrants are no longer concentrating in few urban areas but rather are populating all regions such as urban, suburban, and rural areas
3. Psychology is only as relevant as it is understanding of the people that it supports - because there are such high needs for marginalized populations where mental health is concerned, clinicians must be able to serve their unique needs

The following statistics show the rate of mental illnesses for various demographics (Mental Health America, Inc., 2021):

1. 17% of African Americans have a mental illness
2. 15% of Latinx/Hispanic Americans have a mental illness
3. 13% of Asian Americans have a mental illness

4. 23% of Native and Indigenous people have a mental illness
5. 25% of people who identify as being more than one race have a mental illness
6. 37% of individuals in the queer community (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual) have a mental illness (Mental Health America, Inc., 2021)

The following statistics show mental health statistics where children are concerned (National Center for Children in Poverty, 2021):

1. 1 in 5 children (18 years and younger) has a diagnosable mental illness
2. 1 in 10 youth has serious mental health problems that result in functional impairments
3. The onset of significant mental illnesses can occur as young as 7 to 11 years old
4. Half of all mental health disorders over the lifespan occur by mid-teenage years
5. 31% of white youth receive mental health services
6. 13% of children with diverse backgrounds receive mental health services
7. Non-Hispanic/Latino white children have the highest rates of mental health services usage
8. Asian American/Pacific Islander children have the lowest rates of mental health services usage
9. African-American children have less access to counseling than white children
10. Hispanic and Latino children have less access to counseling than white children

Trauma-informed care

People of color and people in marginalized communities are experiencing trauma at very high rates. Such trauma may result from police brutality against people of color and the inappropriately high incarceration rates of people of color. Black people make up only 12% of the population in the United States but they make up 33% of the total prison population (Mental Health America, 2021). Other current stressors for people of color include living in rural, underfunded areas with resources crises; physical and verbal attacks for speaking their native language; and being told to “go back to their countries”

(Mental Health America, 2021). Because of this kind of ongoing trauma and the extensive historical trauma of all people, but especially people of color, clinicians are ethically responsible for using trauma-informed care models.

Trauma-informed care is a form of behavioral healthcare that seeks to have a full picture of an individual's life and family life to avoid retraumatization in treatment and improve outcomes (Center for Health Care Strategies, Inc., 2021). Trauma-informed care is based on the following six principles (Center for Health Care Strategies, Inc., 2021):

1. Safety: clients and staff feel physically and psychologically safe in the mental health setting and the therapeutic relationship
2. Trustworthiness and transparency: decisions are made with all of the information being clear between parties with a mutual goal of establishing and maintaining trust
3. Peer-support: individuals who have shared experiences are viewed as an important part of the service delivery
4. Collaboration: there is a shared-decision making process without a significant amount of power differences
5. Empowerment: clients and staff understand each other's strengths and validate them to help heal from trauma
6. Humility and responsiveness: biases about stereotypes and traumas are addressed as they arise

Behavioral health agencies can seek to be trauma-informed by doing the following (Center for Health Care Strategies, Inc., 2021):

1. Building understanding and awareness about trauma amongst all staff - not simply clinicians
2. Engaging staff in buy-in for trauma-informed care
3. Supporting a culture of health and wellness amongst staff so that staff members feel empowered to set boundaries and take care of themselves
4. Creating a workforce that feels and is safe
5. Hiring a diverse workforce with individuals who represent the values of trauma-informed care

Summary

At the very core of behavioral health, ethical responsibility includes seeing clients for who they are and serving them in an appropriate manner. While recognizing individual needs and helping those who are struggling, behavioral health professionals must acknowledge the traumas, experiences, cultural differences, and other unique identities that make individuals special. They must work in a way that honors those special experiences and identities and helps clients achieve their goals.

Section 7: Avoiding harm

Introduction

Avoiding harm is an ethical requirement when providing behavioral health. The goal of all mental health services should be to help improve someone's mental health struggles. This is important to remember with youth, especially, because they may perceive mental health services as harming them - simply related to their fear or the stigma associated with accessing care. Behavioral health professionals should always remind minor clients of their desire to help. For example, this can be a very effective statement when communicating a desire to do no harm: "I am really glad you're here. My job is only to support you in feeling better and support your family as well. Nothing else."

Main ways to avoid doing harm

There are three main strategies to avoid harm when working with youth. These are as follows: following through with reporting procedures as necessary, practicing flexibility, and learning constantly (American Academy of Pediatrics, 2021).

Behavioral health professionals are mandated reporters. If they have reason to believe a child is in danger in any way they are legally obligated to report that danger (American Academy of Pediatrics, 2021). Information on mandatory reporting per state guidelines can be reviewed again in earlier sections of this course. Behavioral health professionals are also responsible for reporting any errors that occur that can harm clients. For example, if the wrong medication was administered in a hospital setting it must be reported and the child must be monitored for any adverse side effects. There must be a nonpunitive environment for mandatory reporting in the culture of the workplace to

ensure that mandatory reports are made as they need to be (American Academy of Pediatrics, 2021).

Behavioral health professionals must continue to practice flexibility with their clients (American Academy of Pediatrics, 2021). In practicing flexibility, staff must be willing to learn new strategies, policies, and procedures as demands and needs change. This is true not only for ongoing therapy but in the way assessments are completed, how risk is assessed, and how treatment plans are developed. Flexible teams should maintain their values and be invested in training and supporting each other while also staying abreast of the best evidence-based practices available (American Academy of Pediatrics, 2021).

Finally, behavioral health professionals are responsible for creating a culture of learning and ongoing education (American Academy of Pediatrics, 2021). This is done so that individuals have the competence to work with clients effectively, can implement proper interventions as needed, learn from past mistakes with clients, and continue to ensure the healthiest and safest environment possible in behavioral health (American Academy of Pediatrics, 2021).

Summary

Behavioral health professionals must not harm their clients in any way. Their clients should feel safe, supported, and empowered in the work to be done and in their partnership with their clinicians. It is helpful for clinicians who are employed through an agency to work with one that holds similar values, is flexible, and that promotes ongoing learning as crucial to developing safe environments that do no harm. Of course, they must also notice potential signs of harm and report them to investigative agencies when appropriate.

Section 8: Maintaining neutrality, avoiding bias, keeping healthy boundaries

Introduction

Neutrality, or the art of staying somewhere near the middle line, is important in therapy. Maintaining effective boundaries, being neutral, and noticing and addressing biases is an ethical responsibility of all behavioral health professionals. This helps to promote

positive outcomes in the clients supported. It also ensures the therapeutic relationship is maintained.

Neutrality

Neutrality can be defined in the following two ways (Woolley, 2016):

1. Clients believing that their therapist is not aligned with one single person
2. Therapists not aligning with or against any single person they are working with (Woolley, 2016)

Neutrality is maintained by behavioral health professionals checking their values and beliefs at the door so that they can be nonjudgmental toward the values and beliefs of others (Woolley, 2016). It is also maintained by being an objective observer in the therapeutic relationship (Gelso & Kanninen, 2017). The therapist should not take sides with the client's inner struggle or outer struggles (Gelso & Kanninen, 2017).

Although there are various beliefs about neutrality and a clinician's ability to be neutral in services, the consensus is that therapists should aim to be as neutral as possible (Gelso & Kanninen, 2017). They should only share their values and experiences in the form of self-disclosure when carefully considered and when it has a positive benefit to the therapeutic process. It must not take away from the client's experience or put the focus on the clinician.

Bias

Bias is dangerous to behavioral healthcare. If bias is present then services are likely not equitable or fair. They certainly would not reflect person-centeredness or ethical service delivery. A bias is an attitude toward one person that is either favorable or unfavorable (School of the Art Institute of Chicago, 2021). Bias influences the way that information is received, interacted with, and how behavior toward a group of people is displayed. Bias develops both directly and indirectly. Certain biases may develop due to traumatic or difficult experiences that individuals then generalize toward a group of people. Other people may not notice their biases develop. Some might insist they have no biases at all (School of the Art Institute of Chicago, 2021).

The following are additional definitions about biases (School of the Art Institute of Chicago, 2021):

1. Unconscious bias: “Biased attitude operating outside your awareness and control, are difficult to access or be aware of, & influence your action more than conscious biases”

2. Confirmation bias: “Tendency to favor information that aligns with our existing beliefs or attitudes”

Behavioral health professionals cannot simply recognize their biases. They have an ethical responsibility to challenge them and change them. One way to do so is to notice the biases or thoughts that occur (School of the Art Institute of Chicago, 2021). After clinicians recognize their biases they should stop and think about the bias and its impact. Then they should find something that contradicts that bias. Whether that be in policy, art, an example they saw in the community, or any other situation, they must find a reason to reframe that bias to be untrue. This can be helpful to do when practicing mindfulness (School of the Art Institute of Chicago, 2021).

The following steps are identified further for addressing bias in child welfare (American Bar Association, 2021):

1. **Become aware of your own bias** – “Being aware of the bias enables you to flag and remove that bias when making decisions so a fair, individualized assessment can be made. Becoming aware of bias may require completing tests such as the IAT to identify your biases. Practicing ongoing self-reflection of your beliefs, presumptions, and opinions can assist with checking on pre-existing and newly formed biases. Our biases typically derive from our personal experiences. Therefore, by educating ourselves through reading books, listening to podcasts, participating in training, and having productive discussions that disrupt bias, child welfare providers can gain new perspectives that help them understand their decisions.”

2. **Raise consciousness** - “Child welfare advocates must raise consciousness of bias in practice. For attorneys, bias can impact representation. Zealously representing clients may require attorneys to assess their own biases and ensure other professionals’ biases are not driving decisions or recommendations. Judges should also reduce or eliminate bias in child welfare cases by assessing their biases about families of color or poor families. Judges should also acknowledge and properly assess cases when biases from other practitioners lead to improper case determinations. For social workers this may require acknowledging biases during referrals, recommendations, and home visits.”

"A major area in which child welfare practitioners may raise consciousness of cultural bias is language barriers between families and practitioners. Language barriers often further cultural biases for child welfare professionals. Due to the difficulty of communicating, professionals may act unreasonably due to misunderstandings. Practitioners must advocate for access to tools and resources, such as language services, interpreters, or colleagues with language and culture fluency to foster meaningful communications with clients. Never let language barriers inhibit effective representation."

3. **Deliberate, reflect, and educate** - "To reduce or eliminate our own biases, we should take time to reflect on reasoning and facts before making decisions. Due to high caseloads and the need for triaging, child welfare practitioners often make quick, in-the-moment, decisions. These off-the-cuff decisions are usually biased because individual facts may not be considered.[10] Our brains often fill the gaps with stereotypes or prior cases we have encountered."

   Some tips:

   - Write it down – writing typically induces further deliberation and causes you to consider the justification of the decision made.
   - Explain your reasoning to another person (e.g., colleague or intern). This alternative may provide an opportunity for deliberation. Taking the time to reflect, write down your perspective, or discuss resolutions with a colleague can uncover when and how a bias is impacting decisions."

4. **Change perspectives** - "Working directly with clients can foster an "in their shoes" approach. This means imagining you are the client, considering all factors you may know about the client (race, socioeconomic status, and more), and understanding the client's perspective. Meet your clients "where they are" and understand what they want and need. Exercise cultural empathy to understand how clients with varying backgrounds may differ. Cultural empathy is simply appreciating and considering the differences and similarities of another culture compared to one's own. In addition to personal steps we may take to change perspective, we can work together for structural and systematic changes of perspective.

   Examples include:

- Supporting Parent Advocates. Parent mentoring programs provide additional support for parents involved in the child welfare system. Supporting parent mentoring programs encourages parents to have a voice in the child welfare system to say what they need and how the system can do a better job to serve parents and families.
- Reunification Day Celebrations. These local events celebrate parents who have reunited with their children following child welfare intervention. They are an opportunity for localities to reflect and celebrate the preferred goal of child welfare intervention.
- "Blind Removals." Blind removals require a panel of practitioners to look at a case file with all identifications of race removed before assessing whether a child should be removed from the home or receive services. In one jurisdiction, implementing blind removals resulted in fewer children of color being placed in out-of-home care than under previous methods."

5. **Welcome and embrace diversity** - "Research suggests exposure to varied groups may reduce bias. One mechanism for change may be the "social contact hypothesis." This hypothesis "suggests that prejudice and stereotypes can be reduced by face-to-face interaction between groups."[12] This means meeting and working with individuals from other communities can actually reduce our biases. More specifically, contact with "positive exemplars" can shape and possibly even reduce how we associate stereotypes to particular groups. A great way to introduce positive examples may be embracing a more diverse staff and/or peer mentors. Other positive examples include reunification heroes, parent allies meeting with legislators, and parent allies employed by the child welfare system."

Identifying the steps in reducing bias in child welfare is essential to behavioral health professionals for a variety of reasons. The first being that many behavioral health professionals work with or in the child welfare system. Secondly, a high percentage of children who are engaged in child welfare (foster care, case management, placement, etc.) have mental health disorders. Specifically, up to 80% of children in foster care have significant mental health disorders (National Conference of State Legislatures, 2021).

Boundary setting

Boundary setting is another important ethical consideration for clinicians when working in children's behavioral healthcare. Boundaries exist to protect children and families in

the therapeutic setting (Steinberg Behavior Solutions, 2021). Setting boundaries in behavioral health helps families engage in the work, keeps individuals and families safe, helps the focus stay on the client, enables clinicians to model appropriate communication and skills to their clients, and supports the clinician in avoiding burnout (Steinberg Behavior Solutions, 2021).

Boundaries must be established before the therapy services begin (Steinberg Behavior Solutions, 2021). This helps everyone to feel comfortable and avoid unintentionally crossing boundaries. Each individual and family might establish different boundaries depending on the situation but generally, there will be boundaries around the following (Steinberg Behavior Solutions, 2021):

1. Touch: physical space between clients and the clinician
2. Self-disclosure: this will determine how much is too much to reveal to families about the clinician personally
3. What kinds of services are administered: this reduces the chance that families might feel as though they are not getting what they expect out of services
4. Gift exchanging: generally, it is not done in services
5. Communication: how to communicate when boundaries have been crossed and how to re-establish boundaries

Summary

When working with children, the ability to stay neutral, avoid biases and acting on biases, and setting clear and firm boundaries will ensure the best client outcomes. This helps children understand the therapeutic relationship, focus on their goals, and learn through modeling. Children notice the cues and observe the skills that clinicians show even when they do not verbally teach them. This helps them in all settings: at home, at school, and with their peers.

Section 9: Sharing information

Introduction

How information is shared in mental health is crucial because it can determine the trust that is established between the clinician and their clients. Not adhering to proper sharing and privacy laws is not only an ethical concern but a legal concern as well in behavioral health. Clinicians do have to share information with a variety of other professionals to best support children. This is especially true in high acuity cases, however, how they share that information is crucial.

Sharing with parents

Some parents or legal guardians may want information from children and clinicians that they either are not entitled to or children do not feel comfortable sharing. It is the responsibility of the clinician to understand the privacy and consent laws (referenced earlier) in their state. This will determine what and how information can be shared with parents. If information is being shared with parents it is generally appropriate to explain to the children that the information is being shared. That form of transparency will only help the therapeutic relationship and process.

Sharing with police

Children and adolescents, especially those who interact with the child welfare system, are often interacting with police. How behavioral health professionals and police share information should be strategic. The following collaboration strategies between police and behavioral health professionals are identified (CSG Justice Center, 2019):

1. Work together to understand privacy laws and shared goals to facilitate trusting relationships with each other as professionals
2. Consider the best type of engagement with various partners. For example, monthly recurring meetings or only communicating as needed
3. Clarifying terminology to ensure that communication is being understood as intended
4. Provide basic training on legal topics and issues

Sharing with professionals

Behavioral health professionals do under some circumstances share information with other behavioral health professionals or professional colleagues in healthcare. If clients consent to their information being shared between professionals they are working with, the information will likely be shared between professionals on an as-needed basis specific to the shared goals of the client and professionals supporting the client.

Behavioral health professionals may also share struggles they are having with their clients in clinical supervision and/or case consultations. This information is still protected because the client's name and information are not given but their current struggles or "stuck points" in therapy are discussed. Clinical supervision and case consultation are different, however. Case consultation occurs when therapists have ultimate responsibility for their clients but want guidance and support on how to best support these clients (Psychology Info, 2021). Clinical supervision may occur when supervisors are ultimately responsible for the care being provided to clients, such as when clinicians are students or those who are working toward licensure (Psychology Info, 2021).

Sharing information with minor clients

One of the often-overlooked ethical issues is whether to share information specifically with clients about their care. For example, whether to share a diagnosis, treatment prognosis, etc. All children have a right to understanding and respect for themselves and others (Wheeler, 2021). When children are given information about their health and mental health, they are given the opportunity to understand themselves better, and to have self-compassion for their struggles. Furthermore, they can use this information to learn the best skills and tools for creating the most positive life possible. It is also important to honor dignity and respect and build autonomy by allowing children to make informed decisions about their healthcare. To do so, children should have the most possible information about their care (Wheeler, 2021).

There is no exact age or time at which to tell children they might have mental health conditions (Wheeler, 2021). Clinicians should use their clinical judgment and, if needed, work with parents to determine when is the appropriate time to disclose information about their health. For example, it does not help a child have language and understanding of their own experience in the world if a therapist hides from them their treatment plan and diagnosis. This would not be ethical. It might also not be ethical to disclose all of that information at once before a therapeutic relationship is established.

Clinicians should disclose information in a way that is strengths-based and positive when talking to children about their health. They should have a positive tone and body language. Information should also be shared in a way that is consistent with children's functional abilities of processing, understanding language, and ability to ask questions. Some clinicians and children find it helpful to refer to books or videos for additional information that children can explore outside of sessions to learn about themselves (Wheeler, 2021).

Summary

Sharing information is a necessary piece of the mental health treatment puzzle, however, it must be done with great caution and consideration. Whether information is being shared between professionals, parents, and even to children themselves, clinicians should consider what is enough information to share vs. what is too much information to share; how to share the information; and what the primary reason for sharing information is. This supports the best ethical treatment in behavioral healthcare.

Section 10: Case studies

Case Study #1: Hamlin

Hamlin is a 12-year-old boy who was recently adopted after years of being in the foster care system. He was placed in foster care shortly after birth when his single mother overdosed on opiates. He did not know his father and had no other family to support him. Hamlin was born addicted to opiates and underwent treatment to recover. He has broad developmental delays but is catching up to his peers developmentally. Hamlin struggles with social anxiety. He worries nobody will want to be his friend. This worry prevents him from being willing to engage with his peers, which perpetuates the belief that nobody wants him.

Hamlin asked his newly adopted parents to help him learn to make friends. When his parents asked him if he wanted to see a therapist for help he quickly said "I'm not sure - I saw a lot of therapists before I came to you. It makes me feel different."

Hamlin's parents responded by explaining to him that maybe his story is different but it is uniquely his and that they love him. Hamlin agreed, "Okay - I think I could go."

Hamlin lives in a state where his parents have to consent to his treatment but they report to the therapist that unless there are significant concerns that Hamlin's autonomy and privacy should be respected. They don't want to interfere with the process. Hamlin's therapist is grateful for this.

Hamlin's therapist works with Hamlin to learn friendship skills. They utilize Cognitive Behavioral Therapy techniques and practice in sessions. Hamlin's therapist invites him to practice with his family and adopted siblings at home. Several months after they begin working together Hamlin is assigned homework by his therapist to find one person to invite to be his friend at school. Hamlin becomes panicked immediately. He states "I cannot do that. I won't do that." He reports not wanting to return to therapy and refuses to work with his therapist. His therapist is confused and concerned - she isn't sure what she did wrong. Hamlin missed his upcoming sessions.

Hamlin's therapist decided to staff this case with another peer of hers who works with children who have been adopted and involved in foster care for many years. Hamlin's peer explains that perhaps this was simply too quickly of a transition and a jump for Hamlin. She explains that it might be best to model to Hamlin the kind of behavior that she would want for Hamlin where friendship skills are concerned: call him and apologize for jumping too far too soon. And ask him if he would be willing to simply come to play a game in session but not do any additional work together yet. Hamlin agrees.

After several weeks of playing games in sessions, Hamlin's therapist invites Hamlin to process the situation where he was asked to find one friend and he explains his fear. He said he wanted to take smaller steps. Together they wrote a new treatment plan for ways to continue to practice via storytelling, game-playing, and family practice. Hamlin agreed that when he felt ready to take his homework to school and invite someone to be his friend he would.

This case illustrates how the therapist was willing to regroup and see help from a peer about how best to help Hamlin. In this situation, case staffing was ethical and effective: had this therapist not staffed the case with her peer she might not have thought of an effective way to re-engage Hamlin in therapy. She was also able to re-adjust the treatment plan with Hamlin leading the way.

Case Study #2: Charlie

Charlie is a 15-year-old boy who was recently referred to a school therapist by his English teacher because of consistent inappropriate behavior in class. Charlie has struggled with

impulsive behavior and behavioral outbursts in class before but recently his behavior has become more and more disruptive.

Charlie meets with the school counselor who talks with him about how things are going at home. Upon meeting Charlie the school therapist quickly realizes that Charlie feels unsupported at home. She learns that Charlie is the oldest of four siblings and he is responsible for supporting his younger siblings in the evenings because his 22-year-old sister who has custody of them is working. Charlie reports that sometimes there isn't enough food in the house to get by. Per the school counselor's assessment, there are no indicators of abuse or neglect - but this behavioral issue could likely be related to a lack of essential resources for this family. Charlie's essential needs are not consistently being met. Instead of focusing on providing therapy to "fix" Charlie's behaviors, the school therapist believes it is more effective to support Charlie and his family in a case management role.

Charlie's school therapist contacts his older sister, who serves as his guardian and refers them to the free school lunch program. This ensures that Charlie and his siblings will have free breakfast and lunches at school. His sister didn't want to enroll them in the program initially because of fear of the kids being "made fun of" by their peers but she agrees because she knows how helpful it could be to stop working overtime and to worry less about making enough money to cover all meals every day while also paying the other bills.

Charlie's school therapist also refers the family to state-funded childcare services that will offer a few hours a night of childcare so that Charlie isn't parenting his younger siblings and can focus on his schoolwork. After a few sessions at school Charlie's counselor learns that Charlie acts out in class because he isn't able to do the homework at night and he doesn't feel prepared. He acts out as a way of making it seem like he doesn't care about school or schoolwork. That way people just assume the reason he's failing is that he's "stupid" and not because he's overwhelmed and busy at home.

After ongoing resource needs are met and the essentials are being addressed, Charlie's counselor offers to refer him to community mental health services to learn behavioral management strategies. Charlie enrolls in therapy and sees a therapist weekly who visits him at school so that he doesn't have to worry about transportation to and from school.

The next year Charlie has the same English teacher and she reports his behavior is much better than it was before and that he seems happier overall. Charlie's case illustrates how important it is to address all needs and refer to essential services instead of simply

focusing on behavior or “problem behavior.” This falls under the ethical umbrella of promoting healthy school, family, and community environments and honoring the dignity and worth of the client.

Case Study #3: Lina

Lina is a 17-year-old first-generation immigrant who recently graduated from high school. She moved to the United States when she was in elementary school and has been helping her parents communicate by translating for them ever since. Lina’s father recently passed away and she plans to support her mother by becoming employed rather than going to college. Lina has been struggling with constant worry and stomach sickness. She saw her doctor and her doctor referred her to a therapist as he found nothing medically wrong with Lina.

When Lina was referred to therapy she was quite nervous. She reports that growing up her parents warned her to not “make a fuss” and “never have anyone ask about our family” because much of her family did not have citizenship nor any green card to be in the United States. Lina met with the therapist but was very quiet and only spoke when questions were asked of her for the first few appointments.

Lina’s therapist feels unsure of how to move forward in supporting her because of how hard it is to get her to open up. They have discussed her goals of reducing anxiety but when the therapist prompts conversation about the historical experience of anxiety and where Lina believes the anxiety might come from she refuses to answer.

Lina’s therapist believes that the most honest way to support her is to call to the surface Lina’s fear of opening up but to do so in an emotionally supportive way. At their next appointment, Lina’s therapist opens the conversation by saying, “I’ve got a question for you that I’m hoping will be received by you well. It’s a question I want to ask only for the sake of determining how to best support you and I want to ask it because I care about you and your wellbeing.”

Lina responds nervously but says yes. Lina’s therapist states: “So, I’ve noticed that we have talked about your goals and we have talked about how anxiety shows up for you. You get nauseous and short of breath, but when I ask what prompts your anxiety you struggle to answer me. I’m wondering if there’s something I can do to better support you in being more forthcoming more about this. I only ask because I know that sometimes when we have anxiety it is rooted in another experience and when we process that

experience we can lessen the anxiety and determine the best kind of skills to use to navigate ongoing anxiety."

Lina received this question well as she could tell the therapist honestly wanted to support her and understand her. Because of this feeling of emotional safety and wellbeing, Lina was able to open up. She explained that in her culture there was such a fear of doctors and systems who might learn that some of her family were not legal immigrants, which may in turn result in the people she loved being taken away. Because of this, she was taught to keep quiet and not talk about feelings outside of the home. She said that even in the family home where she was responsible for translating for her parents she never quite felt like she had the chance to be a child - she felt she had been working for a long time. That is making her recent need to put off going to college to work to support her mother even more difficult: she feels she isn't able to transition into adulthood the way she wants. However, she also wants to support her mother so she feels torn.

When Lina's therapist learns all of this background she first thanks Lina for being honest. She validates that it was likely anxiety-producing to share this information and she congratulates her. She also shares the HIPAA policy and privacy laws and ensures Lina that she is not going to share any information about immigrant status with anyone. This provides Lina with relief.

This information helps Lina's therapist determine how to move forward. It helps them decide that processing the childhood pressure and responsibility to act like a functional adult will be important for Lina to release feelings of guilt and responsibility. They also decide to focus on mindfulness and Cognitive Behavioral Therapy strategies for anxiety reduction. Finally, they determine a plan for Lina to support her mother by working part-time but by going to part-time community college courses as well.

Lina's therapist supports her during her entire three years at community college. Over this time Lina was able to help her mother find employment and Lina feels confident she can leave to finish her last two years at a university. Lina plans to study accounting. By the time she attends university, she has reduced her anxiety greatly and no longer has chronic stomach aches. Lina's case is a good example of therapists meeting clients where they are at and asking honestly how to support them. It also illustrates how reminding clients of the privacy laws and honoring cultural values and obligations can support establishing a strong therapeutic relationship.

Case Study #4: Thomas

Thomas is a 13-year-old boy who resides in a group home. He has Post-Traumatic Stress Disorder from physical and sexual abuse in childhood. He recently started showing signs of aggressive behavior toward peers who are new to the group home. Thomas is the child in the group home who has been there the longest and feels the most at home there. The staff members who support him regularly think that he feels comfortable and safe for the first time in his life so when other kids come in and out of the homes it makes him feel unsafe again. Because of this, they believe, he is showing aggression toward them. It almost appears as a coping mechanism for him: intimidate the children before he feels afraid or threatened by them.

Thomas has a therapist who meets with him weekly at the group home. He has generally liked meetings with his therapist because they have played games together in sessions. Thomas' therapist recently asked Thomas about his aggressive behavior and Thomas refused to discuss this. He stated: "I don't do that and I'm not going to talk about it." Thomas' therapist was surprised by this statement because they had such good therapeutic rapport before this. Thomas disengaged in sessions for a few weeks before Thomas' therapist decided to try something new.

Thomas' favorite sport is basketball and he loves to play. At the group home that Thomas lives at there is a basketball court with nice basketballs. Typically he has to play with other children and he doesn't get the chance to play basketball with adults often. Thomas typically meets with his therapist in the therapy room but his therapist wonders if doing an activity he loves while having a session will be helpful to re-engage him with services. Thomas was excited about the potential to play basketball.

Thomas' therapist wondered if this was an appropriate strategy to get him to engage in services. He wants Thomas to choose to be an autonomous participant in therapy but he also knows they are stuck and it's interfering with him learning more helpful behaviors so that he can be appropriate with his peers. After discussing the idea with his supervisor, Thomas' therapist decides to follow through and play basketball during a session.

After fifteen minutes or so of playing basketball, Thomas' therapist brings up his peers. He asked Thomas how playing basketball goes with them and Thomas reports fine. Thomas' therapist then asked why he can safely play basketball with his peers but not coexist with them in the group home. Thomas explained that during basketball he feels good because it's his favorite thing to do. When they are in the group home, however,

he states that he's afraid the new kids won't be nice to him so he wants to "be mean to them first" as he puts it. Thomas' therapist asked Thomas if together they can work on more effective ways of engaging with his peers in sessions and maybe every few sessions they can take one of them outside to the basketball court. Thomas agrees.

After six months Thomas no longer needs a one-to-one staff with him at all times because he has been engaging in services and is more appropriate with his peers. A staff member still remains within a safe distance to provide some oversight if needed. Thomas' case demonstrates the importance of the ethical obligation to promote the optimal wellbeing, functioning and development of youth, both as individuals and as a group. In his case, it had a good outcome for Thomas and his peers at the group home.

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