



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

## **Ethics and Professional Conduct**

**Section Outline:** This course will cover the ethical and professional mandates of the addiction professional as they pertain to: Ethical standards of conduct, client confidentiality, client records confidentiality, professional clinical practices, boundaries, assessing crisis, and the importance of continuing professional development.

### **Section Objectives:**

---

1. Student will be able to demonstrate ethical and professional behavior.
2. Student will learn and understand the Florida Certification Board Code of Ethics and Disciplinary Actions
3. Student will be able to define and recognize boundary issues between client and professional.
4. Student will be able to define, implement and practice client rights.
5. Student will be able to define and implement culturally aware clinical practices.
6. Student will understand the benefits of professional associations.
7. Student will be able to assess risk factors for self-harm and implement crisis interventions.
8. Student will learn to adapt therapeutic strategies to client needs.
9. Student will learn the ethical and professional benefits of clinical supervision.
10. Student will be able to identify and professionally resolve transference and counter-transference issues.
11. Student will accept the responsibility of continuing personal and professional growth.
12. Student will learn to practice self-evaluations for the purpose of professional and personal growth.
13. Student will learn to assess signs of potential professional burn out and implement strategies for self-care.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

## Introduction

*Instructor Note: You all may be asking yourselves “Why another course about ethics and professionalism? Aren’t there more important or practical things we could be learning about?” Truthfully, from my point of view there is a short answer to these questions....No, there isn’t anything more important, useful, purposeful or practical. The reason I give this is answer is simple and basic. As a student you can read more books or articles, as a staff person you can attend trainings, sit for webinars and take part in clinical rounds, all to enhance your working knowledge of addiction, your clinical tool belt, and your style/techniques in working with clients. However, understanding the importance of being ethical and professional is something you must FEEL & BELIEVE is mandatory. The understanding that being responsible for helping other human beings and having those human beings trust you to enter into their lives allowing you to see their frailties and vulnerabilities requires without hesitation, without devaluing the commitment to the highest standards of quality, earnest, ethical and professional care.*

As an addiction professional (certified or not) or behavioral health tech you are required to know, understand and adhere to the Florida Certification Board standards of Ethical Practices, Rules of Conduct and Standards of Care.

Please, **on your own**, go to the following links to read these required readings:

1. <http://flcertificationboard.org/ethics/>
2. [http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2\\_main\\_02.tpl](http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl)
3. <https://www.flrules.org/gateway/ChapterHome.asp?Chapter=65D-30>

All professional’ and behavioral health techs will not only be held to the standards and rules of behavior and practice but they will also be subject to the ramifications of non-compliance as stated in the Florida Certification Board guidelines of ethics and professional practices.

For additional information on what is expected of you as an addiction professional. Please go to the following link:

<http://store.samhsa.gov/product/TAP-21-Addiction-Counseling-Competencies/SMA14-4171>



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

In addition to following all of the professional standards, ethical guidelines, codes of conduct and scope of practice listed above, you must also have a full and complete working knowledge and understanding of client rights and responsibilities, confidentiality rules and regulations, appropriate boundaries, biases – personal & otherwise, multicultural awareness and sensitivity, trauma awareness and sensitivity and a thorough understanding of the difference between the role of the professional counselor and that of a peer counselor or sponsor.

As a professional, you will be faced with many challenges and uncertainties even with knowledge and practice. For this there are two things you, the addiction professional must do:

1. Take part in and seek out ongoing supervision and consultation.
2. Develop and implement a personal self-care plan to maintain your physical and mental health.

For this class we will be examining the roles of transference, counter-transference, boundary guidelines and violations, burn-out, risk assessment and management, crisis assessment and management, the potential influence of personal values and biases and the professional's personal recovery issues impact on job performance and client interactions.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

## Scope of Practice, Ethical Practice, Confidentiality and Informed Consent

The ability to recognize and respond appropriately to ethical dilemmas encountered while treating addictive disorders is a complex task that cannot be taken for granted by even experienced professionals. Full caseloads and busy schedules provide few opportunities for in-depth examinations of ethical dilemmas that often demand an on-the-spot decision. This article sets forth a pragmatic set of principles that can help professionals to evaluate ethically challenging situations. While these ethical principles are relevant to almost any situation, this article focuses on how they apply to the treatment of substance and behavioral addictions.

Numerous written codes of ethical conduct exist to guide the many different counseling professions. These documents may be more useful for giving clients and the public an assurance of the ethical parameters of professional behavior than in providing professionals with a useful frame of reference for dealing with day-to-day dilemmas. There is also an important difference between merely abiding by rules of conduct and embodying the ideals contained within them (Coale, 1998; Tjeltvelt, 1999). A set of common principles derived from these various codes must be sufficiently broad enough to take into account the rich variety of practice settings, counseling theories and treatment approaches in which addiction professionals operate. Any less inclusive formula for determining whether a professional's behavior is ethically appropriate requires knowledge of the context in which it occurs. For example, vigorously challenging a client's beliefs or behaviors may be ethically justifiable under one set of circumstances but not another (Tjeltveit, 1999). Similarly, different professionals may respond to an identical ethical dilemma in very distinct yet equally justifiable ways.

### Informed Consent

---

***Instructor Note: The Informed Consent form is typically provided to the client to read and sign during the initial intake process. This form is provided to client with stack of other important forms. I have sadly seen many professionals, intake workers and admission specialists simply lay the form down in front of the client and say "here is your informed consent and this says you give us permission to treat you and work with you" etc. etc., then "just sign and date". What is wrong with this picture?? Is this how we look out for our clients, our clients who trust that we have their best interest in mind; that we are going to help them and care for them? No, this is lazy, unprofessional and completely unethical practice! Working in addictions treatment requires professionalism, high standards of clinical and conduct practices and care and concern for the well-being of your clients. It is a betrayal of the client, the facility and***



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

***ethics to do anything less. The information in this chapter details many areas that you will be expected to learn, understand and ultimately practice. Be the best you can be always.***

Informed consent is the fundamental bedrock of ethical practice, because it helps to assure the client's autonomy in matters that affect the entire course and direction. Professionals may not always fully appreciate the lengths they must go in order to insure that important decisions about treatment issues are truly made from a basis of informed choice. Rather than being a one-time event, informed consent is an on-going collaborative effort between client and professional for establishing and continuously monitoring the goals and strategies of counseling as well as the roles, rights and responsibilities of all parties. (Tjeltveit, 1999)

***A client's informed consent is not in itself sufficient to determine whether a professional's behavior is ethical. It's conceivable that clients might be willing to give their approval to any number of ethically inappropriate behaviors, so a professional needs other core principles to guide the ethical decision-making process.***

### **Competence and Established Theory**

---

A professional has an ethical responsibility to practice only within the scope of his or her professional competence. Some typical indicators of competence include education, experience, training, and certification (Pope and Vasquez, 1998). Competence in one clinical area doesn't necessarily translate to another. Professionals with extensive experience treating general psychiatric disorders aren't necessarily competent to meet the specific needs of addicted clients, just as addiction professionals without advanced training don't always adequately recognize signs of psychiatric disorders. Cross-referral between such specialists is necessary in such situations.

### **Confidentiality**

---

Another core ethical principle is for a counselor to vigilantly guard against unauthorized disclosure of client information. The assurance of confidentiality is a fundamental guarantee, but it is not an absolute one.

Several ethical dilemmas involving confidentiality commonly arise in the treatment of addictive disorders:

### **Duty to Warn/Protect**

---



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

It is widely accepted that professionals have a general obligation to warn or protect people whom a client places in imminent harm. The right to confidential treatment is therefore balanced by the need to insure the safety of others. The beginning of the relationship is the most appropriate time for a client to learn about these limits on confidentiality as well as any safeguards necessary to protect others, such as policies on notifying law enforcement personnel if a habitual DUI offender drives to an appointment while intoxicated.

Clients who inject drugs or engage in sexually risky behavior while chemically impaired may expose others to the risk of HIV infection. Courts have not generally applied duty-to-warn standards to these situations (Houston-Vega and Nuehring, 1997). Balancing the professional-client relationship with the protection of at-risk populations is a very complex and emotionally charged situation. Professionals should inform clients about their policy for dealing with HIV-related confidentiality issues, educate clients about the health risks of their specific sex and drug practices, communicate any concerns that arise during the course of treatment, offer to help communicate information to partners, and consult with colleagues as appropriate.

### **Minors and Families**

---

All states require professionals to report situations in which minors are in danger of harm, although specific state statutes differ (Corey, Corey and Callanan, 1998). As most professionals know, it can be difficult to distinguish potential from probable risk. For instance, a client who admits to blackouts may deny that she places her children in any danger. A professional who decides not to notify the designated reporting agency in such a situation should document the basis for this decision in the record. Consultation in these situations is again extremely valuable.

A major ethical concern that arises with couples or families is how to deal with the emergence of secrets that so often accompany addictive disorders. For example, consider the situation that could arise when providing marital support to a couple if a husband who attends a session by himself announces that he's relapsed on cocaine but is unwilling to admit this to his wife. A professional who keeps this information secret is not fostering a climate of honesty. On the other hand, revealing information that a client reasonably presumed would remain confidential will damage that client's trust, while threatening to summarily end treatment if the client isn't honest with his spouse is a form of coercion and potential abandonment. This again points to the necessity of informed consent: whatever approach a professional takes in response to these types of situations needs to be thoroughly discussed at the beginning of the relationship so that all clients are aware of the consequences of disclosure (Corey, Corey and Callanan, 1998; Herring, 2001).

### **Maintaining Appropriate Boundaries**

---



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

The next core concept of ethics involves the complex area of maintaining appropriate professional boundaries. Most professionals know that there are ethical risks to developing relationships outside of the therapeutic role, such as supporting a friend or pursuing business or social interactions with clients. These types of dual relationships can impair a professional's objectivity or unintentionally exploit a client's dependence (Pope and Vasquez, 1998). Yet some subtle boundary issues present ethical dilemmas that are neither obvious nor easily avoidable.

### **Professional Self-Disclosure**

---

In order to maintain appropriate clarity of roles, a professional should only reveal intimate personal information when doing so is clearly relevant to the client's treatment goals, carefully tailoring this information to the client and paying close attention to how such sharing affects the clinical relationship (Bloomgarden, 2000). Consultation with colleagues and supervisors can help insure that the true purpose for disclosing personal information is to meet the emotional needs of the client rather than the professional. One helpful guideline is for a professional to reveal information about a personal life problem only well after it has been resolved, and not while it is an ongoing issue (Hunter and Struve, 1998).

### **Touch**

---

Since a significant proportion of clients with addictive disorders have a history of childhood trauma (Briere, 1992), even a simple act of touch can convey a variety of ethically ambiguous messages. The history of addiction support is replete with reassuring hugs. It's very important for a professional who engages in any form of physical contact with clients to have a highly developed sense of boundaries and an astute awareness of the clinical implications of this behavior. The initial stages of the therapeutic relationship may not provide sufficient emotional safety to insure that a client can discuss any uncomfortable feelings involving professional touch (Hunter and Struve, 1998).

### **Sexual Attraction**

---

Sexual involvement with a client constitutes a profound ethical violation with severe emotional consequences. However, occasional sexual feelings are not in themselves either unethical or even particularly abnormal in the context of an intimate therapeutic relationship (Pope and Vasquez, 1998). Professionals must acknowledge and appropriately process the existence of these feelings when they emerge in order to successfully understand and redirect them. The presence of intense preoccupation or sexual fantasies involving client's needs to be forthrightly discussed in consultation and supervision.





6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

## **Recovery Boundaries**

---

Professionals who have successfully dealt with addictive disorders in their own lives can often relate to their clients with profound understanding, empathy and clarity. However, they may also be overly devoted to the treatment approach they personally found successful (Johnson, 2000). For instance, professionals who are strongly 12-step oriented may discount non-abstinence models for addressing substance abuse, such as risk reduction strategies, which threatens to place clients into a one-size-fits-all philosophy of care.

A professional who is candid about being "in recovery" may give clients hope and reduce the shame that inevitably accompanies addiction. However, too much disclosure can be intrusive and distracting for some clients, and can even inadvertently generate unrealistic expectations or a sense of inadequacy (Bloomgarden, 2000). Professionals should therefore carefully reveal information about their personal addiction experience only in as much detail as is necessary to meet a compelling and clearly defined clinical need.

Professionals with less than several years of recovery time may easily lose objectivity when dealing with clients whose clinical picture mirrors their own personal experience. Heightened levels of consultation and supervision are highly advisable in such circumstances.

Nobody is immune to relapse, regardless of the length of time in recovery. A professional who reverts to a previous pattern of addictive behavior must face the ethical dilemma of whether to limit, suspend or terminate duties. Abruptly withdrawing services from a client due to this (or any other) form of professional impairment is likely to be deeply disruptive to the client's healing process (Bissell and Royce, 1994). Clients in such situations must be given the opportunity to continue with another provider. There is no one answer to the problem of professional relapse that is completely satisfying. In this regard the difference between a temporary "slip" that can result in increased self-awareness and an unrestrained relapse may be useful in determining a professional's overall level of clinical impairment. These decisions should be made in a process of supervision and consultation so that the professional is not relying on his or her personal judgment which may be impaired.

All professionals who are in recovery from addictive behavior must establish whatever safeguards are necessary to insure the maintenance of a personal program of sobriety. This may include establishing boundaries around support group meetings that clients are asked not to attend. It is not ethically appropriate for professionals in 12-step recovery to sponsor their own patients or chair meetings where they are employed (Bissell and Royce, 1994).

## **Supervision**

---





6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

The next core ethical concept is for professionals to have a structured process for discussing formulations, interventions, reactions and inevitable difficulties with supervisors and colleagues. There is a heightened need for supervision and consultation for professionals who are working on the outer limits of either personal competence or established theory (Corey, Corey and Callanan, 1998). For example, a professional attempting to implement a new technique should utilize close supervision until it becomes fully integrated into his or her set of skills.

It's an unfortunate reality that not all clinical supervisors have adequate experience or knowledge in the treatment of addictive disorders. In such cases a professional needs to seek out additional sources for case consultation. One solution is to set up and utilize informal telephone and e-mail networks which can be established fairly easily with colleagues and contacts made through professional affiliations. When consultation is not available for discussing a clinical or ethical dilemma, a professional should document in the clinical record a summary of the relevant issues as well as any action taken in response to it.

### **Honoring Diverse Values**

---

All of the preceding ethical principles involve some specific actions for a professional to take. However, the ethical dimension goes far beyond merely abiding by a procedural checklist. An ethical professional consistently demonstrates respect for the client as a person by honoring diversity and appreciating the degree to which his or her personal values influence the entire process of supporting. Since professionals are in the business of helping clients change some aspect of their lives, the great ethical challenge is to effectively guide the process and direction of this change without undermining the client's autonomy. This ethical use of a professional's influence is a skill that cannot be taught as much as developed.

Since every person's view of the world represents a unique combination of diverse personal and cultural perspectives, it is inevitable that professionals will sometimes hold views that are very different from their clients. No professional is ethically justified in assuming that the way he or she views life is the way everybody else does, is the right way, or is the only way. However, some professionals act as if the way to avoid imposing their personal values is to simply not talk about them. But biases don't lose their influence just because they're not discussed; in fact they often become less amenable to change. It is often more ethically beneficial for a professional to invite discussion about his or her personal values while conveying an ability to respect and work with many alternative positions. A professional doesn't need to be neutral about his or her values in order to be nonjudgmental (Coale, 1998; Tjeltveit, 1999).



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

When a client and a professional hold fundamentally incompatible value orientations, the professional should either refer the case or strive to help the client achieve the goals of supporting within the context of the client's value system rather than attempting to change those values. If a professional finds it necessary to attempt to modify a client's values, this should be done to no more extent than is necessary to address that client's particular focus of treatment.

Professionals often avoid initiating discussion with clients about the ethical dimensions of clinical issues.. It takes considerable effort and skill to engage in thoughtful dialogue about the ethical aspects of life, but doing can have great benefit for clients whose history of addiction is marked by diminished personal integrity.

These guidelines are not an exhaustive review of every ethical issue related to addictions support and they cannot substitute for a professional's knowledge of his or her professional code of conduct. Many clinical situations require a more detailed examination of the ethical issues involved or compliance with specific codified procedures, such as guidelines for research involving human subjects. Although professionals almost always operate within ethical parameters, these principles can serve as a helpful reminder of some of the important points to consider when evaluating the proper ethical stance to take when dealing with the many complexities of addictions.

## **FYI**

---

### **Most Frequent Claims to Ethics Boards**

1. Sexual/dual relationship— 35%
2. Unprofessional, negligence— 29%
3. Fraudulent acts—10%
4. Conviction of crimes—9%
5. Inadequate/improper supervision—5%
6. Impairment—4%
7. Improper record keeping—3%
8. Fraud in applying for credential—2%

***Instructor Note: As mentioned in the introduction, there are Federal and state guidelines specific to confidentiality; the keeping and managing of client records including computer, email and faxing; release of information; protecting client's personal health records; grievance procedures and disciplinary actions for violations.***



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

# Confidentiality & Substance Abuse in Addiction Treatment

## Introduction

---

Confidentiality is one of the most basic rights that our clients have. Confidentiality is the ethical principle or legal right that a physician or other health professional will hold secret all information relating to a patient, unless the patient gives consent permitting disclosure. All healthcare workers are legally and morally bound to protect the confidentiality of others.

Confidentiality includes:

- The person's identity
- Physical or psychological condition
- Emotional status
- Financial situation
- Confidential business information
- Any other personal or private information

## The Following Regulation Applies To Confidentiality For Substance Abuse Providers

### ***42 CFR Part 2***

42 CFR Part 2 – The regulations governing “confidentiality of alcohol and drug abuse patient records. Enacted in 1970's, congress recognized that due to stigma of addiction, heightened privacy protections to encourage people to get treatment were needed.

### **HIPAA –Federal rules covering all health related information**

---

Both regulations cover a lot of the same material. Where there are differences the more stringent or more recent rule usually applies. For substance abuse treatment providers, in most cases, the rules of 42 CFR part 2 are the more stringent.

### **42 CFR PART 2 - Code of Federal Regulations**

---

42 CFR, Part 2 protects any and all information that could reasonably be used to identify an individual and requires that disclosures be limited to information necessary to carry out the purpose of the disclosure.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

### *What programs Are Covered by Federal Confidentiality Laws?*

42 CFR part 2 applies to any program that:

- Involves substance abuse education, treatment, or prevention and
- Is regulated or assisted by the federal government

### *What information is protected?*

42 CFR Part 2 applies to all records relating to the identity, diagnosis, prognosis, or treatment of any patient in a substance abuse program that is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.

### *How Can Protected Information Be Shared?*

Information can be shared if written consent is obtained. A written consent form requires ten elements:

1. The names or general designations of the programs making the disclosure
2. The name of the individual or organization that will receive the disclosure
3. The name of the patient who is the subject of the disclosure
4. The specific purpose or need for the disclosure
5. A description of how much and what kind of information will be disclosed
6. The patient's right to revoke the consent in writing and the exceptions to the right to revoke or, if the exceptions are included in the program's notice, a reference to the notice
7. The program's ability to condition treatment, payment, enrollment, or eligibility of benefits on the patient agreeing to sign the consent, by stating
  - a) The program may not condition these services on the patient signing the consent, or b) the consequences for the patient refusing to sign the consent
8. The date, event, or condition upon which the consent expires if not previously revoked
9. The signature of the patient (and/or other authorized person)
10. The date on which the consent is assigned
11. When used in the criminal-justice setting, expiration of the consent may be conditioned upon the completion of, or termination from, a program instead of a date.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

## Disclosures

---

The prohibition of unauthorized disclosure covers all records and communications, whether written or not, about clients who apply for or have been diagnosed, treated or referred for treatment.

Unauthorized disclosure of client information is prohibited, regardless of whether the person seeking disclosure already has the information sought, has other means of obtaining it, is a law enforcement officer or other official, has obtained a subpoena, or asserts another justification or basis for disclosure not expressly permitted by the regulation.

The presence of an identified client in any program may be made only with the client's written consent, unless there is a proper authorizing court order.

*Programs **are** permitted to disclose patient-identifying information in the following cases:*

- Must have written authorization—consent
- Internal communication (“need to know basis within the organization”)
- No client-identifying information is divulged
- Medical emergency (CFR 2.51)
  - Patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.
  - Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patient or their physicians of potential dangers.
  - Immediately following disclosure, the program shall document the disclosure in the patient's records, setting forth in writing:
    - The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;
    - The name of the individual making the disclosure;
    - The date and time of the disclosure; and



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- The nature of the emergency (or error, if the report was to FDA).
- Research (CFR 2.52)
  - -Patient identifying information may be disclosed for the purpose of conducting scientific research if the program director makes the determination that the recipient of the patient identifying information:
- Is qualified to conduct the research;
- Has a research protocol under which the patient identifying information:
  - Will be maintained in accordance with the security of § 2.16 of these regulations (or more stringent requirements); and
  - Will not be re-disclosed except as permitted under paragraph (b) of this section; and
- Has provided a satisfactory written statement that a group of three or more individuals who are independent of the research project has reviewed the protocol and determined that:
  - The rights and welfare of patients will be adequately protected; and
- Audits and evaluations such as financial audits, management audits, or program evaluation.
- Qualified Service Organization/Business Associate Agreement
- Crimes (or threats of) on program premises or against program personnel
- Initial reports of suspected child abuse or neglect
- Court order meeting specifications of CFR 42
- Client is a danger to self or others

#### ***Ask BEFORE DISCLOSURE***

---

- Has the client executed a proper release of information for the requested information?
- Is the requested communication to be made to other staff of the program, or to an entity with direct administrative control over the program?
- Can the proposed communication be made without disclosing that the individual the disclosure concerns, is or was a client?
- Is the proposed communication needed to respond to a medical emergency?
- Is the proposed communication authorized by a valid court order?
- Does the proposed communication concern a crime or a threatened crime on the premises of the program or against program personnel?
- Is the proposed communication for purposes of research?
- Is the proposed communication for the purpose of an audit or an evaluation of a program's activities?



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- Does the proposed communication involve the reporting of a child abuse or neglect?
- Will the proposed communication be made pursuant to an agreement with a business associate or qualified service organization agreement?

### **Revocation**

---

- 42 CFR part 2 is silent on the issue of whether the revocation can be oral or must be in writing. For that reason, drug and alcohol programs have honored oral revocation.
- Client may revoke release of information (consent) at any time.
- If a program has already made disclosures prior to the revocation, the program acted in reliance on the release (consent) and is not required to try to retrieve the information that has already been disclosed.
- 42 CFR Part 2 states that “acting in reliance” includes providing services in reliance on a release (consent) form permitting disclosures to a third party payer. Therefore, a program can bill the third party payer for the past services to the client even after consent has been revoked.

### **Client Records**

---

- Written records must be kept secure and must be kept in a secure room, locked file cabinet, safe or other similar container when not in use.
- At the time of admission each program is required to tell clients that their records are confidential and protected by Federal law and regulation. Clients must be given a written summary of the laws and regulations.

### **Criminal Justice Release of Information To Those that Referred Clients**

Signed release is still required

Information may be released to those persons within the criminal justice system who have a need for information in connection with their duty to monitor the client/inmate progress. (e.g., probation or parole officers responsible for supervision of the patient)

- Release must state the period it will remain in effect, taking into account the length of treatment and type of criminal proceeding
- Once consent is given it cannot be revoked until set time or event is reached. The written consent must state that it is revocable upon the passage of a specified amount





6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

- A person who receives patient information under this section may re-disclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

### **Search and Arrest Warrants**

---

The time may come when a police officer arrives at your program asking to see records of a client, to arrest the client or to question program staff about a client. Under 42 CFR part 2 neither a search warrant nor an arrest warrant constitutes the type of court order that authorizes a program to disclose the client identifying information. You may produce a copy of the CFR Part 2 and explain to the officer that the program is not allowed to cooperate with an arrest warrant without a court order. Never forcibly resist an officer as that can lead to problems with law enforcement and constitute a crime.

### **Responding to Subpoenas**

---

42 CFR Part 2 prohibits treatment programs from disclosing information concerning a current or previous client in response to subpoenas, unless a client signs a proper release form. A court can order the program to release information or records after giving the program and client an opportunity to be heard and after making a good cause determination under the confidentiality law and regulations.

### **Disclosures by Court Order**

---

Separate procedures and requirements apply depending upon whether the purpose of the release is non-criminally related or related to the investigation or prosecution of a crime. A subpoena alone is generally not sufficient to compel disclosure, even if signed by a judge. Instead, a special 'good cause' court hearing must be held prior to a court issuing a Court Order for release of confidential client information.

### **Reports of Violations**

- The report of any violation of these regulations may be directed to the United States Attorney for the judicial district in which the violation occurs.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- The report of any violation of these regulations by a methadone program may be directed to the Regional Offices of the Food and Drug Administration.
- Any person who violates any provision of the regulations may be fined up to \$500 for the first offense and up to \$5,000 for each subsequent offense.

## **Resources**

---

<http://www.law.cornell.edu/cfr/text/42/2.5>

<http://www.northcare-up.org/subA/confidentialityFedReg.pdf>

## **Health Insurance Portability and Accountability Act (HIPAA)**

---

**HIPAA-** Health Insurance Portability and Accountability Act was established in 1996 by the US Congress

On January 25, 2013, the Office for Civil Rights (OCR) amended the HIPAA/HITECH Act Privacy, Security, Breach Notification, and Enforcement Rules. The Omnibus rule is effective on March 26, 2013 and full compliance with these rules is necessary by September 23, 2013.

The major purpose of HIPAA is to define and limit the circumstances in which an individual's protected health information may be used or disclosed; to combat waste, fraud and abuse in health care; to promote medical savings accounts; to improve long-term care services and coverage; and to simplify the health insurance process.

The Federal Government, through the "Health Insurance Portability and Accountability Act" (HIPAA) created national privacy and security standards for the protection of patients and their medical information.

## **Who is affected by HIPAA?**

---

- Covered Entities:
  1. Healthcare provider - Any provider of medical or other health services, or supplies, who transmits any health information in electronic form in connection with a transaction for which standard requirements have been adopted
  2. Health plan - Any individual or group plan that provides or pays the cost of health care



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

3. Healthcare clearinghouse - A public or private entity that transforms health care transactions from one format to another.
- Business Associates-A person (or entity) that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. Examples may include claims processing, data analysis, utilization review, and billing, lawyers, external auditors, accounts, shredding companies.
  - Patients

### **What is PHI?**

---

Protected Health Information - All Individually Identifiable Health Information and other information on treatment and care that is transmitted or maintained in any form or medium (electronic, paper, oral, etc.)

- Oral discussions between caregivers and patients.
- Paper medical records and medical information stored electronically.
- All information created or received; anything relating to past, present, or the future health of a patient.
- Payment information.

### **Examples of PHI:**

- Names
- All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code...
- All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death...
- Telephone numbers
- Fax numbers
- Electronic mail addresses
- Social Security Numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- Internet Protocol (IP) address numbers
- Biometric identifiers, including finger and voice prints
- Full face photographic images and any comparable images...
- Any other unique identifying number, characteristic...

**The Privacy Rule** governs who has access to protected health information (PHI).

**The Security Rule** specifies a series of administrative, technical and physical security procedures to assure the confidentiality, integrity and availability of ePHI.

**The Health Information Technology for Economic and Clinical Health Act (HITECH)**

**HITECH** brings changes to the HIPAA regulations in 3 categories:

- Breach notification
- Business Associate responsibilities
- Penalties

**The Privacy Rule** is designed to protect individuals' health information (PHI) and allows individuals to:

- get a copy of their medical records
- ask for changes to their medical records
- find out and limit how their PHI may be used
- know who has received their PHI
- have communications sent to an alternate location or by an alternate means
- file complaints and participate in investigations

The Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, protected health information to the "minimum necessary" to accomplish the intended purpose.

**There is an exception for every rule:**

---



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

Certain situations allow disclosure without prior written consent. Always check with your supervisor if you're not sure. Examples of possible exceptions include:

- Medical emergencies.
- Reporting communicable disease information to the health department.
- Reporting child or elderly/vulnerable adult abuse.
- For litigation activities.

HIPAA allows you to use or disclose Protected Health Information (PHI) as long as it relates to TPO. What is TPO?

- Treatment – providing care to clients
- Payment – the provision of benefits and premium payments
- Operations – normal business activities such as reporting, quality improvement, training, auditing, customer service and resolution of grievances, data collections and eligibility checks.

If anyone asks you to release protected information outside of routine TPO, you are required to get written authorization. Written authorizations should be in plain language. A description of the disclosed or released information is required.

## **The Security Rule**

---

The HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.

**Consent:** Consents are required for uses and disclosures of client health information for the purposes of health care treatment, payment, and operations.

**Authorization:** An authorization (signature) is required for use and disclosure of client health information for purposes other than treatment, payment, and operations.

## **Omnibus Rule – September 20, 2013**

---

**Final modifications to the HIPAA Privacy, Security, and Enforcement Rules require:**

- Modifications to individual authorization (allows "opt in" check boxes to be used in Consent and Authorization forms)



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- Modifications to the Notice of Privacy Practices and redistribution
- Business associates of covered entities are now responsible for HIPAA Privacy/Security breaches and reporting. (New business associate agreements)
- Individual rights to request e-copies of their health record and to restrict disclosures to a health plan concerning treatment for which one has paid out of pocket.
- New breach reporting requirements
- Privacy rule copies Genetic Information Nondiscrimination Act (GINA) to prohibit health plans from using or disclosing genetic information for underwriting purposes.
- Individuals deceased longer than 50 years are no longer covered

## **The HITECH ACT**

---

HITECH is designed to encourage healthcare providers to adopt health information technology in a standardized manner and to protect private health information.

- The ***Health Information Technology for Economic and Clinical Health Act*** (HITECH) is part of the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA contains incentives related to health care information technology in general (e.g. creation of a national health care infrastructure) and contains specific incentives designed to accelerate the adoption of electronic health record (EHR) systems among providers.
- Because this legislation anticipates a massive expansion in the exchange of electronic protected health information (ePHI), the HITECH Act also widens the scope of privacy and security protections available under HIPAA; it increases the potential legal liability for noncompliance; and it provides for more enforcement.

The HITECH Act - stipulates that, beginning in 2011, healthcare providers will be offered financial incentives for demonstrating meaningful use of electronic health records (EHR). Incentives will be offered to Medicare eligible professionals until January 1, 2015, after which those who are not meaningful users of Certified HER Technology will be subject to a payment adjustment.

Modifications mandated by the Health Information Technology for Economic and Clinical Health or (HITECH) Act.

- Expanded an individual's right to receive electronic copies of health information at the patient's request.
- Restricted disclosures to health plans concerning treatment for which the individual has paid the out-of-pocket amount in full.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- Required modifications to and redistribution of a covered entity's notice of privacy practice.
- Modified the individual authorization and other requirements to facilitate research and disclosure of child immunization proof to schools.
- Enable access to decedent information by family members or others (PHI protections cease 50 years from date of death)
- There are new use and disclosure regulations on using a patient's PHI for sales and marketing as well as fundraising.

### **Enforcement of non-compliance and Reporting Breaches**

---

A **breach** is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information. An impermissible use or disclosure of protected health information is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment of at least the following factors:

1. The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
2. The unauthorized person who used the protected health information or to whom the disclosure was made;
3. Whether the protected health information was actually acquired or viewed; and
4. The extent to which the risk to the protected health information has been mitigated.

There are increased penalties for those entities that do not comply with the new Breach of Notification regulations.

THE OFFICE OF CIVIL RIGHTS (OCR) within the Department of Health and Human Services (HHS) enforces the civil penalties. THE DEPARTMENT OF JUSTICE is responsible for enforcing the criminal penalties.

- When you break confidentiality, everybody loses and nobody wins! You could be subject to civil monetary fines and criminal penalties. The following are the different violation types:
  - Unknown Violation - Individual did not know about the violation, and could not have known about it even with the exercise of reasonable prudence or care.





6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- Reasonable Cause - An act or omission in which a covered entity or business associate knew, or by exercising reasonable diligence would have known, that the act or omission violated an administrative simplification provision, but in which the covered entity or business associate did not act with willful neglect.
- Willful Neglect - The conscious, intentional failure or reckless indifference to the obligation to comply with the regulations.

## HIPAA Violation Penalties

Violation Type	Minimum Penalty	Maximum Penalty
Individual didn't know (and by exercising reasonable diligence would not have known) that he or she violated HIPAA	\$100 per violation, with an annual maximum of \$25,000 for repeat violations	\$50,000 per violation, with an annual maximum of \$1.5 million
Violation is due to reasonable cause and not due to willful neglect	\$1,000 per violation, with an annual maximum of \$100,000 for repeat violations	\$50,000 per violation, with an annual maximum of \$1.5 million
Violation is due to willful neglect, but individual corrected violation within the required time period	\$10,000 per violation, with an annual maximum of \$250,000 for repeat violations	\$50,000 per violation, with an annual maximum of \$1.5 million
Violation is due to willful neglect and is not corrected	\$50,000 per violation, with an annual maximum of \$1.5 million	\$50,000 per violation, with an annual maximum of \$1.5 million

WebPT

Breach Notification for Unsecured Protected Health Information under the HITECH Act - The OCR (Office of Civil Rights), require health care providers and other HIPAA covered entities to promptly notify affected individuals of a breach. The Covered entities that experience a breach affecting more than 500 residents of a State or jurisdiction are, in addition to notifying the affected individuals, required to provide notice to prominent media outlets serving the State or jurisdiction. In addition to notifying affected individuals and the media (where appropriate), covered entities must notify the Secretary of Health and Human Services (HHS) of breaches of unsecured protected health information reported to the HHS Secretary on an annual basis. If a



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

breach of unsecured protected health information occurs at or by a business associate, the business associate must notify the covered entity following the discovery of the breach.

#### *Business Associates and Subcontractors*

Before the HITECH Act, the Security and Privacy Rules did not apply directly to business associates of covered entities. Business Associates and their subcontractors are now directly liable for the HIPAA Privacy and Security Requirements.

#### **How to manage Computerized Health Information:**

---

One key element of protecting our client's PHI lies in maintaining the security of our internal systems which house and transmit **ePHI** (electronically protected health information).

- Only access this Protected Health Information on a **“need to know”** basis to do your job.
- Never access any Protected Health Information even a close relative's for personal interest without prior written consent.
- Don't ask a physician or co-worker to access Protected Health Information for you.
- To safeguard our client's ePHI when using a computer, always “log off” or use the option to lock your computer screen that prevents other users from gaining access to your applications.

Federal and State requirements mandate that we take certain steps when sending sensitive information. To safely send client information you have four options:

1. Calling the person on the phone.
2. Hand delivering information to the person, in an envelope marked “confidential”.
3. Emailing to non-facility employees, by password protecting a Microsoft Word document, or
4. Emailing facility employees, by encrypting the email.

#### Helpful Note:

- Do not follow unsolicited links and do not open or respond to unsolicited email.
- Use caution when visiting websites
- Use caution when entering personal information online

Think before you click! Delete all suspicious emails.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

## How to Manage Texting

---

Text messaging has become a major part of today's form of communication as it is a quick and easy way to communicate. The unfortunate aspect about text messaging is that it is not secure and can violate HIPAA safety and privacy regulations. HIPAA does not specifically prohibit text messaging PHI within an organization or to another healthcare provider, however healthcare providers do need to consider the safeguards of their organization when it comes to transmitting ePHI. Text messages are generally not secure because the information can be exposed to third parties due to such things as lost or stolen mobile devices as well as improper disposal of a device. Considering the security risks involved with text messaging PHI, organizations should explore having encrypted text messaging to protect against privacy breaches or prohibit text messaging ePHI all together. Suggestions for your organization would be to conduct a risk analysis to identify possible exposures related to texting ePHI, and implement policies and procedures and staff training. Each healthcare organization must decide what is the best solution and controls in regards to ePHI.

## Important Notes

---

- Never discuss Protected Health Information where others can hear you such as hallways, lunch rooms, or elevators.
- You are obligated to protect patient/customer privacy and any other confidential information when you see or hear a breach occurring by reporting this to someone who can advocate for the patient/customer. This includes unauthorized use, duplication, disclosure, or dissemination of Protected Health Information.
- Be on our guard:
  - Your responsibility doesn't end on your shift.
  - Don't divulge patient/customer or employee information at your church, school, college, home, the shopping mall, or in other social settings.
  - If you're asked just say - *"I'm sorry, that information is confidential."*
  - Don't copy or reproduce any confidential information unless you need it to do your job.
  - Don't let anyone else copy confidential information either.
- Keep Protected Health Information in a safe location
  - Store away from public view.
  - Don't leave Protected Health Information on countertops in view of customers or visitors.
  - Be aware of computer screen locations – the information should not be



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

viewable to others.

- Log off your computer when you leave your station. Do not remove privacy hoods.

Another key element to the protection of our client's PHI is to keep the physical building or facility where you work secure. Here are a few tips that will help protect our facilities:

- Wear your ID badge at all times
- When entering the building, be sure others who are entering with you are authorized employees with ID badges
- Keep hallway doors that lead to client care areas closed and
- Request vendors and contracted individuals to sign-in and obtain vendor ID badges when visiting a restricted area.

### **Security Management**

---

Various security measures exist in order to increase overall safety and security within the buildings as well as the surrounding outdoor environment. Some of these include: exterior lighting, identification of 'high-risk' areas requiring additional security (medical record areas, medication rooms, business office), security rounds, visitor sign-in and identification, surveillance cameras, employee identification (picture ID badges), management of access to keys and/or door code locks, etc.

Some helpful tips:

- Do not prop open doors that should be locked.
- Correct any physical security problems you can at the time you discover them (for example, closing doors that are propped open) and then report these physical breaches to your Security officer, and
- To reduce the risk of loss and/or prevent identity theft, you should secure valuables, such as purses and briefcases, in locked drawers or cabinets when you are not in your office.

### **Resources:**

---

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>  
[www.youtube.com/watch?v=dv0FYBhpdX0](http://www.youtube.com/watch?v=dv0FYBhpdX0)



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

## The Addiction Professional

*TAP 21 Competency: Recognize the importance of individual differences that influence client behavior, and apply this understanding to clinical practice*

### **Professional Responsibility**

---

The addiction professional espouses objectivity and integrity and maintains the highest standards in the services provided. The addiction professional recognizes that effectiveness in his/her profession is based on the ability to be worthy of trust. The professional has taken time to reflect on the ethical implications of clinical decisions and behavior using competent authority as a guide. Further, the addiction professional recognizes that those who assume the role of assisting others to live a more responsible life take on the ethical responsibility of living a life that is more than ordinarily responsible. The addiction professional recognizes that even in a life well-lived, harm might be done to others by words and actions. When he/she becomes aware that any work or action has done harm, he/she admits the error and does what is possible to repair or ameliorate the harm except when to do so would cause greater harm. Professionals recognize the many ways in which they influence clients and others within the community and take this fact into consideration as they make decisions in their personal conduct.

### **Professional Attributes**

---

1. The addiction professional, as an educator, has a primary obligation to help others acquire knowledge and skills in treating the disease of substance use disorders.
2. The addiction professional practices honesty and congruency in all aspects of practice including accurate billing for services, accurate accounting of expenses, faithful and



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

accurate reporting of interactions with clients and accurate reporting of professional activities.

3. When work involves addressing the needs of potentially violent clients, the addiction professional will ensure that adequate safeguards are in place to protect clients and staff from harm.
4. Addiction professionals shall continually seek out new and effective approaches to enhance their professional abilities including continuing education research, and participation in activities with professionals in other disciplines.
5. Addiction professionals have a commitment to lifelong learning and continued education and skills to better serve clients and the community.
6. The addiction professional respects the differing perspectives that might arise from professional training and experience other than his/her own. In this regard, common ground is sought rather than striving for ascendance of one opinion over another.
7. Addiction professionals, whether they profess to be in recovery or not, must be cognizant of ways in which their use of psychoactive chemicals in public or in private might adversely affect the opinion of the public at large, the recovery community, other members of the addiction professional community or, most particularly, vulnerable individuals seeking treatment for their own problematic use of psychoactive chemicals. Addiction professionals who profess to be in recovery will avoid impairment in their professional or personal lives due to psychoactive chemicals. If impairment occurs, they are expected to immediately report their impairment, to take immediate action to discontinue professional practice and to take immediate steps to address their impairment through professional assistance.

### Did You Know?

---

- Suicide is a leading cause of death among people who abuse alcohol and drugs ([Wilcox, Conner, & Caine, 2004](#)).
- Compared to the general population, individuals treated for alcohol abuse or dependence are at about 10 times greater risk to eventually die by suicide compared with the general population, and people who inject drugs are at about 14 times greater risk for eventual suicide ([Wilcox et al., 2004](#)).
- Individuals with substance use disorders are also at elevated risk for suicidal ideation and suicide attempts ([Kessler, Borges, & Walters, 1999](#)).



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- People with substance use disorders who are in treatment are at especially high risk of suicidal behavior for many reasons, including:
  - They enter treatment at a point when their substance abuse is out of control, increasing a variety of risk factors for suicide ([Ross, Teesson, Darke, Lynskey, Ali, Ritter, et al., 2005](#)).
  - They enter treatment when a number of co-occurring life crises may be occurring (e.g., marital, legal, job) ([Ross et al., 2005](#)).
  - They enter treatment at peaks in depressive symptoms ([Ross et al., 2005](#)).
  - Mental health problems (e.g., depression, posttraumatic stress disorder [PTSD], anxiety disorders, some personality disorders) associated with suicidality often co-occur among people who have been treated for substance use disorders.
  - Crises that are known to increase suicide risk sometimes occur during treatment (e.g., relapse and treatment transitions).

### **Maintain Positive Attitudes**

---

Before working with clients who are suicidal, professionals are advised to conduct their own suicidal attitude inventory. The goal of the inventory is not to change your views but rather to help you understand what your views are and how those views can positively or negatively affect your interactions with clients. Some of the items you might consider in an inventory include:

- What is my personal and family history with suicidal thoughts and behaviors?
- What personal experiences do I have with suicide or suicide attempts, and how do they affect my work with suicidal clients?
- What is my emotional reaction to clients who are suicidal?
- How do I feel when talking to clients about their suicidal thoughts and behaviors?
- What did I learn about suicide in my formative years?
- How does what I learned then affect how I relate today to people who are suicidal, and how do I feel about clients who are suicidal?
- What beliefs and attitudes do I hold today that might limit me in working with people who are suicidal?

These views may also need to be further clarified by consultation with your clinical supervisor or with your peers.





6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

As noted, your attitudes about suicide are strongly influenced by your life experiences with suicide and similar events. Needless to say, your responses to suicide and to people who are suicidal are highly susceptible to attitudinal influence, and these attitudes play a critical role in work with people who are suicidal. An empathic attitude can assist you in engaging and understanding people in a suicidal crisis. A negative attitude can cause you to miss opportunities to offer hope and help or to overreact to people in a suicidal crisis.

Below are some attitudinal issues to consider in working with people who are suicidal:

**Positive Attitude and Behavior 1:** People in substance abuse treatment settings often need additional services to ensure their safety

**Positive Attitude and Behavior 2:** All clients should be screened for suicidal thoughts and behaviors as a matter of routine.

**Positive Attitude and Behavior 3:** All expressions of suicidality indicate significant distress and heightened vulnerability that require further questioning and action.

**Positive Attitude and Behavior 4:** Warning signs for suicide can be indirect; you need to develop a heightened sensitivity to these cues.

**Positive Attitude and Behavior 5:** Talking about a client's past suicidal behavior can provide information about triggers for suicidal behavior.

**Positive Attitude and Behavior 6:** You should give clients who are at risk of suicide the telephone number of a suicide hotline; it does no harm and could actually save a life.

***Instructor Note: I have only one thing to say.....GET PROFESSIONAL HELP.....IMMEDIATELY! EVEN IF YOU THINK THE CLIENT MAY NOT REALLY BE SUICIDAL. THIS IS AN ASSESSMENT AND DECISION THAT SHOULD BE MADE BY A CLINICIAN!***



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

## Warning Signs for Suicide

---

Warning signs are defined as acute indications of elevated risk. In other words, they signal potential risk for suicidal behavior in the near future. Warning signs may be evident at intake or may arise during the course of treatment. Warning signs always require asking follow-up; warning signs can be direct or indirect. **Direct** indications of acute suicidality are given the highest priority. They are:

- **Suicidal communication:** Someone threatening to hurt or kill him- or herself or talking of wanting to hurt or kill him- or herself.
- **Seeking access to a method:** Someone looking for ways to kill him- or herself by seeking access to firearms, available pills, or other means.
- **Making preparations:** Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person.

Warning signs are often in evidence following acute stressful life events. Among people who abuse substances, break-up of a partner relationship is most common. It is also important to look for warning signs in your clients when relapse occurs and during acute intoxication.

Stressful life events include:

- Break-up of a partner relationship.
- Experience of trauma.
- Legal event.
- Job loss or other major employment setback.
- Financial crisis.
- Family conflict or disruption.
- Relapse.
- Intoxication.

Each of the **direct** warning signs indicates potential for suicidal behavior in its own right, and, if present, requires rigorous follow-up. The **indirect** warning signs may or may not signal risk for acute suicidal behavior (for example, “substance abuse” is the norm among your clients). In all cases, they require further follow-up questions to determine if they may indeed indicate acute suicidality.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

## **Risk Factors**

---

Risk factors are defined as indicators of long-term (or ongoing) risk. They are different from warning signs, which signal immediate risk. Risk factors for suicidal thoughts and behaviors among individuals with substance use disorders have been well researched ([Conner, Beautrais, & Conwell, 2003](#); [Conner et al., 2007](#); [Darke & Ross, 2002](#); [Ilgen et al., 2007](#); [Murphy et al., 1992](#); [Preuss et al., 2002](#); [Roy, 2001](#); [Schneider et al., 2006](#)). The list below, although not exhaustive, is informed by these studies.

### **Risk factors for suicidal thoughts and behaviors include:**

- Prior history of suicide attempts (most potent risk factor, although it should be remembered that about half of all deaths by suicide are first-time attempts).
- Family history of suicide.
- Severe substance use (e.g., dependence on multiple substances, early onset of dependence).
- Co-occurring mental disorder:
  - Depression (including substance-induced depression).
  - Anxiety disorders (especially PTSD).
  - Severe mental illness (schizophrenia, bipolar disorder).
  - Personality disorder (best researched are borderline and antisocial personality disorders).
  - Anorexia nervosa.
- History of childhood abuse (especially sexual abuse).
- Stressful life circumstances:
  - Unemployment and low level of education, job loss, especially when nearing retirement.
  - Divorce or separation.
  - Legal difficulties.
  - Major and sudden financial losses.
  - Social isolation, low social support.
  - Conflicted relationships.
- Personality traits:
  - Proneness to negative affect (sadness, anxiety, anger).
  - Aggression and/or impulsive traits.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- Firearm ownership or access to a firearm.
- Probable risk factors (although greater certainty requires more research in people with substance use disorders):
  - Inflexible/rigid personality characteristics.
  - Sexual orientation (lesbian, gay, or bisexual).
  - Chronic pain.

### **Protective Factors**

Protective factors are defined as buffers that lower long-term risk. Unlike risk factors, factors that are protective against suicidal behavior are not well researched ([Goldsmith, Pellmar, Kleinman, & Bunney, 2002](#)). Fewer protective factors than risk factors have been identified among people who abuse substances and other populations. Reasons for living are perhaps the best researched protective factors in the literature ([Linehan Goodstein, Nielsen, & Chiles, 1983](#); [Oquendo Dragasti et al., 2005](#)).

The following are known and likely protective factors:

- Reasons for living.
- Being clean and sober.
- Attendance at 12-Step support groups.
- Religious attendance and/or internalized spiritual teachings against suicide.
- Presence of a child in the home and/or childrearing responsibilities.
- Intact marriage.
- Trusting relationship with a counselor, physician, or other service provider.
- Employment.
- Trait optimism (a tendency to look at the positive side of life).

***A caution about protective factors: If acute suicide warning signs and/or multiple risk factors are in evidence, the presence of protective factors does not change the bottom-line assessment that preventive actions are necessary, and should not give you a false sense of security. Although protective factors may sustain someone showing ongoing signs of risk (e.g., due to chronic depression), they do not immunize clients from suicidal behavior and may afford no protection in acute crises.***



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

Protective factors vary with cultural values. For example, in cultures where extended families are closely knit, family support can act as a protective factor. Others include a strong affiliation with a clan, tribe, or ethnic community; faith in and reliance on traditional healing methods; strong spiritual values shared among community members; and absence of cultural trauma such as that of families of Holocaust survivors and American Indians who were sent unwillingly to boarding schools to be acculturated.

### **Definition of Addiction Professional Characteristics**

---

- Empathy - the ability to identify with and understand another person's feelings or difficulties.
- Genuineness - honest and open in relationships with others.
- Respect - a feeling or attitude of admiration and deference toward somebody or something
- Warmth - affection and kindness, fond or tender feeling toward somebody or something
- Immediacy - moving away from the contents of the sharer's problems and placing the emphasis on the process going on in the moment between the helper and the one seeking help.
- Concreteness - certain and specific rather than vague or general
- Potency - successful, especially in producing a strong or favorable impression on people
- Self-actualization - the successful development and use of personal talents and abilities
- Understanding - a sympathetic, empathetic, or tolerant recognition of somebody else's nature or situation
- Transparent - completely open and frank about things
- Tolerant - accepting the differing views of others
- Patient - able to endure waiting or delay without becoming annoyed or upset or to persevere calmly when faced with difficulties
- Validating - to provide somebody with moral support, or inspire somebody with confidence
- Flexible - able to change or be changed according to circumstances
- Curious - eager to know about something or to get information
- Open-minded - free from prejudice and receptive to new ideas



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- Clarification - to make something clearer by explaining it in greater detail
- Paraphrasing - to restate something using other words, especially in order to make it simpler or shorter
- Reflection - careful thought, especially the process of reconsidering previous actions, events, or decisions
- Neutral - not possessing any particular quality or revealing a particular attitude or feeling

### **Try to Avoid**

- Assumptions - something that is believed to be true without proof, the tendency to expect too much
- Preconceived Ideas - formed in the mind in advance, especially if based on little or no information or experience and reflecting personal prejudices
- Biases - an unfair preference for or dislike of something

### **Advice for the Professional**

---

#### **Tips to Avoid Increasing Resistance**

Behaviors to avoid as they damage rapport, increase resistance, and create conflict between client and professional.

- Arguing for change
- Assuming the expert role
- Criticizing, shaming, or blaming
- Labeling the client's behavior
- Being in a hurry
- Claiming to know what is best

#### **What a Professional Needs To Know**

#### **Show your Professionalism**

- Express empathy
- Develop discrepancy



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- Avoid argumentation and direct confrontation
- Roll with resistance
- Support self-efficacy and optimism

### **Professional Presentation**

- Attending Behavior
- Encourages client talk
- Active Listening
- Eye contact: interested, alert, awake, processing
- Cultural differences: Be aware & sensitive
- Attentive body language
- Vocal qualities – even, soothing
- Verbal tracking—keep to the client's topic
- Silence





6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

## Attitudes and Values

***TAP 21 Competency: Conduct self-evaluations of professional performance applying ethical, legal and professional standards to enhance self-awareness and performance.***

***TAP 21 Competency: Recognize the importance of individual differences that influence client behavior, and apply this understanding to clinical practice.***

### Clarification of Values

---

Individually, we work within standards of care to support our professional role in the helping professions.

#### **We may ask ourselves:**

- Where is my knowledge and skills best used?
- Am I getting the support I need to help the people we serve? Am I getting the support I need to help the people we serve?
- Do my individual practice standards/values conflict the organization's expectations?
- What is our overall agency mission and goals?
- Who's needs are being met? Ours or the clients'?
- How can we improve upon our services to meet the clients' needs?
- Commitment to Clients
- Promote the well-being of clients. In general, clients' interests are primary.
- Self-Determination
- Respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

### **Definition of Culture:**

---

***The word ‘culture’ describes the integrated pattern of human behavior(s) that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group.***

### **Some General Cultural Considerations:**

- Lack of confidentiality (trust)
- Lack of social services (rural/reservation/poorly developed area)
- Limited access to comprehensive health care
- Unresolved trauma(s): historical or otherwise (ex Urban Unresolved trauma(s): historical or otherwise (ex. Urban relocation program, history of abuse –sexual or otherwise)
- Racism – Homophobia – Xenophobia

### **Cultural Humility:**

- Incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician patient dynamic.
- Acknowledges that we can never become truly competent in another’s culture
- Requires simultaneous process of ongoing self-reflection and commitment to lifelong learning

### **Building Trust:**

- Foundation for any and all that we work with...
- Non-judgmental: No “right or wrong” – setting aside biases.
- Strengths-based: Identifying behaviors that support healthy lifestyle (ex. scheduling an appointment).
- Authenticity: Personal connection helps build the therapeutic relationship:
- Important to take time to establish a connection before work can be done, specific with Native clients.
- Introductions are important.
- Make no assumptions regarding sexual behavior (ageism).
- Make no assumptions regarding sexual orientation (straight vs. gay identified).



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

### **Engagement:**

- Can be as simple as offering a glass of water
- Meeting at a place of their choice (creating ease for the client) Consider outdoors/park, client home
- Offer extended hours to meet
- If possible rearrange the furniture (remove any barriers to open communication).
- Professional use of self: ex. humor.
- Utilizing supportive family/connections.
- Accessing cultural knowledge and spiritual practices.

### **Service providers work from a positive-service delivery model:**

- Strengths-based approach: collaborate, identify and exemplify strengths as a way to empower.
- Convey authentic/real interest (mindfulness)
- Acknowledge and provide support for positive steps already made! Ex. scheduling an intake appointment (support)

*Instructor Note: In my classroom I have the students complete a few different self-evaluations that take a look at their feeling about clients, various populations they may serve, their own values, biases and judgments. These exercises always turn out to be the highlight of the course. When the student is honest in answering the self-evaluations they are able to discover things about themselves that set them up to explore these thoughts and feelings and how they may help or hinder their work with clients. As an instructor it is a joy for me to watch students come to different realizations about themselves and how they see things. I suggest that you do a search on the internet, they are plenty of self-evaluations to be printed out and completed.*

## **Know Thyself: Boundaries and Burn Out**

**TAP 21 Competency: Develop and use strategies to maintain one's physical and mental health.**



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

***TAP 21 Competency: Use a range of supervisory options to process personal feelings and concerns about your clients***

## **Understanding Transference and Counter-transference**

---

What does the terms transference and counter-transference mean?

**Transference** refers to clients' placement of feelings originally directed towards significant others in their life onto the professional (Wallin, 2007). For example, clients might project feelings related to their mother or father figure onto the professional. In some cases this may lead to a belief that the professional is nurturing and loving; in other situations feelings of anger and mistrust may arise. In the clients' mind the professional may also come to represent their ideal partner or friend; this may lead to platonic, romantic, or sexual attraction.

Due to the clients' complicated thoughts, beliefs, and emotions entangled with the issue of transference developing ways to guide a professional to work with these issues will be discussed so that clients may gain deeper insight and to preserve the therapeutic relationship.

**Counter-transference** - occurs when professionals' emotions, beliefs, and biases are projected onto their client; as with transference this is typically related to the professional's life history. Counter-transference involves an emotional connection with the client beyond what other professionals would deem as appropriate within the therapeutic relationship. The professional's acceptance of the client's transference is another example of counter-transference (Gelso & Hayes, 2007). For example, when clients project feelings related to their parental figure onto their professionals, the professionals may find themselves wanting to protect the clients and reach beyond their boundaries to assist the clients. In such cases it is important to explore issues of both transference and counter-transference in order to rebalance the therapeutic relationship, re-establish boundaries, and promote client growth. Again, there are many ways to recognize and respond to counter-transference during individual and group supervision. When not addressed, counter-transference can lead to violations of boundaries and potential harm to clients.

Although these are issues which are present in every form of counseling and therapy, some areas are more influential regarding the level of transference and counter-transference experienced. Two of these areas include a higher potentiality for the client to have similar life experiences as the professional (i.e., history of alcohol and other drug (AOD) use, treatment



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

history, legal issues, etc) and the degree of confidence the professional feels working with co-occurring issues (depending on education, training, and experience). As with all other developing professionals, it is imperative to acknowledge what stage the individual professionals are in regarding their professional development and base the intensity of supervision and oversight on their level of development.

#### Maintaining awareness

---

Management of transference and counter-transference is critical to effective support and the prevention of compassion fatigue and ultimately burnout. The intensity of my reaction to a client serves as my personal trigger for counter-transference awareness. When I really like and enjoy (or dislike and don't enjoy) a client, I realize that this is most likely a counter-transference reaction. Experience has taught me to seek supervision when I suspect that counter-transference is percolating in the therapeutic relationship.

Ongoing clinical supervision that allows professional honesty offers the best method for addressing counter-transference. Counter-transference is an inevitable and desired component of the therapeutic relationship and often serves as the vehicle for professional and personal growth for both recovering and non-recovering professionals. However, these reactions must be addressed, because if they are ignored, they usually reappear more intensely. Unaddressed counter-transference can have a destructive impact on the client, the professional, and the therapeutic relationship. Some-times a resolution of the situation requires a break from working with the population that is causing the counter-transference. Giving counter-transference prominence in a burnout prevention plan is critical to professional survival.

Counter-transference that is not managed via supervision and personal therapy can be acted out in ways that never help the therapeutic process. When the professional becomes the good parent and tries to rescue the client or is overprotective, mothering/smothering, and enmeshed, the therapeutic relationship is compromised and the client is encouraged to stay dependent. When the professional forms an alliance with the client, he/she demonstrates counter-transference by avoiding negative feelings and protecting the client from confrontation; this ultimately can divide staff members. Whichever way counter-transference plays out, it has gone too far and never will encourage client growth.

The recovering professional is particularly vulnerable to counter-transference reactions, compassion fatigue, and burnout because of the double-edged sword of personal experience.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

Professionals in recovery have the strength of knowing that addiction can be managed by significant lifestyle and philosophic changes. However, heightened sensitivity to the issues surrounding addiction can occasionally pierce the protective shell of even the best-trained professional. Because 12-Step programs suggest we are equal and can learn from honest sharing, recovering professionals must establish firm role boundaries for themselves. Hyper-vigilance to personal reactions to the stories and issues of clients helps professionals improve quality of care.

## **Boundaries**

---

**Boundary** - Edge of appropriate behavior at a given moment in a relationship between patient/provider, governed by the therapeutic context & contract.

**Boundary crossing** - Benign deviations from standard practice, harmless, non-exploitative, may advance therapy goals, i.e., helping a falling patient, giving patient ride home in a blizzard.

**Boundary violation** - Significant deviations from standard practice, harmful, exploitative, takes therapist out of professional role.

## **Why are Boundary Issues Important?**

- Blurred boundaries distort therapy bond
- Can impair professional's judgment
- Conflict of interest
- Exploitation of client

## **Codes to Practice By:**

- The responsibility for setting & maintaining boundaries always belongs to the professional.
- The patient should not be blamed or stigmatized for violating a boundary.

## **Touch**

- When we touch all patients the same then we know it is therapeutically supportive
- Do nothing in private that you wouldn't do in public

## **Dual Relationships**



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

Dual or multiple relationships occur when professionals assume two or more roles at the same time or sequentially with a client.

The addiction professional understands that the goal of treatment services is to nurture and support the development of a relationship of equals of individuals to ensure protection and fairness of all parties. Addiction professionals will provide services to clients only in the context of a professional setting.

1. Because a relationship begins with a power differential, the addiction professional will not exploit relationships with current or former clients, current or former supervisees or colleagues for personal gain, including social or business relationships.
2. The addiction professional avoids situations that might appear to be or could be interpreted as a conflict of interest. Gifts from clients, other treatment organizations or the providers of materials or services used in the addiction professional's practice will not be accepted, except when refusal of such gift would cause irreparable harm to the client relationship. Gifts of value over \$25 will not be accepted under any circumstances.
3. The addiction professional will not engage in professional relationships or commitments that conflict with family members, friends, close associates or others whose welfare might be jeopardized by such a dual relationship.
4. The addiction professional will not, under any circumstances, engage in sexual behavior with current or former clients.
5. The addiction professional will not accept as clients anyone with whom they have engaged in romantic or sexual relationships.
6. The addiction professional makes no request of clients that does not directly pertain to treatment (giving testimonials about the program or participating in interviews with reporters or students).
7. The addiction professional recognizes that there are situations in which dual relationships are difficult to avoid. Rural areas, small communities and other situations necessitate discussion.
8. When the addiction professional works for an agency such as department of corrections, military, an HMO or as an employee of the client's employer, the obligations to external individuals and organizations are disclosed prior to delivering any services.
9. The addiction professional recognizes the challenges resulting from increased role of the criminal justice system in making referrals for addiction treatment. Consequently he/she



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

strives to remove coercive elements of such referrals as quickly as possible to encourage engagement in the treatment and recovery process.

10. The addiction professional encourages self-sufficiency among clients in making daily choices related to the recovery process and self-care.
11. The addiction professional shall avoid any action that might appear to impose on others' acceptance of their religious/spiritual, political or other personal beliefs while also encouraging and supporting participation in recovery support groups.

### **Examples of Dual Relationships**

- Professional and friend
- Professional and business partner
- Bartering therapy for goods and / or services
- Providing therapy to a relative or a friend's relative.
- Socializing outside of therapy sessions
- Combining the roles of supervisor and therapist
- Becoming emotionally involved with a client or former client.
- Becoming sexually involved with a client or former client

### **Professional Self-Disclosure**

---

The professional should avoid too much self-disclosure. While occasional appropriate self-disclosure can help the client to open up or motivate the client by providing a role model, too much self-disclosure removes the focus from the client's recovery. A good rule regarding self-disclosure, if the professional is so inclined, is that the professional first has a clear purpose or goal for the intervention and then think about why he or she is choosing self-disclosure at this time.

The professional should be aware of when his or her own issues are stimulated by a client's problems and therefore refrain from responding to the client out of his or her own dynamics. For example, if a professional in recovery feels it extremely important to break ties with addicted peers, but a particular client with an addicted spouse or partner cannot break free of the relationship, it is imperative that the professional respond flexibly and creatively to the client's perception of the situation and not rigidly adhere to the notion that breaking ties with all addicts is the only way to recovery.





6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

Research summations have indicated cautions on professional disclosure. The conclusions generally indicate that professional self-disclosure is rarely associated with counseling outcomes, and when it was, the influence was often negative. However, a fine distinction has been made between disclosing (information that is associated with a professional's past) versus self-involvement. The latter is associated more with positive outcomes, and rates higher with clients.

In terms of strict professional disclosure, it would appear that too much is not a good idea. If repeatedly used as a mainstay of support, the client may begin to think, "Who has the problems here?" Yet, utilizing self-involved statements may bring about benefits of rapport and warmth.

Kottler (1991) outlined the following questions for the professional to consider prior to any disclosure:

- What will this accomplish?
- Is there another way to make my point?
- Is the timing right?
- Am I trying to meet some of my own needs?
- How can the client personalize and use what I share?

## **Stress Management & it's Relationship to Professional Burn Out**

---

### **Bio-Psycho-Social Stress:**

**Biological:** Brain, muscles, skin, limbic—emotions, endocrine—glands/hormones, autonomic nervous— expending and conserving energy, cardiovascular, gastrointestinal

**Psychological:** Thoughts and feelings

**Sociological:** Surrounding environment

### **Stress Symptoms:**

- Diminished or over-stimulated sense of humor.
- Skipping rest and food breaks
- Binge eating



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- Increased overtime and no vacation
- Increased physical complaints
- Social withdrawal: church, family, friends
- Changed job performance
- Increase in time away from work (illness, family, and environment)
- Self-medication
- Sleep: too much or lack of
- Emotional Changes (low self-esteem, depression, anxiety, irritation, anger)
- Physiological Changes (Hypertension--high blood pressure, ulcers, migraine or chronic tension headaches, ulcers, acid reflux, skin irritations)

**Stress** ➡ **Burnout**

**Recognize that you can take action in managing your stress and prevent burn-out:**

1. Is your efficiency at work declining?
2. Do you have frequently changing or depressing moods?
3. Have you lost some of your initiative at work?
4. Are you easy to anger?
5. Have you lost interest in your work?
6. Do you get frustrated easily?
7. Does work stress get to you more than it used to?
8. Are you more suspicious than you used to be?
9. Do you feel fatigued or run-down?
10. Do you feel more helpless than you used to?
11. Do you get headaches, stomach aches or back aches?
12. Are you using too many mood altering drugs (sleep aids, alcohol...)
13. Have you lost or gained weight recently?
14. Are you becoming more inflexible?
15. Do you find yourself eating to replace emotion?
16. Are you becoming more critical of your own and others' competencies?
17. Do you have trouble sleeping?
18. Are you working more but feeling that you are getting less done?
19. Do you experience shortness of breath?



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

## 20. Have you lost some of your sense of humor

Compassion Fatigue, Burnout and Vicarious Trauma are all terms that are used within the helping profession. Often Compassion Fatigue is confused with Burnout and it's important that helping professionals understand the difference.

**Burnout:** Burnout refers to the physical and emotional exhaustion that comes from prolonged stress and frustration. When we feel we have too many demands, and not enough resources, we begin to feel powerless to reach our goals. This can lead to a reduced feeling of personal accomplishment and diminished self-care. Burnout can happen in any field/job. It results in significant negative impacts on health and outlook on life.

**Vicarious Trauma:** When a person is continuously exposed to other people's traumatic experiences through witnessing and/or hearing others' stories, vicarious trauma can be experienced. Vicarious trauma (VT) means that you have not been the direct victim of a trauma, but you have experienced it second hand from clients through their stories of pain. Clinicians may begin to experience posttraumatic stress symptoms similar to the person who experienced it. This can include intrusive imagery (images of trauma popping into your head) dreaming about the traumatic situation or avoiding certain activities and so on.

Ongoing vicarious trauma can result in a shift in the helper's world view and sense of meaning, for example, someone who may regularly feel safe can begin to doubt their safety if they work with victims of crime and hear numerous stories of crimes and trauma. If a helper has a previous history of trauma (and many have as more than 70% of the population has experienced one or more event significant enough to be traumatic) that is unresolved, then you are more likely to experience VT. Vicarious trauma is something that people experience on a continuum, you may leave the job but you will still have that foundation of VT within you.

**Compassion Fatigue:** Compassion Fatigue is applied to people who suffer as a result of being in the helping profession. If helpers experience both burnout and VT they are more vulnerable to developing Compassion Fatigue (CF). Compassion Fatigue is when someone who regularly hears/witnesses very difficult and traumatic stories begins to lose their ability to feel empathy for their clients, loved ones and co-workers. This deep physical and emotional exhaustion has been described as "having nothing left to give" and "an occupational hazard". Compassion



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

Fatigue can show as a variety of symptoms presenting behaviorally, emotionally, relationally, physically and spiritually. Sometimes CF is misdiagnosed as depression.

Compassion Fatigue is developed because of the helper's strong ability to care for their clients in the first place. It is the most caring individuals who are most likely to develop CF. The best helping professionals are able to connect with their clients because of their strong ability to empathize with them. It is this gift of empathy that can also lead them to develop CF. By learning about CF and developing ways to manage it, these helpers can continue to do the work they love, and are good at, while still being able to thrive personally. Simply leaving one helping job and moving into another will not reduce one's CF.

So how do we remain in the helping profession while limiting our Compassion Fatigue? One strategy is to **Empathize With Care!** One way to manage Compassion Fatigue is to be aware of the effects of empathizing. We empathize with our clients so that we can connect with them and help them in their suffering and struggles. In her book, *Help for the Helper*, Babette Rothschild explains the neuroscience behind empathy and discusses emotional contagion. In order to do our jobs well, we need to be able to maintain awareness of what feelings are ours and what feelings belong to the people we are working with.

One way to ensure we maintain awareness is to be mindful about our own internal experiences while we are hearing our client's stories. We can do this by picking up on sensations in our bodies, noticing images or sounds that come into our minds, note our breath and muscle tension, as well as any emotions that arise or any thoughts that occur. This will enable us to ensure that we engage in conscious empathy, thereby, allowing us to empathize while still caring for ourselves, managing our own internal experience and being the best helper we can be. The next time you are working with a client who is sharing a difficult story, take a moment to check in with your whole self and ensure you are empathizing with care!

### **More on Burn Out**

- An emotional exhaustion in which the professional no longer has any positive feelings, sympathy, or respect for clients.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- An adverse work stress reaction with psychological, physiological, and behavioral components often associate with:
  - stress
  - fatigue
  - frustration
  - apathy (an absence of emotion or enthusiasm)

### **Stages of Burnout Development:**

Stage One: the honeymoon – satisfied with the job

Stage Two: fuel shortage – fatigue sets in

Stage Three: chronic symptoms – physical effects

Stage Four: crisis – actual illness can develop

Stage Five: hitting the wall – physical and psychological problems can become severe enough to cause illness that is life-threatening.

### **Burn-Out Simply Put:**

Sustained, unmanageable, painful stress.

### **Your response is your responsibility.**

- Burnout has implications for ethical practice.
- Burnout compromises your physical and mental health and social relationships (work, family and friends).

### **Interventions:**

- Seek help!
- Set limits
- Manage symptoms
- Seek deeper meaning in your work
- Ex. new interests, new areas, new challenges
- Implications of burnout for ethical practice



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- Your response is your responsibility

## **Stress Management**

---

Interventions or activities designed to block a stressor from resulting in negative consequences such as illness or disease.

Stress management consists of the use of interventions (diet, exercise, activities, laughter, reading, medication, music, etc.).

- Humor
- Time management – Too little occupational stress is almost as unhealthy as too much
- Meditation
- Prayer/Spirituality
- Volunteer
- Setting goals, prioritizing, scheduling, saying “no”, maximize your rewards, delegate, evaluate, limit interruptions
- Volunteer
- Progressive Relaxation Techniques – nerve/muscle
- Exercise – make it fun!

***Instructor Note: Recognizing, following and respecting these guidelines creates your clinical and professional foundation for a healthy, ethical, successful, clinical practice. Understanding the impact of countertransference and taking care of any unresolved issues you may have is of the utmost importance if you want to help clients, do no harm to your clients and work in this field for a long, long time without burning out and without compromising your ethics or your clinical judgment.***

## **Conclusion**

As an addiction professional you will be called upon to help many people in deep distress during your career. These people will count on you to have some answers, some care and



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

concern, empathy, clinical knowledge and more. But the most important things you can be is ethical and professional.

Your sense of professional moral responsibility to those you serve is what will guide through a long and successful career. Standing solidly on ethical and professional ground keeps you on a path of growth, clinically and personally.

Never mind the others around you, you stick to your ethical and professional guns and feel pride and self-fulfillment.

## References

1. Clients with Substance Use Disorders. National Association of Social Workers; Work Group: Maurice S. Fisher Sr., PhD, LCSW, LSATP, BCD Jessica Holton, MSW, LCSW, LCAS Katherine van Wormer, PhD, MSSW. 2013
2. Code of Ethics / NAADAC/NCC AP Code of Ethics; The Association for Addiction Professionals. 2013
3. Ethics for Addiction Professionals; Berton, Jennifer D. Wiley 12/3/13
4. Getting Started; The Essential Counselor: Process, Skills and Techniques, Ch 2. Hutchinson, David. Sage Publication 2011

## Cultural Competence in Addiction Prevention and the Recovery Process

### Defining Cultural Competency

*TAP 21 Competency: Provide culturally relevant formal and informal education programs that raise awareness and support substance abuse prevention and the recovery process.*

*TAP 21 Competency: Sensitize others to issues of cultural identity, ethnic background, age, and gender in prevention, treatment, and recovery.*

**Administrative Level:**



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

Defines cultural competency as the melding of philosophical and operational practices among three major program administrative levels:

- 1) attitudes, beliefs, values, and skills at the provider level
- 2) policies and procedures that clearly state and outline the requirements for the quality and consistency of care
- 3) readiness and availability of administrative structures and procedures to support such commitments.

The idea is that each person's cognitive style, personal and social history, and family culture contain both the origins and understanding of their problems and are keys to their recovery. Understanding the whole person is necessary in the process of evaluation, assessment, and clinical intervention in determining an appropriate treatment course.

The understanding that clinical interventions and a person's recovery are more successful when the services offered are compatible with cultural values and views of the individual, family, and community.

According to The Pennsylvania Office of Medical Assistance Programs (OMAP) in Appendix CC of "Indicators of the Application of Cultural Competence" (Second Edition, 2003) "Cultural competency entails knowledge of consumers' literacy level, native languages, levels of acculturation and assimilation, and cultural health care beliefs, customs and practices. Making this knowledge a service requirement of the provider encourages the services system to increase consumer access to services and to better design, implement and evaluate services to particular cultural groups."

As addiction professionals we need to develop goals and strategies that meet the behavioral health care needs of the full range of different populations including "differences between urban and rural cultures, the deaf, hard of hearing, late deafened and deaf-blind populations, lesbian, gay, bi-sexual and transgender communities, and other ethnically or culturally defined groups." The goal is to address cultural competence in the delivery of behavioral health services and have it implemented by all behavioral health care providers.

### **Culturally Competent Recovery Models**





6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

The current movement of behavioral health providers to develop and utilize client-centered, strength-based, recovery-oriented, patient-directed models of behavioral health care that include awareness of and sensitivity to cultural competence factors in the delivery of services.

There is growing consensus that patient-centered, strength-based approaches to health care produce better clinical outcomes. The findings of Clarke and DeGannes suggest that developing culturally competent approaches to providing health care services inherently includes a patient-centered and directed approach to service plan design and implementation that will affect the clinical outcomes of any group or specific community, including those defined by gender, sexual orientation, disability, or other cultural variables including age and social class.

OMAP's "Indicators of the Application of Cultural Competence" (Second Edition, 2003) Appendix CC states that services that are culturally competent must be provided by individuals who are trained and skilled to "recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people."

Considering that communication is an essential and often key cultural variable in the therapeutic process, a number of models regarding cross-cultural communication are available to improve providers' ability to elicit patients' understanding of their illnesses and preferences in treatment during the clinical encounter.

One model is LEARN, an acronym for Listen, Explain, Acknowledge, Recommend, Negotiate.

- Listen with sympathy and understanding to the patient's perception of the problem.
- Explain your perceptions of the problem.
- Acknowledge and discuss the differences and similarities in perceptions.
- Recommend treatment.
- Negotiate treatment.

### **The Impact of Traditional Treatment interventions on Diverse Populations**

Those who have been in the drug and alcohol field for some time will recognize the mantra of D&A therapist training 101 - "A drug is a drug is a drug," and "An addict is an addict, is an addict." These old saws formed core concepts of how many D&A counselors and therapists were taught to think about and understand substance abuse and addiction. They helped shape



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

attitudes about treatment models including interventions and treatment approaches. Given today's science, these old saws are no longer valid in their universality and application of treatment to all clients and patients.

It is estimated that up to 60% or more of persons entering into drug and alcohol treatment programs present with both mental and substance abuse disorders. It is noted that these individuals frequently relapse to D&A use or psychiatric symptoms within one year of detox and inpatient treatment. Persons who present with concurrent disorders complicate diagnosis and treatment planning, suggesting more than a universal approach to treatment for all.

Of interest is that despite the proven success of long-used therapeutic methodologies such as twelve step programs, pharmacological interventions, and new personal and group techniques such as motivational interviewing, DBT, and cognitive behavioral methodologies, outcome studies show poorer outcomes in general for ethnic and racial populations.

These differences have generally been explained as being due to inherent tendencies for African Americans, especially males, such as lack of motivation, non-compliance, and resistance in treatment. Similar reasons in addition to language barriers have been given for the poor outcomes of recovering Hispanics and Latinos.

Sadly, the majority of the treatment providing community have been unwilling to attribute some of these poor outcomes to cultural differences. Discomfort in discussing race, ethnicity, prejudice, racism, homophobia, and sexism as a possible explanation can result in anger, resentment and defensive denials on the part of organization and staff.

While substance abuse and chemical dependence are equal opportunity disease, all do not necessarily encounter them in the same way, do not enter treatment in the same fashion, and do not use substances for the same reason. Persons may actually select their substance(s) of choice for different purposes. Some may be more or less affected by treatment due to individual and cultural variables.

Sensitivity and susceptibility differences between men and women to drugs and medications suggest differential approaches to education and prevention efforts, assessment, evaluation, and treatment procedures. The implications regarding treatment compliance related to



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

possible medication side effects, medication effectiveness, and negative previous treatment experiences related to medications suggest more consideration and discussion.

Studies continue to indicate that assessment and diagnosis of ethnic and racial minorities versus those of whites continue to show a higher rate of diagnosis error, uncertainty, and inconsistency among therapists when evaluating African Americans as opposed to whites.

Social class, education, family, legal, and social environmental factors are interdependently linked and are seen as cultural variables that play a significant role in contributing to a person's personality and behavior. They often define a cultural group's cultural difference and uniqueness. These variables influence the understanding of chemical dependence and offer some insight as to possible approaches to treatment engagement and therapeutic options. Sexual orientation and the lifestyles of those belonging to other particular groups suggest service plans focused on social-environmental concerns as well as substance use issues in cultural context.

### **Know Thyself**

Cultural competency cannot occur without people confronting their own biases and prejudices. Historically, education and training in this area has remained in the cognitive and objective domain, preventing self-exploration (Sue, D., & Sue, S., 2008).

Reports from authors/researchers Derald Wing Sue, PhD and David Sue, PhD who indicate that mental health professionals must realize that "good counseling" in the United States uses white Euro-American norms that exclude 75 percent of the world's population. While the extrapolation for the United States was not stated, this fact alone is enough to give pause, they say. Sue and Sue state, "Without awareness and knowledge of race, culture, and ethnicity, helping professionals and other support staff could unwittingly engage in cultural oppression."

***Instructor Note: Thankfully the research in the area of cultural competence and addiction treatment is growing into more and more differing populations. Just as there are and have been continual changes (for the better – mostly ☺) in understanding and treating substance misuse there are now new fresh intervention, prevention and treatment techniques that take into account cultural issues, viewpoints and backgrounds. All of this we do is in the effort to meet the needs of our clients and improve their road to recovery and healing.***



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

## **Incident & Abuse Reporting**

### **Introduction**

---

In accordance with Florida Statute (FS) 397.419 (2) (f) and Chapter 65D-30 of the Florida Administrative Code (F.A.C.) public or private substance abuse service providers, licensed by The Department of Children and Families, must create and maintain an internal quality improvement program which includes policies and procedures for Incident Reporting.

Chapter 65D-30 FAC states:

“Incident Reporting Pursuant to paragraph 397.419(2)(f), F.S. is required of all providers and shall be conducted in accordance with Children and Families Operating Procedure 215-6.” Florida Statute 397.419 (2) (f) requires incident reporting policies and procedures be created and:

“...include verification of corrective action, provision for reporting to the department within a time period prescribed by rule, documentation that incident reporting is the affirmative duty of all staff, and a provision that specifies that a person who files an incident report may not be subjected to any civil action by virtue of that incident report.”

### **Internal Incident Reporting**

---

All DCF Licensed substance abuse providers are required to develop internal procedures regarding reporting incidents to their Incident Coordinator or assigned representative (IC/AR). All staff members are required to document unusual events/incidents that occur involving a patient and/or staff member on an Incident Report Form (IRF) and to notify a supervisor immediately. Unusual events/incidents include, but are not limited to, the following:

- Altercation/verbal between either two patients
- and/or a patient and a staff member
- Violent threat to self or others
- Violent action toward self or others



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- Property loss / stolen property / damage
- Vehicular accident
- Medical problem / seizure
- Employee injury
- Self destructive behavior
- Psychiatric emergency (Baker Act)
- Abuse / neglect
- Altercation/physical between either two
- patients and/or a patient and a staff member
- Procedure break
- Weapon
- Contraband
- Alcohol / drug use
- Bio-hazardous material
- Patient leaving against clinical advice
- Rule violation
- AWOL
- Medication error

### **Internal Reporting Procedure**

---

Please consult your organization's Incident Reporting Policy and Procedure manual for the organization-specific course of action to be taken.

A standard (sample) procedure is outlined below:

- The staff member most immediately involved in and/or observing a particular incident shall complete an IRF as soon as possible and no later than 24 hours from the occurrence of the incident and give the completed IRF to their supervisor immediately.
- The supervisor shall immediately review the IRF and submit a copy to the IC/AR.
- The supervisor shall complete the investigation portion of the IRF within 24 hours of receipt of the form and forward the IRF to the IC/AR.
- The IC/AR shall complete the "Corrective Action/Follow-up" portion of the IRF within 24 hours of receipt of the form.
- The IC/AR will review the completed IRF and ensure all information was obtained and documented accurately and that all follow-up and corrective action has been



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

completed.

- The IC/AR will forward the IRF to the appropriate outside agencies, if required.
- The IC/AR shall maintain all IRFs and subsequent investigation in a confidential file.
- While any event involving a patient needs to be described in their chart, an IRF is NEVER to be made a part of any patient's medical record.
- Appointed staff will notify patient of any adverse outcomes and note this in the IRF.
- In an unusual incident involves a patient with an appointed guardian, the guardian is to be notified of the unusual incident by appointed staff member within 24 hours.
- Data from the IRF will be entered into a database for tracking and trending purposes.

### **Internal Documentation**

- Each employee involved in, witness to, or informed of any unusual event/incident or occurrence involving a patient, visitor or other staff member has an affirmative duty to complete an IRF.
- If a staff member is uncertain as to whether an event should be documented and reported, the Supervisor or IC/AR can advise. If in doubt, an IRF SHOULD be completed.
- If more than one staff member is involved in or witnessed the unusual event, each staff member MUST complete a separate report and follow the organization's Incident

### **Reporting Procedure**

- If more than one client is involved in the unusual event, a separate IRF for each client MUST be completed. Only one client is to be named on each report for confidentiality purposes. For example, if client John Doe was in an altercation with Joe Soap two separate
- Incident Reports would have to be completed. On John Doe's report it would state that John Doe was in an altercation with another client or peer. On Joe Soap's report it would state that Joe Soap was in an altercation with another client or peer.
- When entering narrative documentation on the form, only concise OBJECTIVE statements of fact are to be written. Avoid making personal assumptions and expressing personal opinions.
- Any area of the IRF not requiring a response specific to the incident must be marked as

### **"N/A" (Not applicable)**

- IRFs are confidential reports and are NEVER part of a client's medical records.



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

## **External Reporting Procedure**

---

### **The Department of Children and Families**

In addition to documenting and reviewing/resolving incidents through an internal Quality Improvement Process, it is the responsibility of all DCF licensed substance abuse providers to promptly report within one business day all critical incidents in accordance with CFOP 215-6. Each Department licensed or contracted service provider will designate one staff person to be the Incident Coordinator (IC) for the provider/agency. This person will manage the provider's/agency's incident notification process.

The Department of Children and Families has created an online incident reporting tool that enables the Department to collect and analyze information about critical incidents that occur in substance abuse and mental health facilities. This is called The Incident Reporting and Analysis System (IRAS). In some cases, critical incidents that occur outside of facilities, such as the death of an individual served, must also be reported.

Providers who must report critical incidents through IRAS include:

- Licensed Substance Abuse Providers—(including all providers who are licensed to provide substance abuse prevention and treatment under FS Chapter 397 and CH 65D-30 of the FAC.
- Private (non-contracted) substance abuse providers licensed by the Department are required to submit incident reports to IRAS directly. Private (non-contracted) designated receiving facilities are not required to report incidents to IRAS unless they are licensed by the
- Department as substance abuse providers.
- Managing Entities (MEs)—“The department contracts for behavioral health services through regional systems of care called Managing Entities (MEs).
- Private (non-contracted) designated receiving facilities are NOT required to submit incidents to IRAS unless they are licensed by the Department as substance abuse providers.
- State mental health treatment facilities are NOT required to submit incidents to IRAS
- According to CFOP 215-6 Critical Incidents to be reported include:
  - Child-on-Child Sexual Abuse
  - Child Arrest
  - Child Death



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- Adult Death
- Elopement
- Employee Arrest
- Employee Misconduct
- Escape
- Missing Child
- Security Incident – Unintentional
- Significant Injury to Clients
- Significant Injury to Staff
- Suicide Attempt
- Sexual Abuse/Sexual Battery

Please see CFOP 215-6 attached as Appendix A for full details on the above critical incidents.

#### CFOP 215-6—Guidelines for Reporting Incidents—Staff Discovery of Incident

Any employee of the licensed provider who discovers that a reportable critical incident (as outlined in CFOP 215-6) has taken place will take the following action:

- Ensure the health, safety, and welfare of all individual(s) involved.
- Ensure contacts are made for assistance as dictated by the needs of the individuals involved (911, law enforcement etc.) When the incident involves suspected abuse, neglect, or exploitation, the employee must call the Florida Abuse Hotline to report the incident. The employee must ensure that the client's guardian, representative or relative is notified, as applicable.
- Once the situation is stabilized the employee must report the incident to their supervisor and follow protocol. The supervisor will report to the IC/AR. Each service provider/agency will use their internal reporting process and timeframes for notifying provider/agency leadership of incidents. All critical incidents must be entered into IRAS within one business day of the incident occurring.

#### CFOP 215-6—Guidelines for Reporting Incidents—Actions to be taken by Provider's IC/AR

This person will manage the provider's/agency's incident notification process.

- When a supervisor is informed of a critical incident, that person shall verify what has occurred, confirm the known facts with the discovering employee, and ensure that internal reporting procedures and timeframes have been adhered to.





6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

- If the incident qualifies as a critical incident in accordance with CFOP 215-6, the IC/AR will review for accuracy and forward the incident to the DCF via the IRAS.
- The licensed service provider will ensure timely notification of critical incidents is made to appropriate individuals or agencies such as emergency medical services (911), law enforcement, the Florida Abuse Hotline, the Agency for Health Care Administration (AHCA), or Center for Mental Health Services (for licensed mental health facilities), as required.

#### CFOP 215-6—Guidelines for Reporting Incidents—Actions to be taken by DCF

The actions to be taken by the DCF representative is outlined in CFOP 215-6 as follows:

“(1) The Department’s Incident Coordinator or designee at the Circuit/Region level will review the incident information and clarify or obtain any necessary additional information from the applicable service provider and make revisions as necessary.

(2) The Department’s Incident Coordinator or designee will make a determination regarding any required notifications that should be sent to Department leadership. The Department’s Incident Coordinator or designee is responsible for ensuring appropriate notification is provided and serves as the contact person regarding the IRAS. In addition to Department’s leadership staff, the Department’s Incident Coordinator or designee will notify the Circuit/Region Public Information Officer within two (2) hours of any incident that may have Department impact or media coverage.

(3) The entry of the incident into IRAS does not substitute for a direct phone call to the Department’s leadership staff when the incident type or severity of the incident warrants such contact. This determination is to be made by the Department’s Incident Coordinator or designee in consultation with other Department leadership staff, as needed.

(4) The Department’s Incident Coordinator or designee should submit incidents in IRAS even in cases where there is missing information not readily available. When the information is obtained, the Incident Coordinator or designee should submit an update in IRAS as soon as possible.

(5) The Department’s Incident Coordinator or designee shall ensure all necessary information is entered into the IRAS in order to have a complete notification. The incident report is considered to be “complete” when the initial notifications have been made and sufficient



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

information regarding the incident has been submitted. Additional information, such as from an autopsy or medical examiner report regarding an incident can be submitted into the IRAS after the incident has been determined to be “complete.”

(6) Each Circuit/Region shall develop an internal process for reviewing and analyzing trends regarding critical incidents within their Circuit/Region across all Department program areas. Each service provider/agency including Managing Entities will establish a system for reviewing critical incidents to determine what actions need to be taken, if any, to prevent future occurrences and a follow-up process to assure such needed actions are implemented.”

#### **NOTE**

The entry of the critical incident into IRAS DOES NOT substitute for a direct phone call to the Department’s leadership staff when the incident type or severity of the incident warrants such contact.

These incident reporting procedures do not replace exploitation reporting protocols, as required by law. Allegations of abuse, neglect, or exploitation must always be reported immediately to the Florida Abuse Hotline.

#### **Abuse Reporting**

---

##### **Patient Neglect And/Or Abuse**

In addition to completing an Incident Report Form, Any incident of suspected abuse must immediately be reported.

##### **Mandatory Reporting**

- Any person, including professionally mandatory reports, should contact the Florida Abuse Hotline when they know or have reasonable cause to suspect that a child or vulnerable adult has been abused, abandoned, neglected, or exploited. The Hotline has counselors available 24 hours a day, 7 days a week.
- 39.201 Florida Statute - Mandatory reports of child abuse, abandonment, or neglect; mandatory reports of death;

By Florida Statute 39.201, a therapist or case manager “who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver,



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

or other person responsible for the child's welfare, shall report such knowledge or suspicion" to the DCF Abuse Hotline. As a mandated reporter, a therapist or case manager who fails to call in an abuse report is in violation of the law.

**Definitions:**

**Vulnerable Adult** - A person 18 years of age or older, whose ability to perform the normal activities of daily living, or to provide for his or her own care or protection is impaired due to a mental, emotional, long term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging.

**Abuse** - Any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult's physical, mental, or emotional health. Abuse includes acts and omissions.

**Exploitation** - A person who stands in a position of trust and confidence with a vulnerable adult knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive a vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult.

OR

That a person who knows or should know that the vulnerable adult lacks the capacity to consent, obtains or uses, or endeavors to obtain or use, the vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult.

**Neglect** - Failure or omission on the part of the caregiver or vulnerable adult to provide the care, supervision, and services necessary to maintain the physical and mental health of a vulnerable adult, including but not limited to food, clothing, medicine, shelter, supervision and medical services, which a prudent person would consider essential for the well-being of a vulnerable adult.

The term "neglect" also means the failure of a caregiver or vulnerable adult to make a reasonable effort to protect a vulnerable adult from abuse, neglect or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness, which produces or could



6555 NW 9<sup>th</sup> Avenue, Ste. 210 | Fort Lauderdale, FL 33309  
(954) 771-2091 – Fax (954) 771-2098

reasonably be expected to result in serious physical or psychological injury, or a substantial risk of death.

Sexual Abuse - Acts of a sexual nature committed in the presence of a vulnerable adult without that person's informed consent. Sexual abuse includes, but is not limited to the acts defined in s. 94.011(1)(h), Florida Statutes, fondling, exposure of a vulnerable adult's sexual organs, or the use of a vulnerable adult to solicit for or engage in prostitution or sexual performance. Sexual abuse does not include any act intended for a valid medical purpose or any act that may reasonably be construed to be normal caregiving action or appropriate display of affection.

**To Report Abuse:**

Phone 80096ABUSE (22873) • TDD 8004535145  
Fax 8009140004 URL <http://reportabuse.dcf.state.fl.us>

## References

1. Clients with Substance Use Disorders. National Association of Social Workers; Work Group: Maurice S. Fisher Sr., PhD, LCSW, LSATP, BCD Jessica Holton, MSW, LCSW, LCAS Katherine van Wormer, PhD, MSSW. 2013
2. Code of Ethics / NAADAC/NCC AP Code of Ethics; The Association for Addiction Professionals. 2013
3. Ethics for Addiction Professionals; Berton, Jennifer D. Wiley 12/3/13
4. Getting Started; The Essential Counselor: Process, Skills and Techniques, Ch 2. Hutchinson, David. Sage Publication 2011