Running head: LEGAL AND ETHICAL ISSUES WHEN COUNSELING CHILDREN

The Legal/Ethical Issues When Mental Health

Counselors Counsel Children

Elizabeth M. Garnsey

Pace University

Abstract

When Mental Health Counselors have to counsel children they have to have a strong knowledge in the laws and the ethical codes. The areas that counselors have to take a careful consideration with are competence, informed consent, confidentiality and mandatory reporting. Counselor’s competence deals with the counselor’s skills and knowledge in mental health counseling. Counselors have to know the laws and consideration when it comes to informed consent with children and explaining their limits of confidentiality. There is also mandatory reporting which counselors by law have to report child abuse.

The Legal/Ethical Issues When Mental Health Counselors Counsel Children. Children are seen as little people. When minors are mentioned in the paper they are considered to be around the ages of 0 to fifteen. In the state of New York, a legal adult is considered to be the age of eighteen. There are specific legal and ethical issues and requirements involved when counseling children. Some of the issues involved with counseling children are Counselor Competence, Informed Consent, Confidentiality and Mandatory Reporting. All of these topics will be discussed in further detail. **Competence** Competence is one of the ethical issues when counseling children. It is very important to know if the counselor has special skills, training and knowledge in a particular area. This is especially important when they are counseling children. Counselors must have special knowledge and skills that are unique to children. It is very important for a child counselor to understand the different disorders that many children may experience. Children may experience mental disorders like Attention Deficit Hyperactivity Disorder (ADHD), Separation Anxiety Disorder, and attachment disorders (Lawrence & Kurpius, 2000). When it comes to child counseling there is a lot of course work in child psychopathology and child counseling theory. In terms of age, it is important to know the child’s age. The age of a child can give the counselor an understanding of development. It is also very critical for a counselor to have knowledge in child development because the interventions need to match the child’s level of development (Lawrence & Kurpius, 2000). It is considered unethical to counsel a child without the proper knowledge. All counselors should be aware of gender roles, family roles and culture (Lawrence & Kurpius, 2000).

There are numerous steps that need to be taken in order for someone to become a counselor for children. First, they have to graduate from a credit program and get a Master’s degree. It is important to obtain a license and certificate but it is also important for them to complete 2,000 hours of supervised training in counseling (Carmichael, 2006). In order to become a child counselor they have to do course work related to child development, pathology and ethics. Finding an internship working with children is also recommended. There are many ways to counsel children or minors. A common way to counsel children has been through play therapy. Play therapy is a type of counseling that help children express how they feel through play. In order for a counselor to practice play therapy they have to become a Registered Play Therapist (RPT). An RPT has to do the same course work as a counselor plus additional training. There are requirements like 150 clock hours of play therapy education and continuing education (Seymour & Rubin, 2006). All counselors must demonstrate basic knowledge and ability to apply ethics to their work. Many counselors join professional organizations to help them keep up on changes in ethics or the law. There are professional codes of conduct and standards of practice that when reviewed are placed into law (Carmichael, 2006). According to the APA, ethics pose “competence” to recognize their boundaries and limitations, which they don’t offer services or techniques that are not in their professional field (Goggins, 1979). **Informed Consent** Children need to understand what Informed consent means. Informed consent involves a client or legal guardian giving their consent to treatment (Crespi, 2009). Informed consent is formal permission that allows treatment of a minor from 3-15 years of age. The informed consent falls under the counselor-client legal jurisdiction of contract law (Lawrence & Kurpius, 2000). The only way a minor can enter into a contract for treatment is by parental consent, involuntary consent at a parent’s insistence or by the order of juvenile court. Informed consent must be obtained before a minor may begin treatment. The information that should be included is purpose, goal, expectations, potential risk, confidentiality, limits, fees, and ability to withdraw from treatment (Martin & Huss, 2000). The child and the guardian must be given knowledge of treatment and its consequences. It is also important that both the parent and child understand the consequences and implications of the treatment plan (Lawrence & Kurpius, 2000). It is very important that counselor have informed parental or guardian consent because it is the law. Even a minor or child who is made aware of and understands the consequences and implications of treatment may not give consent. Certain legal and ethical issues arise when minors obtain voluntary informed consent (Martin & Huss, 2000). Counselors must obtain an appropriate consent form to work with a minor. If informed consent is not obtained by the counselor they may risk being sued for battery, failure to gain consent, and child enticement (Lawrence & Kurpius, 2000). Most community agencies have policies requiring parental consent before counseling minors and schools may have their own policies (Martin & Huss, 2000). The ACA ethical code States, “ When counseling clients who are minors or individuals who are unable to give voluntary, informed consent, parents or guardians may be included in the counseling process as appropriate” (ACA, 1995, B.3). One of the issues is deciding who the client is and when it is ok to include parents. Ethically, many counselors view the child as the client but legally the parent is considered the client. If a counselor ethically follows the guidelines then the minor is has the right to privacy and choice of participation. Using a legal perspective however, the parent has the right to make decisions and must give informed consent in order for their child to receive treatment (Martin & Huss, 2000). One question counselors have is what is in the best interest of the child and what is the most ethical way of providing involvement without breaking confidentiality. There are exceptions to obtaining the parents informed consent. Exceptions for the need of parental consent are court ordered, emancipation, mature minor, treatment for dangerous drugs, sexually transmitted disease, pregnancy, birth control and alleged sexual assault of a minor over 12 years old (Lawrence & Kurpius, 2000). There are also issues when the parents are divorced. It is still necessary to get informed consent but especially important to get consent from the primary care giver in order to avoid any malpractice suits (Lawrence & Kurpius, 2000). To help with the counselor-client relationship, minors should be informed that the parents will be informed or asked about participation and content of goals (Martin & Huss, 2000). Children are considered minors in our society. Children are not considered to be legally competent to give consent based on three standards. The standards are knowing, intelligent, and voluntary (Hall, 1995). The knowing consent is the ability for a minor to understand basic terms and concepts on how it is relates to their treatment. The intelligent consent is when a minor has cognitive capabilities, which is the decision-making process; consider the risk, the cost, and alternatives. The third consent is voluntary consent. Voluntary consent is when children react to responses due to the authority position of an adult (Hall, 1995). Professionals suggest that if a minor is 15 years of age or older then they are competent to give treatment consent as an adult. Children that are around the age of 11-14 years old are still in a transition period and might only be competent decision makers in some circumstances but not enough (Hall, 1995). There was a previous study done on “Children’s Recognition of Rights Violations in Counseling” by Belter and Grisso. There have been many child right movements which have changed the attitudes and laws to protect the well being of children. It is important to keep in mind the child’s special needs and interests. Counselors want children to be able to understand their rights. This study wanted to see if minors comprehend information about rights which may be connected to their level of cognitive reasoning (Belter & Grisso, 1984). They wanted to see at which age lower and higher levels of reasoning were and the ability to comprehend information about rights. Young children around the ages 7-11 are considered to have a limited amount of concrete operational thinking. Adolescents around the age of 14 are considered to have achieved formal operational thinking. The adolescents are expected to have developed a capacity to understand their rights (Belter & Grisso, 1984). The children used for this study were considered “normal”, white, middle class and of average intelligence. The 21 year olds recognized each violation. They could also express the violation and took effective action to protect their rights. The 15 year old adolescents could point out each right violation as they occurred. They could comprehend and recognize when their rights were violated without help from adults. The children used in this study were 9 years old. The children understood when words were used that they could comprehend. The children had minimal comprehension of recognition of their rights being violated. There was significant difference between the 9 year old and the 15 year old. The 15 year old had closer representation of the 21 year old that was considered an adult (Belter & Grisso, 1984). The agreement still stands that minor are less capable of understanding and need their legal guardian to help in the minor’s best interest. **Confidentiality** Confidentiality is one of the most difficult issues. Counselors have to decide what to share and what not to share with the parents. Parents or legal guardians have the legal right to all records such as examination, evaluations, and treatment goals. There are four types of confidentiality the counselor can consider. The four types are complete, limited, informed forced and no guarantee (Lawrence & Kurpius, 2000). Complete confidentiality is when the counselor will disclose nothing to the child’s parents. Limited confidentiality is when the counselor requires the minor to waive (in advance) the right to know what is mentioned to the parent. The third position is informed forced confidentiality. Informed force is when the counselor informs the child before disclosing information to the parents but the child has no say in what is disclosed to the parents. Then there is no guarantee, which means there are no guarantees made to the child about confidentiality (Lawrence & Kurpius, 2000).

Confidentiality is an ethical concern. The main idea is to protect the client’s rights to privacy and to ensure that matters are not disclosed to other without informed consent. Counselors have a hard time with confidentiality because parents have to give informed consent, which gives them the right of disclosure (Taylor & Adelman, 1989). Counselors need to discuss confidentiality to children when they are in counseling. They do this in order to encourage communication between them and the minor. When working with children it is very important to make sure they understand the language in order to comprehend what confidentiality is. Privacy and confidentiality are not rights when it comes to a minor (Taylor & Adelman, 1989). When counselors use complete confidentiality may risk legal issues because legally the parents have the right to know (Lawrence & Kurpius, 2000). Issues may also appear from the child due to lack of trust. The child may not seek treatment at all if they know the parent is involved, and seek termination early. A counselor may have to choose between legal and ethical concerns. A counselor who informs the parent is obeying the law but it betrays the ethical guidelines (Lawrence & Kurpius, 2000). Every state has their own laws regarding confidentiality and these laws may differ from state to state. There are some legal exceptions to confidentiality. Legal exceptions are privileged communication, which protects the clients from having their disclosure to professionals revealed during legal proceedings without their informed consent (Taylor & Adelman, 1989). Some issues arise with minors in the school districts. School districts and insurance companies have caused issues in ensuring clients when they are a minor in confidentiality and privileged communication (Taylor & Adelman, 1989). Many counselors will to and involve parents in the initial meeting with their children. This can help create a bond of trust at the beginning of the counselor-client relationship. When counselors create a bond of trust it also may develop a working relationship between the parent and child (Lawrence & Kurpius, 2000). There are 3 instances where a counselor needs to break confidentiality when working with a minor. The first instance is if someone is seriously hurting or abusing the client. At this point the counselor should notify the police. The second is when the minor is seriously hurting themselves, in which case the parents should be notified. The third reason is if the minor is seriously planning to hurt someone else, in which numerous people may need to be notified. This is called Duty to warn (Taylor & Adelman, 1989). Duty to warn is a legal responsibility that was put in place to warn or protect third party individuals. It is very important that the counselor is certain that the minor is a serious threat to themselves or others (Lawrence & Kurpius, 2000). At this point a counselor may add these statements and ask the client if they understand that confidentiality needs to be breached.

Counselors should thoroughly explain to the minor that these issues must be talked about with other people. This may compromise the therapeutic progress between the client and minor. Parents have the privilege to know and counselors must share content if requested by the parent (Crespi, 2009). This is why it is very important for minors to know the limits of confidentiality and disclosure issues. In order for counselors to keep their client they need to have an effective approach which will create trust and cooperation from the minor and the parent (Lawrence & Kurpius, 2000).

There is another study on whether counselors tell their clients (minors/children) about the limitation of confidentiality. The article is “Provision of Confidentiality Information and Its Relation to Child Abuse Reporting” by Nicolai and Scott. A major issue has been reporting child abuse. Before a counselor even worries about reporting they first have to worry about explaining the limits of confidentiality to the minor. There are legal and ethical codes that may cause conflict when a counselor has to breach confidentiality. The study was intended to see if counselors inform their clients that there are legal limits to confidentiality of the counselor-client communication. There have been recent studies that show counselors often do not explain information specific to confidentiality limits. Only half of the therapist used in this study informed the client of the limitations (Nicolai & Scott, 1994). One of the procedures for informed consent is that every individual regardless if they are adult or minor have the right to information that influence their treatment. Limitations of confidentiality may influence the minor’s decision in what they would or would not like to share. This study showed that clients were not provided specific information regarding limits of confidentiality despite the ethical guidelines of the American Psychological Association. Secondly, the way counselors provided confidentiality information to clients was related to reporting decisions (Nicolai & Scott, 1994). The limits of confidentiality can lead to issues when it comes to mandatory reporting. **Mandatory Reporting** Mandatory reporting laws were put into place in 1962. The laws were put into place because of the medical diagnosis of “Battered child Syndrome”. The syndrome was very severe but was taken lightly. Battered child Syndrome was when a child suffered from an injury to the soft tissue and skeleton (Conti, 2011). It also provided evidence of neglect, which included poor skin hygiene, soft tissues injuries, and malnutrition. Many professional were reluctant to report neglect out of fear that it would affect their relationship with their clients. Mandatory reporting laws were put in place to help with the issue of child abuse or neglect. If a professional does not protect the child then they are aiding the child abuser (Conti, 2011). It has been reported that more than 700 children were battered in 1962 (Lawrence & Kurpius, 2000). This surprised the community and increased legal and public concern. It wasn’t until 1968 when all 50 states passed laws for mandatory reporting. These laws were designed to identify abused children, investigate, and prevent further abuse to children. Many of the laws are still under control by the states (Conti, 2011).

All reporting laws adhere to the following: who, what, and when reporting is required. Legislation has been expanded to all professions when it comes to mandatory reporting and it is applicable to different settings and relationships. Mental Health professionals are all mandated to report in every state (Conti, 2011). The problem of child abuse is still very high today. There have been over 3 million reports of abuse and neglect each year (Lawrence & Kurpius, 2000). It is also estimated that more than child abuse is underreported by 5:1, which would bring the cases of child abuse up to 15 million per year. The most important first step is reporting child abuse because children need the protection. It is also true that all people are responsible for the care and treatment of a child not just the counselor (Lawrence & Kurpius, 2000). Mandatory reporting can be a difficult experience for a counselor. It is especially hard when the situation is not clear and if the client is unresponsive. At this point the counselor may feel torn between hurting the therapeutic relationship and following the law (Bean, Softas-Nall & Mahoney, 2011). There may be an impact on the minor when it comes to reporting, which may cause the attitude of the client to change.

Counselors may make a mistake when it comes to reporting because there are many gray areas in which abuse may or may not be taking place. The ethical codes may also dictate the counselor’s responsibilities for informed consent and confidentiality (Bean, Softas-Nall & Mahoney, 2011). Failure to report child abuse/neglect does breach law and ethical standards. Mandatory reporting laws protect professionals from criminal or malpractice liability when it comes to breaking confidentiality in order to protect children. There have been a large number of reports by mental health professionals which means they are compliant with the law (Bean, Softas-Nall & Mahoney, 2011). According to both Strozier et al. (2005) and Steinberg et al. (1997), “empirical studies about the impact of reporting on the therapeutic relationship suggest about three quarters of mandated reports have either no effect or a positive effect on the therapeutic relationship, while about one quarter of such reports have a negative impact on the relationship” (Bean, Softas-Nall & Mahoney, 2011). In this area of legal and ethical issues there is a more positive outcome than a negative outcome. **Conclusion** In conclusion, there are many legal and ethical issues when it comes to counseling children. Counselor’s competence is an important area when it comes to having the proper knowledge and skills. There is also informed consent. Informed consent has an impact on whether treatment will or will not happen for the children. Another important issue is confidentiality because a child must have trust and open communication with their counselor. The therapeutic may be hindered if trust is not established and maintained. Limits of confidentiality are also important and must be explained in the very beginning of treatment. Finally there is mandatory reporting. Mandatory reporting protects the child from any abuse or neglect. It is important to know about these legal and ethical issues and practice the best ethical and legal choice possible when counseling a child.

References

Bean, H., Softas-Nall, L. & Mahoney, M. (2011) Reflections on Mandated Reporting and Challenges in the Therapeutic Relationships. *The Family Journal,* 19(3), 286-290.

Belter, R. & Grisso, T. (1984) Children's recognition of rights violations in counseling. *Professional Psychology: Research and Practice,* 15(6), 899-910.

Carmichael, K. (2006) Legal and Ethical Issues In Play Therapy. *International Journal of Play Therapy,* 15(2), 83-99.

Crespi, T*.* (2009)Group Counseling in the School: Legal, Ethical and treatment Issues in School Practice. *Psychology in the Schools,* 46(3), 273-280*.* doi:10.1002/pits.20373

Conti, S. (2011) Lawyers and Mental Health Professionals Working Together: Reconciling the Duties of Confidentiality and Mandatory Child Abuse Reporting. *Family Court Review,*  49(2), 1-16.

Goggin, J. & Goggin, E. (1979) When Adult Therapist Work With Children: Differential Treatment Considerations. *Professional Psychology,* 330-337.

Hall, A. & Lin, M. (1995) Theory and Practice of Children’s Rights: Implication for mental health counselors. *American Mental Counselors Associations Journal,* 17(1), 63-80.

Henkelman, J. & Everall, R. (2001) Informed Consent with Children: Ethical and Practical Implications. *Canadian Journal of Counseling,* 35(2), 109-119.

Kendall, P. & Morris, R. (1991) Child Therapy: Issues and Recommendations. *Journal of Consulting and Clinical Psychology,* 59 (6), 777-784.

Lawrence, G., & Kurpius, S. (2000) Legal and Ethical Issues Involved when Counseling Minors in a Nonschool Setting. *Journal of Counseling and Development,* 78, 130-136.

Nicolai, K., & Scott, N. (1994) Provision of Confidentiality Information and Its Relation to Child Abuse Reporting. *Professional Psychology: Research and Practice,* 25(2), 154- 160.

Martin, R., & Huss, S. (2000) Recruitment and Screening of Minors for Group Counseling. *The Journal for Specialist in Group Work,* 25(2), 146-156.

Seymour, J. & Rubin, L. (2006) Principles, Principles, and Process (P3): A Model for Play Therapy Ethics Problem Solving. *International Journal of Play Therapy,* 15(2), 101-123.

Taylor, L. &Adelman, H. (1989) Reframing the confidentiality dilemma to work in children’s best interest. *Professional Psychology: Research and Practice,* 20, 79-83.