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Chapter 8—Ethical Issues

Ethics is a term that can imply lofty, philosophical discussions, far removed from the everyday world. In reality, workers in the substance abuse treatment field are constantly faced with ethical dilemmas on an individual as well as a societal level. Ethics is an intellectual approach to moral issues, a philosophical framework from which to critically evaluate the choices and actions people take to deal with various aspects of daily living (National Association of Social Workers [NASW], 1997).

Working in the substance abuse treatment field presents dilemmas relating to personal beliefs, judgments, and values. The history of how society views persons with addictions is fraught with emotion, misperceptions, and biases that have affected the care of drug abusers. For example, it is not unusual in a health care setting for a patient to be perceived negatively just by being labeled a drug abuser (Carroll, 1995). Because of the highly charged emotional nature of the substance abuse treatment field, providers should possess the tools to explore ethical dilemmas objectively. By doing so, and by examining their own reactions to the situation, providers can proceed with the most ethical course of action. (See Appendix E for the Federal and State codes of ethics for programs treating HIV-infected substance-abusing clients.) Chapter 9 discusses the legal constraints, obligations, and options that provide the framework within which ethical issues must be decided.

Ethical Issues for Treatment Providers

The Ethics of HIV/AIDS

Taking the most ethical course of action becomes even more complex when HIV/AIDS is thrown into the mix of concerns that the client may present. HIV/AIDS has its own unique ethical issues. Because HIV can be transmitted through sexual activity and by sharing drug equipment, it evokes significant personal feelings and judgments in the general public, as well as in health and social service providers. Advocates for persons with HIV have fought for years to maintain confidentiality, avoid mandatory reporting, and ensure access to care for those with the disease. Because of the labels "drug abuser" or "homosexual" and the fear of a backlash toward people with HIV, advocates have been pushing strongly toward preventing discrimination. This has led to creating safeguards to protect these individuals from discrimination in health care, employment, housing, and other services.

Ethics on Micro and Macro Levels

Ethical issues are both personal (micro) and societal (macro) in nature. There is an ongoing struggle between legislating morality for the "public good" and fighting to retain an individual's right to autonomy. It is the intense emotional nature of such concerns that takes an issue from a personal level to a societal level.

Syringe exchange programs (SEPs) are a good example of such ethical dilemmas. While the Secretary of the U.S. Department of Health and Human Services announced in 1998 that a review of scientific reports indicated that SEPs can be an effective component of a comprehensive strategy to prevent HIV, the restriction on Federal funding for SEPs has not been lifted. At issue is whether giving out clean syringes may sanction or encourage illegal drug use (see Chapter 4 for more information).

Alcohol and drug counselors may find that their time is spent not only sorting out client-level ethical dilemmas, but also dealing with societal-level dilemmas. This could involve advocating for legislation that protects the rights of clients or adapting to the impacts of a policy that will further restrict a provider's ability to intervene effectively with a client group.

Balancing Personal and Professional Standards

Alcohol and drug counselors must balance what is right for them personally with what may be right based on professional standards. Substance abuse treatment professionals who are social workers, for example, should be familiar with the NASW Code of Ethics and may have to reconcile personal beliefs with the profession's code. There also may be agency standards that conflict with an individual's personal beliefs. In either case, there is a

constant need to weigh what may "feel right" personally with the standards and policies of the environment and profession.

Perhaps the most difficult dilemma occurs when there are conflicts between the clinicians's values and the client's behaviors. Professionals know that if a client threatens suicide or homicide, there is a duty to report. But most of the daily concerns that arise are not so simple. Ethical issues come up in numerous, seemingly insignificant ways. Did the client understand what the release of information stated, or did she rush so that the provider could make the next appointment? Did the clinician listen to what the client said about her culture, and how the treatment plan would not work because it was not created in a culturally competent manner? Was information about the client shared with another helping agency, even though she did not give a release to that particular agency? These are the kinds of issues that arise every day, affecting client care and reflecting on one's status as a clinician, as well as on the agency's reputation.

The Need for Staff Training

Issues relating to ethics rarely are covered in orientation sessions or continuing education activities within agencies. Perhaps this is because these issues can be so personal and there are no right or wrong answers in many of the case examples. Yet, the intense nature of the job and the problemsolving required in the daily work of a substance abuse treatment professional require that further training about ethics be provided. This section can be a starting point for ongoing discussions among those treating persons with HIV in substance abuse treatment programs.

Basic Ethical Principles

The study of ethics has produced an abundance of writings, and many standards and principles have been brought forth. However, there are five general principles that provide a firm basis from which to explore the ethical concerns that arise daily in the substance abuse treatment and HIV/AIDS fields (Kitchener, 1985). These are reviewed below.

Justice

The principle of justice assumes impartiality and equality. It means that a clinician will treat all clients equally and give everyone their due portion of services. This principle applies to the individual client as well as on the larger societal level. Yet, given human nature, how possible is it really to treat everyone equally? Can it be honestly said that a clinician does not have "favorite" clients? Are there clients with whom a clinician instinctively wants to limit contact? Are there agency policies or informal agency practices that limit access to a program? Counselors may find that their comfort level is being challenged as increasing numbers of substance abusers with HIV/AIDS comprise their caseloads. Although they may have felt entirely comfortable working with someone who has a substance abuse disorder, they may not understand, or feel awkward working with, someone with HIV/AIDS.

While it is normal to have bias, it is important to know when and how it affects one's ability to practice within the principle of justice, so that no client is discriminated against or denied access to treatment that other clients have. This requires an understanding of countertransference--one's conscious and unconscious reactions to what the client may present in treatment. It also requires knowing when to ask for consultation with a supervisor, so that personal issues do not stand in the way of working with clients.

Although it may be difficult for a provider to treat everyone exactly the same, there are safeguards that agencies and providers can institute to ensure an equitable level of service. Standards can call for every new client to receive an intake interview within 24 hours, or the agency may work toward clarifying its criteria for services so that they are weighed more heavily on objective information rather than on the personal impressions of a substance abuse treatment worker. These sorts of policies can help ensure a general level of fairness, regardless of a worker's personal feelings.

Autonomy

The principle of autonomy assumes that individuals have the right to decide how to live their own lives, as long as their actions do not interfere with the welfare of others. This principle respects the unconditional worth of the individual and promotes the concepts of self-governance, self-determination, and self-rule. In working with HIV-infected substance abusers, the substance abuse treatment counselor can play a key role in determining if the client is competent to make his own decisions and establishing whether or not the client has the information needed to make a personal choice.

The issue of competence can be one of the most difficult ethical issues when working with this population.

Persons with HIV/AIDS can be affected by numerous neuropsychiatric, metabolic, nutritional, and psychological concerns that can affect their judgment. Substance abusers also can experience poor judgment due either to active substance use or to the results of long-term use. In cases of incompetence, it is not fair to the client to allow for full autonomy in decisionmaking as the client could unwittingly harm himself. Yet it is not always clear whether the person is truly incompetent, and the process of proving incompetence can be burdensome and time consuming.

Competency issues are rarely clear cut. There are several factors that can temporarily make a client seem incompetent. A client may seem unable to make independent decisions one day, and then the next day be quite lucid. In reviewing a client's ability to maintain autonomy, consider not only the initial impression, but the duration and severity of the behavior, as well as reports by other persons in the client's life. Consultation with other medical or psychiatric professionals, reports by the client's support system, and a strong baseline assessment can help clarify the presence of mental state changes.

If it appears that a client may be experiencing a loss of mental functioning that is unrelated to a medication-based problem, the question of the client's competency must be addressed. Competency can be complete or partial in nature. The client may demonstrate full competency in some areas of her life and only partial competency in others. For instance, she may be quite capable of caring for herself physically but may no longer be able to make sound financial decisions. In this particular case, she may have to sign a power of attorney to allow someone else to deal with her financial affairs. (However, the client must be of sound mind before she can legally sign such an authorization; if the client is not of sound mind, provider staff should petition the court for appointment of a guardian to make such a decision.)

Before the client became incompetent, she may have signed other legal instruments, like a living will or health care proxy, and these may come into effect if the client appears to be incapable of attending to her own physical or medical care. Finally, if the client appears seriously incompetent, provider staff should petition the court to appoint a guardian.

The other issue involved in autonomous decisionmaking is whether the individual has the necessary information to make a sound decision. This is where bias and personal values on the part of the substance abuse treatment professional can cloud the issue. For example, a clinician strongly believes in combination therapy for persons with HIV and takes on a Native American client whose doctor is suggesting more aggressive treatment. The client wants to know about alternative therapies. Can the clinician set aside personal beliefs and provide an objective array of information without biasing the client's decision?

In many cases, it may be extremely difficult not to "push" the client toward a decision by emphasizing certain information. If nothing else, the biases should be acknowledged to the client. A client will then be able to listen to what the worker is saying, knowing that there is a bias, and be able to respect the worker for acknowledging bias up front. In addition, the client may be more open to asking about the combination therapies at another stage in treatment because he was not "pushed" early on.

Beneficence

Beneficence assumes a responsibility to improve and enhance the welfare of others, or more simply put, to "do good" for others. But what does "doing good" really mean? What may be doing good in the eyes of the substance abuse treatment counselor may be seen as doing harm in the eyes of the client. The counselor needs to consider whether it is the client's agenda or his own agenda. The counselor's or agency's culture also may conflict with the client's. The role of the family, medical practices, and lifestyle issues all affect treatment, and these can differ greatly, depending on the various social norms of all those involved.

The issue of paternalism also must be considered. For example, a clinician might feel justified in telling a physician that the client is not a candidate for the complex regimen of combination therapy. The reasons for doing this may be justified to the clinician because the client is still using drugs and there is concern about the client's ability to take the medications. However, is the clinician's assumption that the client cannot comply based on fact or on personal perceptions and attitudes about drug abusers? In fact, some drug abusers live incredibly organized lives in order to maintain their addiction. Has the clinician discussed the regimen with the client, and has the client had the opportunity to advocate for herself? The clinician must take the client's point of view and cultural context into account before determining what "doing good" truly means.

Nonmaleficence

Similar to beneficence, nonmaleficence means "to do no harm." This principle often has been highlighted when discussing client exploitation, such as sexual contact or financial exploitation. Both of these examples are active

means of doing harm to a client. However, doing harm also can be more subtle, especially given the complex population of HIV-infected substance abusers. An example of conflicting interpretations of this principle is in the debate over abstinence versus risk reduction approaches to drug treatment. Advocates of abstinence may claim that a risk reduction approach harms a client by enabling his addiction, keeping the client from truly "hitting bottom" and seeking help. Risk reduction advocates argue that the abstinence-based model harms the client because it does not allow for compassion or for meeting the basic needs of individuals who are in the throes of addiction. Advocates for risk reduction may claim that the abstinence-based model actually prohibits recovery because it does not take into account that recovery is a process, rather than a rigid philosophy. This is one ethical dilemma that truly reflects the passionate nature of personal values and beliefs.

Another example, on a micro level, is termination or transfer of clients. In both the HIV/AIDS and substance abuse treatment fields, there is a high degree of staff burnout. As an individual clinician becomes increasingly stretched, her ability to be flexible with clients and to treat them as individuals diminishes. In some situations, a client who breaks a rule or shows up late may suffer the wrath of a clinician only because he is the third client to show up late that day, and this is the last time the clinician is going to deal with a lack of respect. Thus, the client may be terminated or transferred to another clinician. This may be a fairly common experience, but what does it mean to the client? Will it harm the development of future relationships? What if the client knows of other clients who were late that day but who were not transferred or terminated? What impression does that give the client about her own self-worth?

Clinicians must be sure that they are not acting like parents to clients and making the clients feel like bad children. If rules regarding transfers and terminations are not clear from the start and followed through consistently, then the clinician is violating the principle of nonmaleficence.

Fidelity

The principle of fidelity requires telling the truth and keeping promises. Fidelity is a fairly simple concept that can be violated easily. When a substance abuse treatment counselor takes on a client, there is an implicit contract with the client. The contract assumes that the counselor will work to resolve the client's concerns and that information will be shared in a truthful manner between the counselor and the client. By having the client sign consent forms, the counselor is promising that the information provided will remain confidential to anyone who is not listed on the form. The client agrees to follow the agency's rules. (Of course, confidentiality must be extended to the client whether or not he obeys program rules.) How frequently is the first session taken up with the more interesting issues, and the paperwork given to the client quickly at the end?

If a clinician is going to keep promises, he must be clear up front about when the promises may have to be broken. If the client is suicidal or homicidal, for example, confidentiality may be breached. If the client speaks of child abuse, the contract will be breached. If the client breaks certain agency rules, the relationship between the clinician and the client may be terminated. It is important that the clinician is extremely clear about the limitations to fidelity so there are no surprises later on. (See the "Confidentiality" section later in this chapter and Chapter 9 for specific details about the legal issues involved.)

Another issue of fidelity is the counselor's focus on the primary client. If the counselor is involved with a complicated family system, it can be difficult to remember who the client is, especially at times of conflict. In working with clients who have questionable competency, it can be convenient to let someone else speak for the client. But it is the counselor's responsibility to ensure that until the competency issue is resolved, she will have to represent the primary client and act according to the client's wishes.

Ethical Issues in Working With HIV-Infected Substance Abusers

There are several specific ethical issues that predominate in the substance abuse and HIV/AIDS treatment fields that warrant more focused attention. These issues are discussed below in a social and ethical context; further information on the legal aspects of these issues is provided in Chapter 9.

Duty To Treat

The duty to treat, from an ethical perspective, is especially relevant when working with disenfranchised populations. A clinician involved with homeless, chronic alcohol-dependent individuals may find it difficult to access adequate medical care for a client with HIV. Or it may not be easy to find a dentist willing to work with an HIV-infected client. Substance abuse treatment professionals may have to take on an advocacy role within their community to educate and campaign for care.

At the same time, it is important that the counselor and the counselor's agency appear accessible to all and that

there are no restrictions that could impede the care of one client just because the client is different in some way.

The impact of welfare reform may augment concern about access issues. This is compounded by the increasing focus on managed care and the decreasing availability of health insurance for the poor. Adding restrictions to a population that is already disenfranchised will require more creativity, patience, and determination on the part of the clinician who is trying to advocate for a client.

In addition, it is important for clinicians to remember that when taking the ethically or morally correct action in a duty-to-treat situation they do not inadvertently create situations where the clinician and agency are legally culpable. Take the example of a counselor who has a substance abuse client who is a minor and engages in prostitution in exchange for drugs. This client is at a high risk of contracting HIV. The counselor feels ethically obligated to treat the client and intervenes to help the client receive clinical treatment or receive information about HIV in a medical setting. Later the client's parents say that they did not approve the medical treatment for their child, and a legal situation is created.

Duty To Warn

In working with HIV-infected substance abusers, there are unique concerns that are raised regarding the duty to warn. Besides the more obvious issues relating to reporting abuse and suicidal or homicidal threats, providers are concerned about clients who are transmitting HIV by not taking necessary precautions. For example, there have been several high profile news reports about individuals with HIV who knowingly infected multiple partners through sexual contact (Richardson, 1998). What does a clinician do if she knows that a client is aware of his HIV-positive status but is still not taking precautions?

Again, counselors must be aware of creating legal culpabilities when taking the ethically or morally correct action in a duty-to-warn situation. For example, if a client has HIV but has not informed his partner about his HIV status, the counselor could be held liable in a civil law suit for knowing and not telling the client's partner. Counselors should consult with their supervisors about agency policy regarding duty-to-warn situations and may report the client to the public health department. Each situation should be examined on a case-by-case basis.

For some counselors, the knowing transmission of HIV is as serious as hearing their client threaten to kill someone. There are some differences, however, between knowingly transmitting HIV and murder. For one, the campaign to stop the transmission of HIV has encouraged people to protect themselves. Therefore, every individual is responsible for safer sex practices, so it is not entirely the responsibility of the person with HIV. Additionally, how can a counselor realistically prevent a client from sharing contaminated syringes or having sex? Finally, there is a greater chance that by using education and counseling, a clinician may be more successful in convincing a client to use protective measures than if the clinician immediately threatened punitive action.

This situation also highlights the conflicts between principles such as beneficence, fidelity, and nonmaleficence. Is the provider "doing good" by reporting a client and trying to help the greater society? Or is the provider doing harm by not working with the client to stop the behavior on a long-term basis? To what extent is the provider breaking the contract with the client by disclosing the client's actions? The ethical nature of these kinds of dilemmas does not lend itself to an easy decision but requires a case-by-case analysis while looking at the long-term and immediate consequences of action (Reamer, 1991). See Chapter 9 for more information about the legal implications of duty-to-warn issues.

End-of-Life Issues

Treatments for HIV are dramatically lowering the death rate from AIDS, but people are still dying from this disease. When an individual's HIV status is compounded by chronic drug use, her survival is less likely. Thus, a clinician may be faced with dying clients and the ethical dilemmas that relate to dying. Persons with HIV generally have been vocal about their right to self-determination. They have campaigned for access to drugs that are still in the trial stage, they have fought for organizations that advocate for dying individuals, such as the Hemlock Society and Compassion in Dying, and they have been highly effective in organizing a compassionate continuum of care services within certain communities, especially the gay and lesbian communities. Given this activist culture, a client with HIV may decide at a certain point to stop medical interventions and will not expect to be dissuaded in this decision.

In some cases, a client may decide that he wishes to end his life because treatment is not working. Clearly, this has implications for the clinician, who should make it clear that he cannot hold a client's suicide threat confidential. The worker should also tell the client again, at the time the threat is made, that he plans to report it. It is important that the clinician discuss the limitations of his role clearly with the client and that this discussion take place before the client reveals, for example, that she is going to take an overdose of medication. The clinician should explain

the professional and agency limitations, and what he would have to do if the client provided certain information. This provides the client with the information needed to make a later decision not to tell the clinician about any such intentions (or, if the client wants intervention, she may decide to tell the clinician, knowing where such information would lead). It is imperative that providers recognize the laws in their own jurisdictions regarding these issues.

For providers who are concerned about liability, it is helpful to note that if a case were to go to court, the provider would be judged on the community standard for that profession. Thus, if the clinician were following the code of ethics for the profession and it was well documented, or if the clinician was adhering to the accepted standards of the institution in which he worked, the chances of being found liable in a lawsuit are greatly reduced. Although there is much concern about liability in the profession of social services, it is extremely rare for a judgment to be made against a clinician who was following appropriate procedures and standards.

Dual Relationships

Dual relationships pose another dilemma that clinicians may find themselves in. Dual relationships, where a provider may have had contact with a client in a social context as well as in a professional role, bring up the ethical issue of boundaries. The line between social and professional roles can become blurred, especially in rural areas or in certain cultural communities. In the treatment provider network, a clinician may be seeing someone with whom she used to socialize or shoot up, or a gay male counselor may be case managing a peer from his community.

Dual relationships should be avoided if possible. A clinician who knows a client via a past social or sexual encounter should not assume a professional role with that client. Some clients may avoid accessing services because they are afraid of seeing someone they know, and the ethical issues regarding disclosure and trust are many. If there is no other provider available to the client, it is imperative that the clinician clarify what the professional role means, and how the information shared will remain confidential. It may also be necessary throughout the treatment process to frequently check the client's comfort level and to continually emphasize the role and boundaries of the clinician.

Scarce Resources

Given the limited resources available, treatment providers may find it difficult to treat all the clients who seek treatment. Providers will need to plan for the complex decisions that need to be made in such cases. They should consider the following questions:

- How can providers, and society in general, ensure that resources are distributed fairly?
- How can such allocations be free of bias and assumptions about certain individuals, cultures, and populations?

The provider can work to make certain that the method of allocation is objective and applied consistently. This means using objective criteria for access to services or treatment and perhaps instituting a review process to ensure that decisions are not made only on the basis of one provider's recommendation. In some facilities or agencies, for example, there is a team that determines who qualifies for services once certain objective eligibility criteria have been met.

Resources available to many substance abuse treatment providers, particularly for clients with HIV/AIDS, are limited. As interest in HIV has "peaked," organizations serving this population have seen revenues drop. As a result, an agency needing to limit services to a specific number of people may turn down an individual who has failed in treatment a number of times. The justification may be that the resources could be better spent on someone who has a greater likelihood of recovery.

Issues such as these also are affecting the allocation of combination therapies. The provider may block a client's access to the expensive treatments if the client is not up to managing the medication regimen. The case manager or treatment specialist who sees the client on a consistent basis can support or deny the validity of such a decision.

Confidentiality

The issue of confidentiality is the "connecting issue" among the general principles outlined above (NASW, 1997). Ensuring confidentiality is perhaps the strongest element in the foundation of a therapeutic relationship. Clients must feel that what they say to a clinician is protected information. Unfortunately, the nature of managed care requires more extensive justification for treatment, and the number of individuals that need information about a

person's treatment is increasing. Additionally, the influx of computerized data can further jeopardize the concept of protected information.

It is the ethical responsibility of the provider to be honest with the client about what data need to be reported to funding sources such as insurance companies, and what information needs to be shared with other agencies or individuals. It is the legal responsibility of the provider to obtain consent for any information shared outside of the client-provider relationship (see Chapter 9). A provider must ensure that clients understand the agreement they are entering into by accepting treatment from the agency or provider. Clients should have all the information they need to make decisions about the services being provided, including to what specific amount and types of disclosure they are willing to consent.

This does not mean that the provider has no control over what is disclosed to others about the client. It is imperative that the provider use discretion in conversations with individuals outside of the therapeutic relationship and only report what is relevant to the situation. The provider also should use discretion in documentation of work with the client. Some providers document everything in detail in case they are sued. The provider should only document what is essential. For example, if a client comes into treatment for substance abuse, the provider should document the client's substance abuse history, motivation for entering treatment, any medical or emotional issues that relate to the treatment, and the plan for service. But there is a significant difference between an entry that states, "Client is upset regarding recent divorce," and an entry that reads, "Client claims his ongoing promiscuity has caused his wife to leave him." The latter may be of interest, and perhaps even relevant to treatment, but it should not be documented until it is necessary treatment information.

A Step-by-Step Model for Making Ethical Decisions

All programs should have a consistent process for dealing with ethical concerns. Although ethical issues are usually complex enough to require a case-by-case evaluation, agency practices should provide for a routine process for approaching an ethical issue. For example, an agency might have, as a policy and procedure, a practice where the employee consults with a supervisor or an ethics consultation team within the agency, within a specified timeframe, and guidelines are provided for how to document such discussions. There could also be agency protocols for situations that have arisen in the past, such as a client's admission that she is suicidal or homicidal, clients who come to the facility intoxicated and insist on driving home, or clients who admit to illegal activity. Given the ambiguous nature of ethical dilemmas, it is helpful to clarify the process for resolving dilemmas, even if the resolution may differ from case to case.

NASW's *Ethical Issues, HIV/AIDS, and Social Work Practice* training manual (NASW, 1997) outlines a process for working through ethical issues. By practicing the following steps, suggested by the NASW, the clinician can move to a more rational level of decisionmaking.

- **Identify the clinical issues.** When an ethical issue arises, the provider should review the larger picture in her work with the client or system. Identifying the clinical issues is the first step. What are the clinical needs of the client? How does the ethical dilemma relate to what the client presented with initially? It is important to assess the clinical issues so that pertinent information is not missed. For example, if a client with advanced AIDS is asking for help in ending his life, the provider would review the client's previous mental health history and current emotional issues, look for any significant changes in the client's support system, and determine if the client is experiencing social or psychological issues that might influence his decision. Until this is done, it is impossible for the clinician to address the ethical issue regarding end of life.
- **Identify the legal issues.** There can be significant legal issues to consider. Has the clinician reviewed the State and local laws regarding the issue? If necessary, has the clinician checked with an attorney for consultation or informed his supervisor of possible liability questions?
- **Identify the system issues.** What are the policies and procedures of the clinician's agency regarding the ethical question? In some agencies, the answers may be hard to find, but they can shed light on any restrictions the clinician may face or make the choices clear. For example, if it is against policy to accept a gift from a client, the clinician can avoid a personal rejection by referring to the policy. Agency policy also can help a clinician in a legal challenge. For example, if the clinician followed agency policy, it is less likely that the clinician can be challenged legally for actions pertaining to that policy (although the agency can still be challenged).
- **Identify the cultural issues.** Cultural issues often are glossed over in the midst of a dilemma or crisis. Yet cultural issues are significant for understanding the client's motivation and whether or not the client will act according to the proposed treatment plan. For example, a gay, African American client may have

difficulty dealing with his homosexuality and as a result may be having anonymous unprotected sex impulsively. In the African American culture it can be especially difficult for men to acknowledge their homosexuality. If the client is HIV positive, there is an ethical need to educate him about protecting others. If the clinician does not acknowledge the client's discomfort on a cultural level, the education process will be limited and the clinician will miss the "larger picture."

- **Identify the ethical issues.** What is the clinician's reaction to the situation? Ethical issues often are revealed when there is a "gut instinct" that something is not right. Confusion, anxiety, or uncertainty about what to do next with the client are indicators that an ethical issue is at stake. If basic principles seem to be compromised, the clinician should stop and evaluate further. A significant step is for the clinician to examine her own feelings about the situation. The clinician needs to identify any countertransference issues regarding the situation to ensure that the issue can be viewed objectively.
- **Review what principles are at stake.** What is the true dilemma? Is there a dilemma at all? So much can be occurring with a client that it is difficult to see the real issue, or whether the issue is significant. Is harm being done either by the client or to the client? Can the client make her own decisions, and is she not being allowed to do so? Is the client being treated fairly regardless of race, culture, or lifestyle? Is there a threat to the client's confidentiality? These are the questions relating to basic ethical principles.
- **What are the possible options?** By this point, the clinician's next step may be clear already. Or, there may be choices of possible options. It is useful to simply list all of the possible options and then examine them.
- **Review the pros and cons of each option.** List the pros and cons of each possible option, noting the impact of the options on the welfare of the client, the clinician, the agency, and others involved in the situation, such as the client's support system.
- **Act.** At this point, the clinician should be ready to make a decision. Sometimes the decision may not be one that everyone is comfortable with, but it may be the least objectionable plan. The client should understand the rationale for the clinician's decision, and there should be evidence of the clinician's thought process in the documentation of consultations, discussions with the client, and supervisory meetings.
- **Follow up and evaluate.** An ethical decision should be evaluated and the impact to the client monitored. For example, if the clinician decided to breach confidentiality for the protection of the client, how has this affected the clinical work with the client? These issues should be considered once an initial crisis has passed.

Additional Resources for Ethical Problemsolving

This section identifies several resources that can provide professional guidance on ethical issues.

Consultation

Consultation can be formal or informal. A supervisor is an obvious choice but may not always be available in some resource-strapped agencies or facilities. In lieu of formal supervision, there can be consultation with peers, lead workers, or other providers within the community who understand what the clinician does. For cultural questions, it is vital to use the community that represents that culture; however, the clinician should be cautious about consulting individuals who claim to represent the community but in actuality do not. The clinician also needs to ensure confidentiality with any consultation. If there is a chance that the information cannot be shared without divulging confidentiality, the provider may have to contact resources from another city, county, or State to ensure that the client's confidentiality is not threatened. Without the client's consent, however, the provider should never share identifying information.

Professional Standards or Codes of Ethics

Professional standards, and the documents that reflect them, are another resource. Social work, medicine, nursing, and psychology are examples of professions that have professional standards and codes of ethics. These documents do not provide answers to every ethical dilemma, but they do provide parameters for what is allowed or disallowed by the profession. They may also provide substantive questions to guide a provider toward making a decision. To find such documents, contact the association office for the particular professional group.

Legal Consultation

For many providers, obtaining legal advice may seem unrealistic given limited resources, but there are low-cost strategies for obtaining advice in some situations. Most bar associations have a pro bono legal component that may provide consultation at no charge or at a reduced rate. Legal service agencies that operate as a social service to the community may have expertise regarding certain ethical dilemmas. Another often untapped resource is the board of the organization that employs the clinician. The board is legally responsible for any impact to the agency, so it would have a vested interest in assisting with a decision that could have legal repercussions. Many boards have attorneys as members.

It is worthwhile to examine the agency board, discover the specialty areas of the individuals who make up the board, and talk with the agency administration about building a relationship with those board members in advance of a legal issue. In addition, there is a Single State Authority charged with funding and regulating the field of substance abuse treatment. Such an entity may have an attorney available who can assist with legal issues relating to treatment.