BEHAVIOR ANALYST CERTIFICATION BOARD®

Professional and Ethical Compliance Code for Behavior Analysts

The Behavior Analyst Certification Board's (BACB's) Professional and Ethical Compliance Code for Behavior Analysts (the "Code") consolidates, updates, and replaces the BACB's Professional Disciplinary and Ethical Standards and Guidelines for Responsible Conduct for Behavior Analysts. The Code includes 10 sections relevant to professional and ethical behavior of behavior analysts, along with a glossary of terms. Effective January 1, 2016, all BACB applicants, certificants, and registrants will be required to adhere to the Code.

In the original version of the Guidelines for Professional Conduct for Behavior Analysts, the authors acknowledged ethics codes from the following organizations: American Anthropological Association, American Educational Research Association, American Psychological Association, American Sociological Association, California Association for Behavior Analysis, Florida Association for Behavior Analysis, National Association of Social Workers, National Association of School Psychologists, and Texas Association for Behavior Analysis. We acknowledge and thank these professional organizations that have provided substantial guidance and clear models from which the Code has evolved.

Approved by the BACB's Board of Directors on August 7, 2014.

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[RBT= The Code element is relevant to Registered Behavior Technicians™]

1.0 Responsible Conduct of Behavior Analysts.

Behavior analysts maintain the high standards of behavior of the profession.

1.01 Reliance on Scientific Knowledge. [RBT]

Behavior analysts rely on professionally derived knowledge based on science and behavior analysis when making scientific or professional judgments in human service provision, or when engaging in scholarly or professional endeavors.

1.02 Boundaries of Competence. [RBT]

(a) All behavior analysts provide services, teach, and conduct research only within the boundaries of their competence, defined as being commensurate with their education, training, and supervised experience.
(b) Behavior analysts provide services, teach, or conduct research in new areas (e.g., populations, techniques, behaviors) only after first undertaking appropriate study, training, supervision, and/or consultation from persons who are competent in those areas.

1.03 Maintaining Competence through Professional Development. [RBT]

Behavior analysts maintain knowledge of current scientific and professional information in their areas of practice and undertake ongoing efforts to maintain competence in the skills they use by reading the appropriate literature, attending conferences and conventions, participating in workshops, obtaining additional coursework, and/or obtaining and maintaining appropriate professional credentials.

1.04 Integrity. [RBT]

(a) Behavior analysts are truthful and honest and arrange the environment to promote truthful and honest behavior in others.
(b) Behavior analysts do not implement contingencies that would cause others to engage in fraudulent, illegal, or unethical conduct.
(c) Behavior analysts follow through on obligations, and contractual and professional commitments with high quality work and refrain from making professional commitments they cannot keep.
(d) Behavior analysts' behavior conforms to the legal and ethical codes of the social and professional community of which they are members. *(See also, 10.02a Timely Responding, Reporting, and Updating of Information Provided to the BACB)*
(e) If behavior analysts' ethical responsibilities conflict with law or any policy of an organization with which they are affiliated, behavior analysts make known their commitment to this Code and take steps to resolve the conflict in a responsible manner in accordance with law.

1.05 Professional and Scientific Relationships. RBT

(a) Behavior analysts provide behavior-analytic services only in the context of a defined, professional, or scientific relationship or role.

(b) When behavior analysts provide behavior-analytic services, they use language that is fully understandable to the recipient of those services while remaining conceptually systematic with the profession of behavior analysis. They provide appropriate information prior to service delivery about the nature of such services and appropriate information later about results and conclusions.

(c) Where differences of age, gender, race, culture, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status significantly affect behavior analysts' work concerning particular individuals or groups, behavior analysts obtain the training, experience, consultation, and/or supervision necessary to ensure the competence of their services, or they make appropriate referrals.

(d) In their work-related activities, behavior analysts do not engage in discrimination against individuals or groups based on age, gender, race, culture, ethnicity, national origin, religion, sexual orientation, disability, language, socioeconomic status, or any basis proscribed by law.

(e) Behavior analysts do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, race, culture, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status, in accordance with law.

(f) Behavior analysts recognize that their personal problems and conflicts may interfere with their effectiveness. Behavior analysts refrain from providing services when their personal circumstances may compromise delivering services to the best of their abilities.

1.06 Multiple Relationships and Conflicts of Interest. RBT

(a) Due to the potentially harmful effects of multiple relationships, behavior analysts avoid multiple relationships.

(b) Behavior analysts must always be sensitive to the potentially harmful effects of multiple relationships. If behavior analysts find that, due to unforeseen factors, a multiple relationship has arisen, they seek to resolve it.

(c) Behavior analysts recognize and inform clients and supervisees about the potential harmful effects of multiple relationships.

(d) Behavior analysts do not accept any gifts from or give any gifts to clients because this constitutes a multiple relationship.

1.07 Exploitative Relationships. RBT

(a) Behavior analysts do not exploit persons over whom they have supervisory, evaluative, or other authority such as students, supervisees, employees, research participants, and clients.

(b) Behavior analysts do not engage in sexual relationships with clients, students, or supervisees, because such relationships easily impair judgment or become exploitative.
(c) Behavior analysts refrain from any sexual relationships with clients, students, or supervisees, for at least two years after the date the professional relationship has formally ended.
(d) Behavior analysts do not barter for services, unless a written agreement is in place for the barter that is (1) requested by the client or supervisee; (2) customary to the area where services are provided; and (3) fair and commensurate with the value of behavior-analytic services provided.

2.0 Behavior Analysts' Responsibility to Clients.

Behavior analysts have a responsibility to operate in the best interest of clients. The term client as used here is broadly applicable to whomever behavior analysts provide services, whether an individual person (service recipient), a parent or guardian of a service recipient, an organizational representative, a public or private organization, a firm, or a corporation.

2.01 Accepting Clients.

Behavior analysts accept as clients only those individuals or entities whose requested services are commensurate with the behavior analysts' education, training, experience, available resources, and organizational policies. In lieu of these conditions, behavior analysts must function under the supervision of or in consultation with a behavior analyst whose credentials permit performing such services.

2.02 Responsibility. RBT

Behavior analysts' responsibility is to all parties affected by behavior-analytic services. When multiple parties are involved and could be defined as a client, a hierarchy of parties must be established and communicated from the outset of the defined relationship. Behavior analysts identify and communicate who the primary ultimate beneficiary of services is in any given situation and advocates for his or her best interests.

2.03 Consultation.

(a) Behavior analysts arrange for appropriate consultations and referrals based principally on the best interests of their clients, with appropriate consent, and subject to other relevant considerations, including applicable law and contractual obligations.
(b) When indicated and professionally appropriate, behavior analysts cooperate with other professionals, in a manner that is consistent with the philosophical assumptions and principles of behavior analysis, in order to effectively and appropriately serve their clients.

2.04 Third-Party Involvement in Services.

(a) When behavior analysts agree to provide services to a person or entity at the request of a third party, behavior analysts clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and any potential conflicts. This clarification includes the role of the behavior analyst (such as therapist, organizational consultant, or expert witness), the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality.

(b) If there is a foreseeable risk of behavior analysts being called upon to perform conflicting roles because of the involvement of a third party, behavior analysts clarify the nature and direction of their responsibilities, keep all parties appropriately informed as matters develop, and resolve the situation in accordance with this Code.

(c) When providing services to a minor or individual who is a member of a protected population at the request of a third party, behavior analysts ensure that the parent or client-surrogate of the ultimate recipient of services is informed of the nature and scope of services to be provided, as well as their right to all service records and data.

(d) Behavior analysts put the client's care above all others and, should the third party make requirements for services that are contraindicated by the behavior analyst's recommendations, behavior analysts are obligated to resolve such conflicts in the best interest of the client. If said conflict cannot be resolved, that behavior analyst's services to the client may be discontinued following appropriate transition.

2.05 Rights and Prerogatives of Clients. RBT

(a) The rights of the client are paramount and behavior analysts support clients' legal rights and prerogatives.

(b) Clients and supervisees must be provided, on request, an accurate and current set of the behavior analyst's credentials.

(c) Permission for electronic recording of interviews and service delivery sessions is secured from clients and relevant staff in all relevant settings. Consent for different uses must be obtained specifically and separately.

(d) Clients and supervisees must be informed of their rights and about procedures to lodge complaints about professional practices of behavior analysts with the employer, appropriate authorities, and the BACB.

(e) Behavior analysts comply with any requirements for criminal background checks.

2.06 Maintaining Confidentiality. RBT

(a) Behavior analysts have a primary obligation and take reasonable precautions to protect the confidentiality of those with whom they work or consult, recognizing that confidentiality may be established by law, organizational rules, or professional or scientific relationships.

(b) Behavior analysts discuss confidentiality at the outset of the relationship and thereafter as new circumstances may warrant.

(c) In order to minimize intrusions on privacy, behavior analysts include only information germane to the purpose for which the communication is made in written, oral, and electronic reports, consultations, and other avenues.

(d) Behavior analysts discuss confidential information obtained in clinical or consulting relationships, or evaluative data concerning clients, students, research participants, supervisees, and employees, only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

(e) Behavior analysts must not share or create situations likely to result in the sharing of any identifying information (written, photographic, or video) about current clients and supervisees within social media contexts.

2.07 Maintaining Records. RBT

(a) Behavior analysts maintain appropriate confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, electronic, or in any other medium.

(b) Behavior analysts maintain and dispose of records in accordance with applicable laws, regulations, corporate policies, and organizational policies, and in a manner that permits compliance with the requirements of this Code.

2.08 Disclosures. RBT

Behavior analysts never disclose confidential information without the consent of the client, except as mandated by law, or where permitted by law for a valid purpose, such as (1) to provide needed professional services to the client, (2) to obtain appropriate professional consultations, (3) to protect the client or others from harm, or (4) to obtain payment for services, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. Behavior analysts recognize that parameters of consent for disclosure should be acquired at the outset of any defined relationship and is an ongoing procedure throughout the duration of the professional relationship.

2.09 Treatment/Intervention Efficacy.

(a) Clients have a right to effective treatment (i.e., based on the research literature and adapted to the individual client). Behavior analysts always have the obligation to advocate for and educate the client about scientifically supported, most-effective treatment procedures. Effective treatment procedures have been validated as having both long-term and short-term benefits to clients and society.

(b) Behavior analysts have the responsibility to advocate for the appropriate amount and level of

service provision and oversight required to meet the defined behavior-change program goals.
(c) In those instances where more than one scientifically supported treatment has been established, additional factors may be considered in selecting interventions, including, but not limited to, efficiency and cost-effectiveness, risks and side-effects of the interventions, client preference, and practitioner experience and training.
(d) Behavior analysts review and appraise the effects of any treatments about which they are aware that might impact the goals of the behavior-change program, and their possible impact on the behavior-change program, to the extent possible.

2.10 Documenting Professional Work and Research. RBT

(a) Behavior analysts appropriately document their professional work in order to facilitate provision of services later by them or by other professionals, to ensure accountability, and to meet other requirements of organizations or the law.
(b) Behavior analysts have a responsibility to create and maintain documentation in the kind of detail and quality that would be consistent with best practices and the law.

2.11 Records and Data. RBT

(a) Behavior analysts create, maintain, disseminate, store, retain, and dispose of records and data relating to their research, practice, and other work in accordance with applicable laws, regulations, and policies; in a manner that permits compliance with the requirements of this Code; and in a manner that allows for appropriate transition of service oversight at any moment in time.
(b) Behavior analysts must retain records and data for at least seven (7) years and as otherwise required by law.

2.12 Contracts, Fees, and Financial Arrangements.

(a) Prior to the implementation of services, behavior analysts ensure that there is in place a signed contract outlining the responsibilities of all parties, the scope of behavior-analytic services to be provided, and behavior analysts' obligations under this Code.
(b) As early as is feasible in a professional or scientific relationship, behavior analysts reach an agreement with their clients specifying compensation and billing arrangements.
(c) Behavior analysts' fee practices are consistent with law and behavior analysts do not misrepresent their fees. If limitations to services can be anticipated because of limitations in funding, this is discussed with the client as early as is feasible.
(d) When funding circumstances change, the financial responsibilities and limits must be revisited with the client.

2.13 Accuracy in Billing Reports.

Behavior analysts accurately state the nature of the services provided, the fees or charges, the identity of the provider, relevant outcomes, and other required descriptive data.

2.14 Referrals and Fees.

Behavior analysts must not receive or provide money, gifts, or other enticements for any professional referrals. Referrals should include multiple options and be made based on objective determination of the client need and subsequent alignment with the repertoire of the referee. When providing or receiving a referral, the extent of any relationship between the two parties is disclosed to the client.

2.15 Interrupting or Discontinuing Services.

(a) Behavior analysts act in the best interests of the client and supervisee to avoid interruption or disruption of service.

(b) Behavior analysts make reasonable and timely efforts for facilitating the continuation of behavior-analytic services in the event of unplanned interruptions (e.g., due to illness, impairment, unavailability, relocation, disruption of funding, disaster).

(c) When entering into employment or contractual relationships, behavior analysts provide for orderly and appropriate resolution of responsibility for services in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the ultimate beneficiary of services.

(d) Discontinuation only occurs after efforts to transition have been made. Behavior analysts discontinue a professional relationship in a timely manner when the client: (1) no longer needs the service, (2) is not benefiting from the service, (3) is being harmed by continued service, or (4) when the client requests discontinuation. *(See also, 4.11 Discontinuing Behavior-Change Programs and Behavior-Analytic Services)*

(e) Behavior analysts do not abandon clients and supervisees. Prior to discontinuation, for whatever reason, behavior analysts: discuss service needs, provide appropriate pre-termination services, suggest alternative service providers as appropriate, and, upon consent, take other reasonable steps to facilitate timely transfer of responsibility to another provider.

3.0 Assessing Behavior.

Behavior analysts using behavior-analytic assessment techniques do so for purposes that are appropriate given current research.

3.01 Behavior-Analytic Assessment. RBT

(a) Behavior analysts conduct current assessments prior to making recommendations or developing behavior-change programs. The type of assessment used is determined by client's needs and consent, environmental parameters, and other contextual variables. When behavior analysts are developing a behavior-reduction program, they must first conduct a functional assessment.
(b) Behavior analysts have an obligation to collect and graphically display data, using behavior-analytic conventions, in a manner that allows for decisions and recommendations for behavior-change program development.

3.02 Medical Consultation.

Behavior analysts recommend seeking a medical consultation if there is any reasonable possibility that a referred behavior is influenced by medical or biological variables.

3.03 Behavior-Analytic Assessment Consent.

(a) Prior to conducting an assessment, behavior analysts must explain to the client the procedure(s) to be used, who will participate, and how the resulting information will be used.
(b) Behavior analysts must obtain the client's written approval of the assessment procedures before implementing them.

3.04 Explaining Assessment Results.

Behavior analysts explain assessment results using language and graphic displays of data that are reasonably understandable to the client.

3.05 Consent-Client Records.

Behavior analysts obtain the written consent of the client before obtaining or disclosing client records from or to other sources, for assessment purposes.

4.0 Behavior Analysts and the Behavior-Change Program.

Behavior analysts are responsible for all aspects of the behavior-change program from conceptualization to implementation and ultimately to discontinuation.

4.01 Conceptual Consistency.

Behavior analysts design behavior-change programs that are conceptually consistent with behavior-analytic principles.

4.02 Involving Clients in Planning and Consent.

Behavior analysts involve the client in the planning of and consent for behavior-change programs.

4.03 Individualized Behavior-Change Programs.

(a) Behavior analysts must tailor behavior-change programs to the unique behaviors, environmental variables, assessment results, and goals of each client.
(b) Behavior analysts do not plagiarize other professionals' behavior-change programs.

4.04 Approving Behavior-Change Programs.

Behavior analysts must obtain the client's written approval of the behavior-change program before implementation or making significant modifications (e.g., change in goals, use of new procedures).

4.05 Describing Behavior-Change Program Objectives.

Behavior analysts describe, in writing, the objectives of the behavior-change program to the client before attempting to implement the program. To the extent possible, a risk-benefit analysis should be conducted on the procedures to be implemented to reach the objective. The description of program objectives and the means by which they will be accomplished is an ongoing process throughout the duration of the client-practitioner relationship.

4.06 Describing Conditions for Behavior-Change Program Success.

Behavior analysts describe to the client the environmental conditions that are necessary for the behavior-change program to be effective.

4.07 Environmental Conditions that Interfere with Implementation.

(a) If environmental conditions prevent implementation of a behavior-change program, behavior analysts recommend that other professional assistance (e.g., assessment, consultation or therapeutic intervention by other professionals) be sought.
(b) If environmental conditions hinder implementation of the behavior-change program, behavior analysts seek to eliminate the environmental constraints, or identify in writing the obstacles to doing so.

4.08 Considerations Regarding Punishment Procedures.

(a) Behavior analysts recommend reinforcement rather than punishment whenever possible.

(b) If punishment procedures are necessary, behavior analysts always include reinforcement procedures for alternative behavior in the behavior-change program.

(c) Before implementing punishment-based procedures, behavior analysts ensure that appropriate steps have been taken to implement reinforcement-based procedures unless the severity or dangerousness of the behavior necessitates immediate use of aversive procedures.

(d) Behavior analysts ensure that aversive procedures are accompanied by an increased level of training, supervision, and oversight. Behavior analysts must evaluate the effectiveness of aversive procedures in a timely manner and modify the behavior-change program if it is ineffective. Behavior analysts always include a plan to discontinue the use of aversive procedures when no longer needed.

4.09 Least Restrictive Procedures.

Behavior analysts review and appraise the restrictiveness of procedures and always recommend the least restrictive procedures likely to be effective.

4.10 Avoiding Harmful Reinforcers. RBT

Behavior analysts minimize the use of items as potential reinforcers that may be harmful to the health and development of the client, or that may require excessive motivating operations to be effective.

4.11 Discontinuing Behavior-Change Programs and Behavior-Analytic Services.

(a) Behavior analysts establish understandable and objective (i.e., measurable) criteria for the discontinuation of the behavior change program and describe them to the client. *(See also, 2.15d Interrupting or Discontinuing Services)*

(b) Behavior analysts discontinue services with the client when the established criteria for discontinuation are attained, as in when a series of agreed-upon goals have been met. *(See also, 2.15d Interrupting or Discontinuing Services)*

5.0 Behavior Analysts as Supervisors.

When behavior analysts are functioning as supervisors, they must take full responsibility for all facets of this undertaking. *(See also, 1.06 Multiple Relationships and Conflict of Interest, 1.07 Exploitative Relationships, 2.05 Rights and Prerogatives of Clients, 2.06 Maintaining Confidentiality, 2.15 Interrupting or Discontinuing Services, 8.04 Media Presentations and Media-Based Services, 9.02 Characteristics of Responsible Research, 10.05 Compliance with BACB Supervision and Coursework Standards)*

5.01 Supervisory Competence.

Behavior analysts supervise only within their areas of defined competence.

5.02 Supervisory Volume.

Behavior analysts take on only a volume of supervisory activity that is commensurate with their ability to be effective.

5.03 Supervisory Delegation.

a) Behavior analysts delegate to their supervisees only those responsibilities that such persons can reasonably be expected to perform competently, ethically, and safely.

b) If the supervisee does not have the skills necessary to perform competently, ethically, and safely, behavior analysts provide conditions for the acquisition of those skills.

5.04 Designing Effective Supervision and Training.

Behavior analysts ensure that supervision and trainings are behavior-analytic in content, effectively and ethically designed, and meet the requirements for licensure, certification, or other defined goals.

5.05 Communication of Supervision Conditions.

Behavior analysts provide a clear written description of the purpose, requirements, evaluation criteria, conditions, and terms of supervision prior to the onset of the supervision.

5.06 Providing Feedback to Supervisees.

a) Behavior analysts design feedback and reinforcement systems in a way that improves supervisee performance.

b) Behavior analysts provide documented, timely feedback regarding the performance of a supervisee on an ongoing basis. *(See also, 10.05 Compliance with BACB Supervision and Coursework Standards)*

5.07 Evaluating the Effects of Supervision.

Behavior analysts design systems for obtaining ongoing evaluation of their own supervision activities.

6.0 Behavior Analysts' Ethical Responsibility to the Profession of Behavior Analysis.

Behavior analysts have an obligation to the science of behavior and profession of behavior analysis.

6.01 Affirming Principles. RBT

a) Above all other professional training, behavior analysts uphold and advance the values, ethics, and principles of the profession of behavior analysis.
b) Behavior analysts have an obligation to participate in behavior-analytic professional and scientific organizations or activities.

6.02 Disseminating Behavior Analysis. RBT

Behavior analysts promote behavior analysis by making information about it available to the public through presentations, discussions, and other media.

7.0 Behavior Analysts' Ethical Responsibility to Colleagues.

Behavior analysts work with colleagues within the profession of behavior analysis and from other professions and must be aware of these ethical obligations in all situations. *(See also, 10.0 Behavior Analysts' Ethical Responsibility to the BACB)*

7.01 Promoting an Ethical Culture. RBT

Behavior analysts promote an ethical culture in their work environments and make others aware of this Code.

7.02 Ethical Violations by Others and Risk of Harm. RBT

(a) If behavior analysts believe there may be a legal or ethical violation, they first determine whether there is potential for harm, a possible legal violation, a mandatory-reporting condition, or an agency, organization, or regulatory requirement addressing the violation.
(b) If a client's legal rights are being violated, or if there is the potential for harm, behavior analysts must take the necessary action to protect the client, including, but not limited to, contacting relevant authorities, following organizational policies, and consulting with appropriate professionals, and documenting their efforts to address the matter.
(c) If an informal resolution appears appropriate, and would not violate any confidentiality rights, behavior analysts attempt to resolve the issue by bringing it to the attention of that individual and documenting their efforts to address the matter. If the matter is not resolved, behavior analysts report the matter to the appropriate authority (e.g., employer, supervisor, regulatory authority).
(d) If the matter meets the reporting requirements of the BACB, behavior analysts submit a formal complaint to the BACB. *(See also, 10.02 Timely Responding, Reporting, and Updating of Information Provided to the BACB)*

8.0 Public Statements.

Behavior analysts comply with this Code in public statements relating to their professional services, products, or publications, or to the profession of behavior analysis. Public statements include, but are not limited to, paid or unpaid advertising, brochures, printed matter, directory listings, personal resumes or curriculum vitae, interviews or comments for use in media, statements in legal proceedings, lectures and public presentations, social media, and published materials.

8.01 Avoiding False or Deceptive Statements. RBT

(a) Behavior analysts do not make public statements that are false, deceptive, misleading, exaggerated, or fraudulent, either because of what they state, convey, or suggest or because of what they omit, concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated. Behavior analysts claim as credentials for their behavior-analytic work, only degrees that were primarily or exclusively behavior-analytic in content.

(b) Behavior analysts do not implement non-behavior-analytic interventions. Non-behavior-analytic services may only be provided within the context of non-behavior-analytic education, formal training, and credentialing. Such services must be clearly distinguished from their behavior-analytic practices and BACB certification by using the following disclaimer: “These interventions are not behavior-analytic in nature and are not covered by my BACB credential.” The disclaimer should be placed alongside the names and descriptions of all non-behavior-analytic interventions.

(c) Behavior analysts do not advertise non-behavior-analytic services as being behavior-analytic.

(d) Behavior analysts do not identify non-behavior-analytic services as behavior-analytic services on bills, invoices, or requests for reimbursement.

(e) Behavior analysts do not implement non-behavior-analytic services under behavior-analytic service authorizations.

8.02 Intellectual Property. RBT

(a) Behavior analysts obtain permission to use trademarked or copyrighted materials as required by law. This includes providing citations, including trademark or copyright symbols on materials, that recognize the intellectual property of others.

b) Behavior analysts give appropriate credit to authors when delivering lectures, workshops, or other presentations.

8.03 Statements by Others. RBT

(a) Behavior analysts who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) Behavior analysts make reasonable efforts to prevent others whom they do not oversee (e.g.,

employers, publishers, sponsors, organizational clients, and representatives of the print or broadcast media) from making deceptive statements concerning behavior analysts' practices or professional or scientific activities.

(c) If behavior analysts learn of deceptive statements about their work made by others, behavior analysts correct such statements.

(d) A paid advertisement relating to behavior analysts' activities must be identified as such, unless it is apparent from the context.

8.04 Media Presentations and Media-Based Services.

(a) Behavior analysts using electronic media (e.g., video, e-learning, social media, electronic transmission of information) obtain and maintain knowledge regarding the security and limitations of electronic media in order to adhere to this Code.

(b) Behavior analysts making public statements or delivering presentations using electronic media do not disclose personally identifiable information concerning their clients, supervisees, students, research participants, or other recipients of their services that they obtained during the course of their work, unless written consent has been obtained.

(c) Behavior analysts delivering presentations using electronic media disguise confidential information concerning participants, whenever possible, so that they are not individually identifiable to others and so that discussions do not cause harm to identifiable participants.

(d) When behavior analysts provide public statements, advice, or comments by means of public lectures, demonstrations, radio or television programs, electronic media, articles, mailed material, or other media, they take reasonable precautions to ensure that (1) the statements are based on appropriate behavior-analytic literature and practice, (2) the statements are otherwise consistent with this Code, and (3) the advice or comment does not create an agreement for service with the recipient.

8.05 Testimonials and Advertising. RBT

Behavior analysts do not solicit or use testimonials about behavior-analytic services from current clients for publication on their webpages or in any other electronic or print material. Testimonials from former clients must identify whether they were solicited or unsolicited, include an accurate statement of the relationship between the behavior analyst and the author of the testimonial, and comply with all applicable laws about claims made in the testimonial.

Behavior analysts may advertise by describing the kinds and types of evidence-based services they provide, the qualifications of their staff, and objective outcome data they have accrued or published, in accordance with applicable laws.

8.06 In-Person Solicitation. RBT

Behavior analysts do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential users of services who, because of their particular circumstances, are vulnerable to undue influence. Organizational behavior management or performance management services may be marketed to corporate entities regardless of their projected financial position.

9.0 Behavior Analysts and Research.

Behavior analysts design, conduct, and report research in accordance with recognized standards of scientific competence and ethical research.

9.01 Conforming with Laws and Regulations. RBT

Behavior analysts plan and conduct research in a manner consistent with all applicable laws and regulations, as well as professional standards governing the conduct of research. Behavior analysts also comply with other applicable laws and regulations relating to mandated-reporting requirements.

9.02 Characteristics of Responsible Research.

(a) Behavior analysts conduct research only after approval by an independent, formal research review board.
(b) Behavior analysts conducting applied research conjointly with provision of clinical or human services must comply with requirements for both intervention and research involvement by client-participants. When research and clinical needs conflict, behavior analysts prioritize the welfare of the client.
(c) Behavior analysts conduct research competently and with due concern for the dignity and welfare of the participants.
(d) Behavior analysts plan their research so as to minimize the possibility that results will be misleading.
(e) Researchers and assistants are permitted to perform only those tasks for which they are appropriately trained and prepared. Behavior analysts are responsible for the ethical conduct of research conducted by assistants or by others under their supervision or oversight.
(f) If an ethical issue is unclear, behavior analysts seek to resolve the issue through consultation with independent, formal research review boards, peer consultations, or other proper mechanisms.
(g) Behavior analysts only conduct research independently after they have successfully conducted research under a supervisor in a defined relationship (e.g., thesis, dissertation, specific research project).
(h) Behavior analysts conducting research take necessary steps to maximize benefit and minimize risk to their clients, supervisees, research participants, students, and others with whom they work.
(i) Behavior analysts minimize the effect of personal, financial, social, organizational, or political factors

that might lead to misuse of their research.
(j) If behavior analysts learn of misuse or misrepresentation of their individual work products, they take appropriate steps to correct the misuse or misrepresentation.
(k) Behavior analysts avoid conflicts of interest when conducting research.
(l) Behavior analysts minimize interference with the participants or environment in which research is conducted.

9.03 Informed Consent.

Behavior analysts inform participants or their guardian or surrogate in understandable language about the nature of the research; that they are free to participate, to decline to participate, or to withdraw from the research at any time without penalty; about significant factors that may influence their willingness to participate; and answer any other questions participants may have about the research.

9.04 Using Confidential Information for Didactic or Instructive Purposes.

(a) Behavior analysts do not disclose personally identifiable information concerning their individual or organizational clients, research participants, or other recipients of their services that they obtained during the course of their work, unless the person or organization has consented in writing or unless there is other legal authorization for doing so.
(b) Behavior analysts disguise confidential information concerning participants, whenever possible, so that they are not individually identifiable to others and so that discussions do not cause harm to identifiable participants.

9.05 Debriefing.

Behavior analysts inform the participant that debriefing will occur at the conclusion of the participant's involvement in the research.

9.06 Grant and Journal Reviews.

Behavior analysts who serve on grant review panels or as manuscript reviewers avoid conducting any research described in grant proposals or manuscripts that they reviewed, except as replications fully crediting the prior researchers.

9.07 Plagiarism.

(a) Behavior analysts fully cite the work of others where appropriate.
(b) Behavior analysts do not present portions or elements of another's work or data as their own.

9.08 Acknowledging Contributions.

Behavior analysts acknowledge the contributions of others to research by including them as co-authors or footnoting their contributions. Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Minor contributions to the research or to the writing for publications are appropriately acknowledged, such as, in a footnote or introductory statement.

9.09 Accuracy and Use of Data. RBT

(a) Behavior analysts do not fabricate data or falsify results in their publications. If behavior analysts discover errors in their published data, they take steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.
(b) Behavior analysts do not omit findings that might alter interpretations of their work.
(c) Behavior analysts do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.
(d) After research results are published, behavior analysts do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release.

10.0 Behavior Analysts' Ethical Responsibility to the BACB.

Behavior analysts must adhere to this Code and all rules and standards of the BACB.

10.01 Truthful and Accurate Information Provided to the BACB. RBT

(a) Behavior analysts only provide truthful and accurate information in applications and documentation submitted to the BACB.
(b) Behavior analysts ensure that inaccurate information submitted to the BACB is immediately corrected.

10.02 Timely Responding, Reporting, and Updating of Information Provided to the BACB. RBT

Behavior analysts must comply with all BACB deadlines including, but not limited to, ensuring that the BACB is notified within thirty (30) days of the date of any of the following grounds for sanctioning status:
(a) A violation of this Code, or disciplinary investigation, action or sanction, filing of charges, conviction or plea of guilty or nolo contendre by a governmental agency, health care organization, third-party payer or educational institution. Procedural note: Behavior analysts convicted of a felony directly related to behavior analysis practice and/or public health and safety shall be ineligible to apply

for BACB registration, certification, or recertification for a period of three (3) years from the exhaustion of appeals, completion of parole or probation, or final release from confinement (if any), whichever is later; *(See also, 1.04d Integrity)*

(b) Any public health- and safety-related fines or tickets where the behavior analyst is named on the ticket;

(c) A physical or mental condition that would impair the behavior analysts' ability to competently practice; and

(d) A change of name, address or email contact.

10.03 Confidentiality and BACB Intellectual Property. RBT

Behavior analysts do not infringe on the BACB's intellectual property rights, including, but not limited to the BACB's rights to the following:

(a) BACB logo, ACS logo, ACE logo, certificates, credentials and designations, including, but not limited to, trademarks, service marks, registration marks and certification marks owned and claimed by the BACB (this includes confusingly similar marks intended to convey BACB affiliation, certification or registration, or misrepresentation of an educational ABA certificate status as constituting national certification);

(b) BACB copyrights to original and derivative works, including, but not limited to, BACB copyrights to standards, procedures, guidelines, codes, job task analysis, Workgroup reports, surveys; and

(c) BACB copyrights to all BACB-developed examination questions, item banks, examination specifications, examination forms and examination scoring sheets, which are secure trade secrets of the BACB. Behavior analysts are expressly prohibited from disclosing the content of any BACB examination materials, regardless of how that content became known to them. Behavior analysts report suspected or known infringements and/or unauthorized access to examination content and/or any other violation of BACB intellectual property rights immediately to the BACB. Efforts for informal resolution (identified in Section 7.02 c) are waived due to the immediate reporting requirement of this Section.

10.04 Examination Honesty and Irregularities. RBT

Behavior analysts adhere to all rules of the BACB, including the rules and procedures required by BACB approved testing centers and examination administrators and proctors. Behavior analysts must immediately report suspected cheaters and any other irregularities relating to the BACB examination administrations to the BACB. Examination irregularities include, but are not limited to, unauthorized access to BACB examinations or answer sheets, copying answers, permitting another to copy answers, disrupting the conduct of an examination, falsifying information, education or credentials, and providing and/or receiving unauthorized or illegal advice about or access to BACB examination content before, during, or following the examination. This prohibition includes, but is not limited to, use of or participation in any "exam dump" preparation site or blog that provides unauthorized

access to BACB examination questions. If, at any time, it is discovered that an applicant or certificant has participated in or utilized an exam dump organization, immediate action may be taken to withdraw eligibility, cancel examination scores, or otherwise revoke certification gained through use of inappropriately obtained examination content.

10.05 Compliance with BACB Supervision and Coursework Standards. RBT

Behavior analysts ensure that coursework (including continuing education events), supervised experience, RBT training and assessment, and BCaBA supervision are conducted in accordance with the BACB's standards if these activities are intended to comply with BACB standards *(See also, 5.0 Behavior Analysts as Supervisors)*

10.06 Being Familiar with This Code.

Behavior analysts have an obligation to be familiar with this Code, other applicable ethics codes, including, but not limited to, licensure requirements for ethical conduct, and their application to behavior analysts' work. Lack of awareness or misunderstanding of a conduct standard is not itself a defense to a charge of unethical conduct.

10.07 Discouraging Misrepresentation by Non-Certified Individuals. RBT

Behavior analysts report non-certified (and, if applicable, non-registered) practitioners to the appropriate state licensing board and to the BACB if the practitioners are misrepresenting BACB certification or registration status.

Glossary

Behavior Analyst

Behavior analyst refers to an individual who holds the BCBA or BCaBA credential, an individual authorized by the BACB to provide supervision, or a coordinator of a BACB Approved Course Sequences. Where Code elements are deemed relevant to the practice of an RBT, the term "behavior analyst" includes the behavior technician.

Behavior-Analytic Services

Behavior-analytic services are those that are explicitly based on principles and procedures of behavior analysis (i.e., the science of behavior) and are designed to change behavior in socially important ways. These services include, but are not limited to, treatment, assessment, training, consultation, managing and supervising others, teaching, and delivering continuing education.

Behavior-Change Program

The behavior-change program is a formal, written document that describes in technological detail every assessment and treatment task necessary to achieve stated goals.

Client

The term client refers to any recipient or beneficiary of the professional services provided by a behavior analyst. The term includes, but is not limited to:

(a) The direct recipient of services;
(b) The parent, relative, legal representative or legal guardian of the recipient of services;
(c) The employer, agency representative, institutional representative, or third-party contractor for services of the behavior analyst; and/or
(d) Any other individual or entity that is a known beneficiary of services or who would normally be construed as a "client" or "client-surrogate".

For purposes of this definition, the term client does not include third-party insurers or payers, unless the behavior analyst is hired directly under contract with the third-party insurer or payer.

Functional Assessment

Functional assessment, also known as functional behavior assessment, refers to a category of procedures used to formally assess the possible environmental causes of problem behavior. These procedures include informant assessments (e.g., interviews, rating scales), direct observation in the natural environment (e.g., ABC assessment), and experimental functional analysis.

Multiple Relationships

A multiple relationship is one in which a behavior analyst is in both a behavior-analytic role and a non-behavior-analytic role simultaneously with a client or someone closely associated with or related to the client.

Public Statements

Public statements include, but are not limited to, paid or unpaid advertising, brochures, printed matter, directory listings, personal resumes or curriculum vitae, interviews or comments for use in media, statements in legal proceedings, lectures and public presentations, social media, and published materials.

Research

Any data-based activity designed to generate generalizable knowledge for the discipline, often through professional presentations or publications. The use of an experimental design does not by itself constitute research. Professional presentation or publication of already collected data are exempt from elements in section 9.0 (Behavior Analysts and Research) that pertain to prospective research activities (e.g., 9.02a). However, all remaining relevant elements from section 9.0 apply (e.g., 9.01 Conforming with Laws and Regulations; 9.03 Informed Consent relating to use of client data).

Research Review Board

A group of professionals whose stated purpose is to review research proposals to ensure the ethical treatment of human research participants. This board might be an official entity of a government or university (e.g., Institutional Review Board, Human Research Committee), a standing committee within a service agency, or an independent organization created for this purpose.

Rights and Prerogatives of Clients

Rights and prerogatives of clients refers to human rights, legal rights, rights codified within behavior analysis, and organizational and administrative rules and regulations designed to benefit the client.

Risk-Benefit Analysis

A risk-benefit analysis is a deliberate evaluation of the potential risks (e.g., limitations, side effects, costs) and benefits (e.g., treatment outcomes, efficiency, savings) associated with a given intervention. A risk-benefit analysis should conclude with a course of action associated with greater benefits than risks.

Service Record

A client's service record includes, but is not limited to, written behavior-change plans, assessments, graphs, raw data, electronic recordings, progress summaries, and written reports.

Student

A student is an individual who is matriculated at a college/university. This Code applies to the student during formal behavior-analytic instruction.

Supervisee

A supervisee is any individual whose behavior-analytic services are overseen by a behavior analyst within the context of a defined, agreed-upon relationship.

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The Health Insurance Portability and Accountability Act (HIPAA)

Introduction

Case Study 1

Barbara is a 55-year-old woman with chronic depression who has been seeing Dr. Hart in weekly therapy for the past year. Dr. Hart has seen some improvement in Barbara's symptoms, but as much of her depression is related to childhood issues and has been longstanding, Dr. Hart has continued to see Barbara weekly. Barbara's husband has recently changed jobs, and Dr. Hart is now billing her new healthcare plan. Dr. Hart receives an explanation of benefits denying coverage for Barbara's treatment and with the explanation code "preexisting condition." Distraught and unable to pay for services without insurance, Barbara leaves treatment.

Prior to 1996, scenarios such as the one detailed above were all too common. Insurance companies often denied consumers coverage for needed treatment if a mental health or medical condition preceded the coverage date for th insurance plan, or insurance carriers imposed lengthy waiting periods on coverage. The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996 and focused on protecting employees and their families from insurance practices such as these. The initial version of HIPAA focused primarily on health care coverage, specifically ensuring that employees are not in danger of not having coverage if they lose or change their jobs.

In 2003, the Federal government expanded the scope of HIPAA to include Privacy and Security standards. Although maintaining client privacy and confidentiality has always been a hallmark of mental health treatment, HIPAA has resulted in practitioners being held accountable for privacy practices under Federal law. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and addresses the security and privacy of health data. This will mean changes to existing procedures for many mental health providers.

These training materials will focus on HIPAA and the implications for mental health practitioners. Additional resources are provided in at the end of the training material.

Objectives:

After finishing this course, the participant will be able to:

- Define HIPAA and list its components
- Discuss portability of health plans
- Define Protected Health Information (PHI)
- Discuss incidental uses of health information and reasonable safeguards

- Discuss changes to the informed consent procedure, including the Notice of Privacy Practices
- Distinguish between psychotherapy notes and the clinical record
- Describe patient access to information
- Discuss HIPAA implications for forensic services
- Describe the HIPAA Security Rule

Components of HIPAA

Although many mental health providers have heard the term “HIPAA” they are uncertain what HIPAA actually entails or whether HIPAA rules apply to them. HIPAA is the acronym for the Health Insurance Portability and Accountability Act. HIPAA has several components:

Portability standards that ensure the continuity of healthcare
Privacy standards that govern the disclosure of protected health information
Security standards that protect the development and maintenance of health information

Health Care Portability

As initially enacted in 1996, HIPAA was devised to ensure portability of employee health coverage. HIPAA:

Limits the ability of a new employer plan to exclude coverage for preexisting conditions
Provides individuals with the opportunity to enroll in a group health plan if they lose other coverage or experience certain life events
Prohibits discrimination against employees and their dependent family members based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information

One of the most important protections under HIPAA is that it helps those with preexisting conditions get health coverage. Previously some group health plans limited or denied, coverage if a new employee had such a condition before enrolling in the plan. Under HIPAA such denials are not allowed. If a plan generally provides coverage but denies benefits to an individual because they had a condition before coverage began, this is a HIPAA violation.

Under HIPAA, a plan is allowed to look back only 6 months for a condition that was present before the start of coverage in a group health plan. The law says that a preexisting condition exclusion can be imposed on a condition only if medical advice, diagnosis, care, or treatment was recommended or received during the 6 months prior to that individual’s enrollment date in the plan. Take, for example, if a person that was diagnosed in the past with anxiety but did not receive treatment for the anxiety in the 6 months before they

enrolled in the plan. Because there had been no treatment, the anxiety cannot be subject to a preexisting condition exclusion.

HIPAA limits the preexisting condition exclusion period for most people to 12 months, although some plans may have a shorter time period or none at all. In addition, many plans allow people who have had prior health coverage to reduce the exclusion period even further. This is called a "creditable coverage" provision. Despite the fancy moniker, this simply means that a person was enrolled in another health plan prior to becoming enrolled in the new plan. Most health coverage can be used to establish creditable coverage, including participation in a group health plan, COBRA continuation coverage, Medicare and Medicaid, as well as coverage through an individual health insurance policy. It is advisable that individuals try to avoid a significant break in coverage (63 days) if they want to be able to count their previous coverage. Most of the time employers will provide an individual with a certificate of credible coverage after termination of employment or individuals can request this should the new plan deny coverage based on a preexisting condition clause.

Case Study 1 (continued)

Dr. Hart, concerned by Barbara's abrupt termination of treatment further researches HIPAA guidelines. He asks Barbara's husband to request a certificate of coverage from his previous employer, and Barbara's husband submits this to the new health care plan. This allows Barbara's previous claims to be covered and she resumes treatment.

Protected Health Information

Prior to looking at the HIPAA privacy and security standards it is important to define the term **protected health information** (PHI). Protected health information is any information about health status, provision of health care, or payment for health care that can be connected to a person. This broadly includes any part of a client's medical record or payment history. HIPAA standards apply only to PHI.

According to the 1996 HIPAA guidelines, protected health information includes:

Any information about a person's past, present or future mental health status
Names
All client address information other than their state of residence
Dates (except year) related to an individual, including birth date, admission date, discharge date
Client phone or fax numbers
E-mail address
Social Security numbers
Client photographs

HIPAA Privacy Standards

A key component of HIPAA is the Privacy Rule. The HIPAA Privacy Rule creates national standards to protect individuals' medical records and other personal health information.

It sets boundaries on the use and release of health records.

It enables clients to find out how information may be used, and about certain disclosures of their information that have been made.

It gives patients the right to examine and obtain a copy of their health records and to request corrections if data is incorrect.

It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.

It enforces civil and criminal penalties if there is a violation of clients' privacy rights

Although this may sound daunting, it actuality the requirements for most mental health providers are fairly straightforward. The Privacy Rule requires activities, such as:

Notifying clients about their privacy rights and how their information can be used. Providers are required to notify cliens about Privacy Practices during their first session (notice of privacy practices)

Adopting and implementing privacy procedures

Training any employees that work for them (such as billing specialists and administrative personnel) so that they understand the privacy procedures.

Designating an individual to be responsible for seeing that the privacy procedures are followed

Securing client records containing individually identifiable health information so that they are not readily available to those who do not need them

Who is a "Covered Entity"?

If you are an individual mental health provider or work for a hospital, health plan or health care clearinghouse that transmits information electronically you are affected by HIPAA. HIPAA provisions call these individuals or institutions "covered entities."

The term "covered entity," includes any mental health provider who submits billing information to managed care companies or other third parties. Currently HIPAA does not apply to providers who bill clients directly, receive out-of-pocket payments, or ask clients to submit reimbursement requests to third parties on their own. Please note that if there is

even a single electronic transmission to an insurance carrier or other third party, the HIPAA requirement states that you must immediately become compliant with all guidelines. Those providers who do bill insurance companies may have noted that there has been a trend away from paper submission of billing information. It is important, then, that all mental health professionals be familiar with HIPAA and, if indicated, take steps to become compliant with the guidelines.

Since the Privacy Rule became effective in 2003, many mental health professionals have integrated these regulatory requirements into their existing procedures. These regulations may change procedures related to informed consent, therapy notes, forensics, and psychological testing. Each of these areas will be considered later in this training module.

Case Study 2

Dr. Carter is a psychologist who runs a practice in which clients pay directly for psychotherapy and testing services. He routinely provides clients with receipts and many of them submit their expenses to insurance companies. Many of his clients have mentioned that they then submit requests for reimbursement online. Dr. Carter wonders whether he needs to conform with HIPAA guidelines.

At the present time, Dr. Carter is not considered a “covered entity” under HIPAA guidelines and does not need to change his already ethical practices for ensuring confidentiality and security of records. This may change in the future should the definition of who is affected by HIPAA broaden, or if Dr. Carter changes his billing practices to include any electronic transmission of information. In that case, HIPAA guidelines require immediate compliance with all privacy and security standards.

Incidental Uses of Health Information

Many practices play an important role in ensuring that clients receive effective mental health care, and the goal of HIPAA is not to hamper the providers ability to communicate with clients, to engage in treatment planning or to coordinate care with other professionals. HIPAA policies recognize that there may be instances in which protected health information may be disclosed inadvertently. This is called “incidental disclosure” of protected health information. Many health care providers, for example, have been in a position in which someone other than the client has overheard portions of a provider’s conversation with a client. There may also be the need to share some aspect of a client’s information with someone not directly involved in the patient’s clinical care, such as the fact that a person doing the provider’s billing will need access to a diagnostic code. The Privacy Rule permits these incidental disclosures of health information when the provider takes reasonable safeguards to protect an individual's privacy. Examples of reasonable safeguards include:

Speaking quietly when discussing a client’s condition with family members

in a public area;

Avoiding using clients' names in public hallways and elevators

Using passwords on computer files containing personal information.

Case Study 3

Jane is the director of a Partial Hospital Program. The program is based in a hospital that submits information electronically, thus falling under HIPAA provisions. In the PHP, clients are assigned to various therapy groups, including drug and alcohol-specific programming. Jane places a whiteboard with clients' names at the front of the main therapy room, and color-codes the groups a client is to participate in. Is this a HIPAA violation? If so, how can Jane change this procedure?

This example is a good one to look at the ambiguities that may be evident in applying HIPAA guidelines. Although the whiteboard displaying information may be considered an "incidental disclosure," the key question to answer here is whether the PHP has taken adequate precautions to safeguard the client's confidentiality. In this situation, other clients are privy to who is struggling with addiction issues. In this situation, minimal changes in procedure, such as handing each client a sheet specifying the groups that they should attend, could serve as a safeguard.

The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information.

It is also important to note that HIPAA does not restrict providers from communicating with one another. For example, a psychologist or social worker can discuss information with a client's psychiatrist or with other members of a client's treatment team. In fact, disclosures for treatment are explicitly exempted from the minimum necessary requirements. Uses of protected health information for treatment are not exempt from the minimum necessary standards, however. The Privacy Rule does provide substantial discretion with respect to how providers implement the minimum necessary standards.

Notice of Privacy Practices

One change that has occurred as a result of HIPAA is the need for individual providers and hospitals that are covered under HIPAA to provide clients with a Notice of Privacy Practices. This document details client rights involving release of information. The Notice of Privacy Practices should be incorporated into the informed consent process, and the provider must obtain a signature showing that the Privacy Notice was received. If for any reason a client refuses to sign the Privacy Notice, a note indicating that the form was offered and that the client refused to sign is sufficient. If the client is a minor, the parent is required to sign the notice of Privacy Practices.

An issue that complicates providing a Notice of Privacy Practices as well as other

HIPAA policies involves the interaction between state law and HIPAA. In general, HIPAA **preempts** state law that is "contrary" to the federal rule. A provision of state law is contrary to HIPAA if:

the provider would find it impossible to comply with both the state and federal law provisions

the provision of state law would be an obstacle to the accomplishment and execution of the goals of HIPAA

Many providers, then, ask the question "Can I comply with both state law and HIPAA?" The answer is generally that they can. It is helpful to look at which presents a stronger standard: state law or HIPAA. For example, if state law gives a provider 10 days to respond to a patient's request for a copy of his medical records, and HIPAA allows 30 days, you can comply with both state and federal law by responding within 10 days.

As evident from the above discussion, the content of the Privacy Practices notice will vary. In general, this document details routine uses and disclosures of protected health information as well as an individual's rights and the provider or hospital's duties with respect to protected health information. The discussion below will describe some issues common to mental health care. It is not intended to provide an exhaustive list of what can be included but some general guidelines.

Treatment Issues: Many mental health providers disclose PHI to provide, coordinate, or manage health care and any related services. This includes the coordination or management of PHI with a third party. For example, PHI may be provided to a health provider to whom a client has been referred to ensure that the provider has the necessary PHI to diagnose or treat them. Clients must be made aware that such disclosures will occur.

Payment: PHI is often used to obtain payment for mental health services. This may include speaking to representatives of health insurance plans before it approves or pays for the health care services. Depending on the client's level of care, more or less PHI may be provided for coverage decisions. Routine requests by insurance companies include information about diagnosis, dates of service, and type of service provided (e.g., individual or family therapy.)

Exceptions to Confidentiality: This is both and ethical and HIPAA mandate. The Notice of Privacy Practices should include information about instances when providers may need to disclose protected health information and do not specifically need to inform clients about these. These vary by state law but may include disclosing PHI when there is a threat to self or others or when the professional is ordered to do so by law.

Sensitive Health Information: This mandate involves how details about psychological information is disseminated, such as removing patient

identifiers when able to do so, as well as treatment of particularly sensitive information such as HIV/AIDS information, disability status, alcohol and drug information. The Notice of Privacy Practices must detail steps that are taken to protect this information

Right of Access: The Notice of Privacy Practices should also describe how patient access to medical records. The following section on psychotherapy notes will provide additional information on what is considered a medical record. It is important to know state laws with regard to access (these can sometimes be more inclusive than HIPAA guidelines). Providers should include a statement indicating “ownership” of medical records. Clients should be informed of their right to access their medical record and to amend or correct errors in medical records.

The primary criticism of the Privacy Practices is the sheer amount of information that is covered in these documents. Many clients do not read these documents and a verbal explanation of confidentiality continues to be helpful. There are many excellent examples of Privacy Practices Notices available online and through the APA Practice Organization.

Patient Access to Records

The HIPAA Privacy Rules allow clients to view their medical records. Previously access was dependent on state laws, however, HIPAA sets Federal standards for such access. HIPAA allows clients to view copies of records only and does not require that practitioners provide clients with the original chart. It does not require that a practitioner be given written notice of the request for medical records, but providers can establish such standards if the client is apprised of this in the Notice of Privacy Practices.

The Privacy Rules recognize that there are situations in which access to records would be contraindicated. An individual’s request to access PHI can be denied for the following reasons:

If access is reasonably likely to endanger the life or physical safety of the individual or another person

The PHI refers to another person (except for a health care provider) and access is reasonably likely to cause substantial harm to that person; or

If PHI is created during research, the access to PHI may be temporarily suspended if the individual is notified in advance

If the PHI was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would reveal the source of the information

As will be described in the following section, the Privacy Rule does not require that clients have access to psychotherapy notes. Although rules about access to psychotherapy notes do vary from state to state, in general it is assumed that such notes belong to the provider, and that a provider may restrict access to them. Some states may require that a summary of such notes be provided if clients request them. It is always advisable to know the rules of the particular state in which you practice.

Under the HIPAA privacy regulation, providers are faced with deadlines for responding to requests for medical records, and the regulation establishes a procedure for reviewing denials of these requests. Providers are allowed to charge reasonable fees for copying and postage. The practitioner has 30 days to reply to the request. HIPAA does not include a record retention period. It does specify, however, that clients can request an accounting or report of who has accessed their records for six years prior to the date of the request.

The HIPAA guidelines generally apply to requests that originate from the client. Clients may designate a friend or relative to receive information related to care and treatment. Permission should be given in writing and filed with the care provider or facility. This is important in the case of elderly or impaired clients.

HIPAA provides parents with the right to access their minor child's medical records. There are some exceptions to allowing access:

> When the minor is the one who consents to care and the consent of the parent is not required under State or other applicable law.
>
> When the minor obtains care at the direction of a court or a person appointed by the court.
>
> When, and to the extent that, the parent agrees that the minor and the health care provider may have a confidential relationship.

HIPAA also allows clients to amend information in medical records that they consider inaccurate. Clients must detail any amendment in writing. Providers do have the right to refuse changes to the medical records, but must respond within 60 days verifying the correction or disputing the information. Clients can ask to have it noted in their chart that there is a disagreement on information.

Although this training material is primarily concerned with HIPAA mandates it is also important to consider the clinical implications of a client viewing his or her medical record. A recent review article published in the Journal of the American Medical Association found that there were no adverse consequences associated with allowing patients to review records in medical settings, however, there were more risks for psychiatric patients. In one case series, for instance, a psychotic patient's paranoia was further entrenched when a minor piece of information, which she regarded as vital to proving her sanity was missing from the record. In a study of psychiatric inpatients, a substantial minority (32%) felt more pessimistic after reading their records. From 12% to 50% of psychiatric patients report becoming upset when they read their medical records (see Ross, MD & Chen-Tan Lin,

2003). In situations in which a practitioner is concerned about client requests to access medical records, it is important for the provider to discuss his or her concerns with the client in advance, and to limit access should the provider determine that this would cause substantial harm. More suggestions will be provided in the section on therapy notes versus the clinical record.

Case Study 4

Lena, a clinical social worker in a hospital setting received a phone call from a former patient of the hospital requesting his records. The patient had previously been treated for bipolar disorder, and made allegations during the course of the conversation that lead Lena to suspect that he was in an active manic state. Concerned about HIPAA regulations with regard to patient access, Lena discussed the case with her supervisor, and together they called to patient to inform him such access would not be possible. They followed up on this conversation with a letter.

Therapy Notes vs. The Clinical Record

A concern that is commonly expressed by mental health professionals is how HIPAA guidelines affect access to psychotherapy notes. It is important for providers to be familiar with state rules governing access to psychotherapy notes. Under HIPAA, psychotherapy notes are defined as "notes recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a private counseling session." The Privacy Standards provide particular protection for psychotherapy notes by enabling some types of information in mental health notes to remain confidential, notably the content and process of a therapy session, as well as the provider's impressions about the client or session. Many providers refer to such notes as process notes.

In addition to providing protections on access to psychotherapy notes, HIPAA specifically states that insurance companies may not predicate coverage on the review of therapy notes. Thus, health plans cannot refuse to provide reimbursement if a patient does not agree to release information covered under the psychotherapy notes provision.

There is another caveat to the psychotherapy notes provision. The HIPAA definition of psychotherapy notes specifically states that such notes must be kept separate from the rest of an individual's record. If the provider keeps therapy notes in a patient's general chart, or if it's not distinguishable as separate from the rest of the record, access to the information doesn't receive specific protections. Many providers have chosen to keep a separate set of more general notes as a "clinical record."

An important question to consider, then, is what to keep in the clinical record versus the psychotherapy notes. A good rule of thumb is that the clinical record must contain information to meet minimum documentation guidelines. The HIPAA guidelines specifically list the following as being separate from psychotherapy notes:

modalities and frequencies of treatment furnished
dates of treatment
results of clinical tests
treatment plan
symptoms
prognosis
progress to date

Case Study 5

Robert is a psychologist in private practice. He is working with Mark, a gay male, who is HIV positive. Knowing that this information is sensitive, Robert chooses to keep written documentation related to the HIV diagnosis only in his psychotherapy notes on the patient, rather than in the general medical record he keeps for broader use. When Mark discovered this, he was relieved that this information could not find its way to third parties such as his employer.

Forensic Services

Although HIPAA has caused some confusion among mental health providers that provide forensic services it has not generally had a great impact on forensic services. To understand why that is, it is important to think back to the definition of protected health information discussed previously in these training materials: any information about health status, provision of health care, or payment for health care that can be connected to a person." Forensic services are intended to serve a legal purpose, and are not related to an individual's treatment. Such services are generally unable to be submitted to third party health insurers for payment. In addition, although clients are able to access and amend their medical records, HIPAA specifically exempts "information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding" from client review. This information would continue to be subject to state laws concerning access to forensic information. Providers who engage in both clinical and forensic activities must comply with HIPAA in non-forensic areas of practice.

Although forensic services do not generally fall under HIPAA guidelines, it is still necessary to have clients sign an informed consent agreement.

HIPAA Security Standards

The final HIPAA practicality for mental health practitioners concerns the HIPAA Security Rule. This rule establishes standards to help keep client information safe and to protect information from unintended disclosure. For example, in some larger group practices with administrative personnel, computer monitors containing confidential client information may be visible to others. The HIPAA Security Rule requires mental health

providers to anticipate threats to, or inappropriate uses of, confidential information.

Unlike the Privacy Rule, which applies to all protected health information the Security Rule applies only to “electronic protected health information” or EPHI. EPHI is protected health information that is transmitted or maintained in electronic form rather and does not include hand-written or orally transmitted information. Examples of EPHI include:

Health care claims
Health care payment and remittance advice
Electronic requests for coordination of benefits
Electronic treatment request forms

The Security Rule discusses administrative, physical, and technological safeguards. These include access to offices, computers and files needed to keep electronic health care information confidential and secure. Thus it looks at a practitioner or facility’s administrative procedures, the way that data on computers is secured and identified, and how information is transmitted.

The first step in the compliance process involves the provider doing a “risk analysis” of his or her practice. This analysis is a thorough assessment of the potential security risks and vulnerabilities related to EPHI. The analysis entails reviewing established security procedures, and it provides the basis for making appropriate modifications to these procedures. Many of the changes that a provider may need to make may be simple ones, such as ensuring that rooms in which computers are placed are locked when not in use, making certain that computer files contain passwords known only to those who need to access data. The Security Rules take into account the concept of scalability.” This means that a solo practitioner will not be expected to take the same steps to comply as will a large practice or a health care facility.

Case Study 6

Dr. Robb, a psychologist in private practice has just become familiar with the HIPAA Security Rules. He does a risk analysis and takes steps to make changes to administrative procedures. In completing his risk analysis, Dr. Robb notes that his assistant will often take files home to work on billing and will submit payment requests on her home computer. As Dr. Robb cannot ensure the security of offsite transmissions, Dr. Robb asks his assistant to only work on client information and needs in the office.

Summary

HIPAA has changed the way that many mental health providers approach a client’s confidential health information. Although confidentiality has always been essential in the practice on mental health, the Federal guidelines increase accountability to ensure such privacy. It is important for practitioners to note:

HIPAA standards apply to protected health information: “information

about health status, provision of health care, or payment for health care that can be connected to a person." This broadly includes any part of a client's medical record or payment history.

HIPAA sets boundaries on the use and release of health records.

HIPAA patients the right to examine and obtain a copy of their own health records and request corrections.

It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.

Providers must notify clients about their privacy rights and how their information can be used.

Mental health practitioners must adopt and implement privacy procedures

Resources

APA Online. Patient Protections: The Core of the Privacy Rule.
http://www.apa.org/practice/pf/winter02/core_of_rule.html

Connell, M. & Koocher, G.P. HIPAA & Forensic Practice
http://www.kspope.com/ethics/hipaa.php

Daw Holloway, J. (Feb. 2003). More protections for patients and psychologists under HIPAA. http://www.apa.org/monitor/feb03/hipaa.html

Daw Holloway, J. (Feb. 2003). What takes precedence: HIPAA or state law?
http://www.apa.org/monitor/jan03/hipaa.html

HIPAA for Psychologists - Questions and Answers
http://www.apait.org/apait/resources/hipaa/faq.aspx

U.S. Department of Health & Human Services
HIPAA
http://www.hhs.gov/ocr/privacy/index.html

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

Stephen E. Ross, MD and Chen-Tan Lin, MD (2003). The Effects of Promoting Patient Access to Medical Records: A Review. J Am Med Inform Assoc. 2003 Mar–Apr; 10(2): 129–138.

CONFIDENTIALITY PROTOCOL

Confidential Patient/Client/Child Information (PII) includes:

☑ Anything that has the patient's name on it:

1. Child's or parent's names
2. Parent's signature
3. Child's birthday and/or address
4. Child's clinical or diagnosis information
5. Child's data collect with his/her name or parent's names

Patient Identification Information or (PII) should always remain with you when you do home sessions or travel with you to other sessions.

☑ Do not leave documents with PII on them in your car.

1. You must take all PII documents with you in a closed, zipped, non-see-through bag to all the sessions you see that day.
2. Don't leave your bags with PII on it in your car. It must stay with you. You can leave it at your house…but not in the car because someone could break into your car.

Don't use the child's/parent's name around others. They should not know who you are talking about.

☑ Keep voices down when talking about cases with others in public.

☑ Return PII documents to office as soon as possible to prevent others from seeing or it getting lost.

☑ Send all electronic documents with PII on them to our secure Encrypted email account.

Mandatory Reporting

RBT Task List Requirements:

E-04 Comply with applicable legal, regulatory and workplace reporting requirements (e.g., mandatory abuse and neglect reporting)

Introduction

An estimated 896,000 children across the country were victims of abuse or neglect in 2002 (U.S. Department of Health and Human Services 2004). That is almost 1 in every 100 Americans. These numbers imply that most mental health professionals have seen several abused children throughout the course of their practice. Psychologists, counselors and social workers are in unique positions to observe and interact with children and elders. They are often pivotal in noticing changes in clients that may indicate abuse or neglect. A client may also disclose such abuse.

Professionals working with children under the age of 18 are considered mandated reporters. Simply put, being a mandated reporter means that an individual is *required* to report suspected cases of abuse to their local Child Protective Services (CPS) agency. All states have passed some form of mandatory child abuse and neglect reporting law in order to qualify for funding under the Child Abuse Prevention and Treatment Act (CAPTA). In addition to child abuse reporting laws, many states also have laws pertaining to mandatory reporting of elder abuse. The laws apply to mental health providers working in private practice and institutional settings.

Mandated reporters make more than half of the reports that CPS receives in a given year. In 2005, school-related reporters made about 15% of reports to CPS (the largest single source of non-law enforcement related reports). Social services workers, including social workers, psychologists and other mental health professionals followed closely behind, making 10% of all such reports (US Department of Health and Human Services, 2005).

While it is clear that child abuse cases are identified in large part due to mandated reporting laws, the mandated reporting system does have a number of criticisms. The primary criticisms are underreporting, overreporting, discrimination and violation of confidentiality.

Many mental health professionals vary in their understanding and opinions of mandated reporting laws. Research is unclear, with some studies identifying a tendency to underreport, and other studies showing a tendency to overreport. For example, Kalichman and Brosig (1993) found a tendency to err on the side of overreporting as did Renninger et al. (2002). Renninger et al. (2002) conducted a

survey of licensed psychologists. Although they had knowledge of reporting laws, their performance on a knowledge measure suggested information deficits and a tendency to overreport suspected abuse. Legal considerations were the strongest factor that encouraged reporting. Opinions of the mandatory reporting laws were generally favorable, with some concerns about child protection systems and the impact of reporting on the therapeutic alliance. Other researchers have found that mandated reporters underreport suspected child abuse. Delaronde, King, Bendel & Reece (2000), for example, administered a self-report questionnaire to 382 social workers, pediatricians, and physician assistants in Connecticut and Massachusetts. Their findings showed that more than half of these clinicians failed to report cases of suspected abuse and maltreatment. There are consequences to both the overreporting and underreporting of abuse.

In addition to concerns with overreporting and underreporting, mandated reporters often lack certainty of when to report suspected maltreatment. While they can certainly identify overt abuse, such as physical or sexual abuse, other forms of abuse are harder to identify. Neglect, for instance, is often harder to identify and more complex (Alvarez, Kenny, Donohue & Carpin, 2004).

Another concern with mandated reporting laws involves concerns about reporting and discrimination. The question here concerns whether race is a risk factor for certain types of abuse. The US Department of Health and Human Services releases incidence studies of child maltreatment. Prior to the fourth national incidence study (2010), researchers found that child maltreatment did not discriminate by race; the 2010 report, however, found race differences in maltreatment rates, with Black children experiencing maltreatment at higher rates than White children in several categories. While there are several reasons that these results could be the case, such as the disparity in income or socioeconomic status, there may also be a reporting bias (Lau, Krase & Morse, 2009).

Once a mandated reporter files a report of suspected abuse, the family often become eligible to receive a variety of services that will improve the family's ability to care for the child or elder. These services may include parenting classes, counseling, treatment for substance abuse, medical services and anger management classes.

This training will provide an overview of issues related to mandated reporting and support the mental health professional in fulfilling this important role.

Objectives

After finishing this course, the participant will be able to:

- Describe their role as a mandated reporter
- Discuss ethical standards pertaining to confidentiality
- Discuss the concept of a “good faith” report
- Define child abuse including characteristics that may lead the practitioner to believe that a child is being abused
- Discuss making a report
- Describe the stages of the investigatory process

Ethical Standards Pertaining to Confidentiality

Reporting suspected child abuse brings with it some weighty issues. Psychologists, social workers and counselors all have ethical guidelines that highlight as a key standard that of confidentiality. The APA ethical code, for example, states:

> Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship (4.01 Maintaining Confidentiality).

Although the need to maintain client confidentiality is an important standard, no client can be given the guarantee of complete confidentiality. Although child abuse will be defined in more detail in the next section of this text, this is clearly an area in which other ethical standards merit consideration. In discussing this issue Braebeck (as quoted in Ethics Rounds, 2002) states that the principles of nonmaleficence (avoid harm) and beneficence (ensure people's well-being) require that psychologists break confidentiality when a client's actions pose potential harm to self or others that is, that "Psychologists disclose confidential information without the consent...to protect the patient or client or others from harm" (Standard 5.05 [a]). Psychologists must be aware of state mandated limits and inform their clients of the exceptions to confidentiality (Standard 5.02).

Similarly Lau, Krause and Morse (2009) discuss the role of the social worker as a mandated reporter. These authors state that the profession of social work encompasses many different professional roles, and that the primary mission of social work is to “enhance human well-being and help meet the needs of all people who are vulnerable or oppressed.” In this role, social workers assist families where there are serious domestic consequences, which may involve child maltreatment. These authors acknowledge the difficult role of the social worker as a mandated reporter, stating that when making a report of suspected abuse “using their professional judgment, social workers must act by limiting the client’s right to self-determination when client actions or potential actions pose a

serious, foreseeable and imminent risk to themselves or others." (Lau, Krause & Morse, 2009, p. 17).

There has been some discussion as to whether mandated reporting laws hinder confidentiality (Kalichman, 1993, Locke, 1995). For that reason some professionals are reluctant to report suspicions of child abuse. Koocher suggests that when faced with the issue of disclosing suspected abuse, one must be fully aware of the legal requirements but then also consider what the client wants from the therapist. He states: "Most likely, the client wants to process the long-concealed distress and address myriad emotions, including anger, shame, sadness, guilt and a host of other issues commonly experienced by victims of sexual abuse. The client wants and needs to do this in a supportive, safe and reassuring context in order to regain a sense of control and mastery over the frightening events of the past that radiate into her present." Although professionals are mandated to report abuse, the clinical aspects also need careful consideration.

Defining Child Abuse

Child abuse or neglect is defined as "any recent act or failure to act resulting in imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation of a child (usually a person under the age of 18, but a younger age may be specified in cases not involving sexual abuse) by a parent or caretaker who is responsible for the child's welfare" (Smith, 2007). Although child abuse is divided into the categories of physical abuse, neglect, sexual abuse, and emotional abuse, it is important to note that child abuse is more typically found in combination than alone. A physically abused child, for example, is often emotionally abused as well, and a sexually abused child also may be neglected. In many states, the definition of child abuse also includes acts or circumstances that threaten the child with harm or create a substantial risk of harm to the child's health or welfare. For instance, a parent who allows a child to be exposed to a known sex offender (i.e., if this person is the mother's boyfriend), may be seen as liable for child abuse even if the offender does not harm the child.

The National Center on Child Abuse and Neglect defines child physical abuse as: "The physical injury or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened." The parent or caretaker need not have intended to hurt the child for it to constitute physical abuse. Examples of physical abuse include: beating with a belt, shoe, or other object; burning a child with matches or cigarettes; hitting a child; shaking, shoving, or slapping a child. It is sometimes difficult to distinguish physical abuse from corporal punishment. McClennen (2010) suggests that various factors should be taken into account when categorizing whether an act is

abusive including: 1) age of the child; 2) developmental levels of the child; 3) severity of the action; 4) frequency of the action, and 5) the "contextual" (historical or cultural) perspectives of family and community. Another form of child physical abuse is Munchausen syndrome by proxy (MBP). MBP is the intentional simulation of physical illness by a parent in his or her child, usually for the purpose of attention. This may include fabricating symptoms or actually inducing symptoms (such as causing a child to have a fever, feeding the child things he or she should not ingest, etc.)

Child neglect is defined as "failure to provide for the child's basic needs. Neglect can be physical, educational, or emotional. Physical neglect includes refusal of or delay in seeking health care, abandonment, expulsion from the home or refusal to allow a runaway to return home, and inadequate supervision. Educational neglect includes the allowance of chronic truancy, failure to enroll a child of mandatory school age in school, and failure to attend to a special educational need. Emotional neglect includes such actions as marked inattention to the child's needs for affection, refusal of or failure to provide needed psychological care, spouse abuse in the child's presence, and permission of drug or alcohol use by the child. Medical neglect generally encompasses a parent or guardian's denial of or delay in seeking needed healthcare for children. Lack of supervision may also fall under neglect laws. Some states specify the amount of time children of various ages can be left unsupervised or the age at which they can be left alone. The assessment of child neglect requires consideration of cultural values and standards of care as well as recognition that the failure to provide the necessities of life may be related to poverty." (National Center on Child Abuse and Neglect.)

One of the most difficult categories of abuse to prove and quantify is emotional abuse. Most US states and territories have mandates that include emotional abuse. What unifies these definitions is that they have two provisions 1) emotional injury and 2) a change in emotional stability of the child. California, for instance, defines emotional abuse as "an injury to the psychological capacity or emotional stability of a child evidenced by observable or substantial change in behavior, emotional response or cognition." An observable or substantial change in behavior may include anxiety, depression or aggressive behavior. Examples of emotional abuse include making fun of a child, calling a child names, and always finding fault are forms of emotional abuse. Emotional abuse is more than just verbal abuse. It is an attack on a child's emotional and social development, and is a basic threat to healthy human development.

Sexual abuse is defined as employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or any simulation of such conduct for the purpose of producing any visual depiction of such conduct; or rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with

children" (Smith, 1997). All states include sexual abuse in their definitions of child abuse. Some states specify specific acts of abuse. Sexual exploitation is defined as "the use of a child for sexual purposes in exchange for cash or in-kind favors between a customer, intermediary or agent and others who profit from the trade in children for these purposes—parent, family member, procurer, or teacher" (Segen's Medical Dictionary, 2012). Some common examples include allowing a child to engage in prostitution or in child pornography.

Risk Factors for Child Maltreatment

What puts a child at risk for maltreatment? Identification of risk factors is an important question, and invaluable in implementing prevention programs. It is a question that mental health professionals have looked at for some time. Initial schemas of risk used the idea of child vulnerability, and attempted to isolate those child risk factors (Action for Child Protection, 2003). These authors recommended conducting a family safety assessment to determine whether a vulnerable child resides in the household. In a nutshell, vulnerability was equated to a child's ability to defend him or herself. These "child risk factors" are still utilized today (CDC, n.d.) and include:

> Young age (especially infants and young children). This is due to their small physical size, early developmental status, and need for constant care are more likely to experience certain forms of maltreatment, such as shaken baby syndrome and non-organic failure to thrive. There also appears to be a connection between premature//low birth weight and child abuse.
>
> Teenagers, are at greater risk for sexual abuse.
>
> Disabilities – Children with physical, cognitive, and emotional disabilities experience higher rates of maltreatment as do children with chronic illnesses. These children are highly dependent on others to meet their basic needs. They may also be at greater risk be due in part of caretaker demands and bonding or attachment issues. Children with cognitive disabilities may have difficulty recognizing danger, knowing who can be trusted, meeting their basic needs and seeking protection.
>
> "Provocative" Children – A child's emotional, mental health, behavioral problems can be such that they irritate and provoke others to act out toward them or to avoid them. Emotional issues such as attention deficit disorder, disruptive behavior disorders, aggression and difficult temperament have thus been found to be risk factors.

Non-Assertive/Powerless Children – Regardless of age, a child who is so passive or withdrawn not to be able to make his or her basic needs known is vulnerable. A child who cannot or will not seek help and protection from others is vulnerable.

Gender – girls were sexually abused about three times more frequently than boys. Boys were at somewhat greater risk of serous injury (24% higher) and boys significantly more likely to be emotionally neglected.

Looking at these child factors is important, but it is more likely that a combination of factors contribute to the risk of child maltreatment. These include individual, parent/caregiver factors, and family characteristics. Risk factors are those characteristics associated with child maltreatment—they may or may not be direct causes. The following are risk factors for child maltreatment (CDC, n.d.)

Parent/Caregiver Factors:

Personality characteristics – Low self esteem, external locus of control, poor impulse control, depression, anxiety, antisocial behavior

History of abuse or neglect as a child

Substance abuse, leading to parental instability, diversion of money needed for child's care to habit, inability to maintain employment, interference with parent's need to provide care and nurturance

Younger maternal age (may be connected to lower economic status, lack of social support, and high stress levels) as is dependency

Untreated depression

Family Characteristics:

Family structure: Single families - primarily with lower income, families with few social supports, large family or many household members, chaotic homes

Marital conflict and domestic violence

Stress – stressful life events, parenting stress

Parent/Child interaction – lack of parenting skills, harsh discipline, lack of recognition of positive behaviors

Severity of Problems – the severity of a family's problems may

predict outcomes

Environmental Factors (often in combination with parent, family, and child factors)

Unemployment or inability to provide economically
Poverty
Social isolation
Violent communities

Community Factors

Community violence
Neighborhood disadvantage (high poverty/residential instability, high unemployment rates, and high density of alcohol outlets), and poor social connections

Recognizing Signs of Child Abuse

While some communications to mental health providers may be direct, unless there is an obvious reason to doubt the veracity of the client's report, such disclosures should be considered evidence of child abuse. In other cases, signs may not be so obvious. The presence of a single sign does not prove child abuse, but a closer look is warranted when these signs appear repeatedly or in combination.

The Child Welfare Information Gateway (2007) Factsheet: Recognizing Child Abuse and Neglect: Signs and Symptoms, lists the following signs that may signal the presence of child abuse or neglect. The list below has been adapted for use by mental health professionals

Signs of Physical Abuse

The Child	**The Parent**
Has unexplained burns, bites, bruises, broken bones, or black eyes Frequent injuries that are described as “accidental” or “unexplained” Has fading bruises or other marks noticeable after a weekend or absence Has fractured or displaced teeth Human bite marks Seems frightened of parents/protests	Offers conflicting, unconvincing, or no explanation for the child's injury Describes the child as "evil," or in some other very negative way Uses harsh physical discipline with the child Verbalizes unrealistic expectations of child

or cries when it is time to go home Shrinks at the approach of adults Reports injury by adult caregiver	

Signs of Neglect

The Child	The Parent
Persistent diaper rash or failure to thrive Frequently misses appointments Frequently misses school without explanations States there is no one at home to provide care Begs or steals food or money Consistently dirty or severe body odor Frequent absences from school	Appears to be indifferent to child Seems apathetic or depressed Behaves irrationally bizarre manner Is abusing alcohol or other drugs Is chronically ill Has low intellectual functioning

Signs of Sexual Abuse

The Child	The Parent
Reports sexual abuse by a parent or other adult caregiver Has difficulty walking or sitting Torn, stained or bloody underclothing Experiences genital pain or Suddenly refuses to change for gym or to participate in physical activities Reports nightmares or bedwetting Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior or acts out sexually Becomes pregnant or contracts a venereal disease, particularly if under age 14	Is sexual with child Buys the child inappropriate clothing or “gifts” Comments on child’s body in an inappropriate way Is unduly protective of the child or limits child’s contact with other children, especially of the opposite sex Is secretive and isolated Is jealous and controlling with family members

Signs of Emotional Maltreatment

The Child	The Parent
Shows extremes in behavior, such as	Constantly blames, belittles, or

overly compliant or demanding, extreme passivity, aggression Is either inappropriately adult or inappropriately infantile Is delayed in physical or emotional development Lack of attachment to the parent Reacts oddly to persons in authority Is fearful or anxious about doing something wrong or making a mistake Exhibits delayed physical or emotional development; engages in self-soothing behaviors, thumb sucking, rocking, etc., outgrown by peers	berates the child Is unconcerned about the child and refuses to consider offers of help for the child's problems Overtly rejects the child Withholds love

Good Faith Reporting

One common question is how certain about clinicians need to be in order to make a report of abuse. Although this will vary from situation to situation, Pass (2007) provides some guidelines that may be helpful. She states that when the professional observes only behavioral symptoms, it is best to document this and continue to assess the situation; that when the professional observes physical symptoms it is best to consult on the situation and also to speak with a parent or guardian; and that when a combination of physical and behavioral symptoms are seen a report is indicated. On a therapeutic level it is important to consider the potential consequences of reporting, and thoroughly assess the situation. There is no timeframe; a 2-3 week assessment is ok if the child is not in immediate danger. Although the clinician should certainly err in favor of the child's safety it is also important to consider the implications of making a report

Specific reporting guidelines vary in terms of wording, from state to state. For example some statutes call for reporters to have a "reasonable suspicion" of abuse, while others the reporter to "know or suspect."

Professionals who are concerned about their responsibility, whether mandatory or voluntary, to report suspected elder abuse often want to know if they may face civil or criminal liability for making such a report. This is often of particular concern if the report is not substantiated. CAPTA requires states to enact legislation that provides for immunity from prosecution arising out of the reporting abuse or neglect. In most states, a person who reports suspected child abuse in "good faith" is immune from criminal and civil liability. There are similar statutes that cover reporting of suspected elder abuse.

How to Report Suspected Abuse

The procedures for reporting child abuse vary from state to state. All states have a governmental department that investigates suspected child abuse. It is always important for clinicians to be aware of the nuance of state reporting laws, as well as the exact reporting procedures (e.g., phone call, written reports, etc.)

When reporting suspected abuse the provider should be able to provide the following information:

- child's name, age, gender, and address
- parent or guardian's name and address
- nature and extent of the injury or condition observed
- prior injuries and when observed
- actions taken by the reporter (e.g., talking to the child or parent)
- where the act allegedly occurred
- your assessment of current level of safety
- child's siblings and any related safety concerns
- previous situations of Family involvement with the child welfare system
- reporter's name, location, and contact information

Making A Report

One of the reasons that providers sometimes hesitate in making a report is that they are fearful that it will damage their relationship with the family they need to report. While this is sometimes unavoidable, some guidelines that may help include:

Talk to families about your role as a mandated reporter during the informed consent process

If you do have to report child maltreatment, speak to the parent first

Reiterate your role, your intentions of ensuring the child's safety, and your ability to provide continued family support

Let the parent know that you have formally made the report

Explain the process, including contact you will have with child protective services

Support, support, support

After finishing this course, the participant will be able to:

Child Protective Services (CPS) is the name of the governmental agency in that responds to reports of child abuse or neglect. Some states have opted to use other names in an attempt to be more family-centered (as opposed to child-centered such as "Department of Children & Family Services". CPS is also known by the name of "Department of Social Services" (DSS) or simply "Social Services."

CPS has the legal authority and obligation to assess, investigate and evaluate reports of child abuse and neglect and to provide services when needed. Child welfare workers are responsible for determining:

Whether abuse or neglect has occurred
Whether there is immediate danger or risk to the child
What the motivation, and intent of the alleged perpetrator
What the ability of a non-offending caregiver to protect child

Investigatory Stages

McClennan (2010) identifies the following stages of the CPS process:

Step 1: Identifying and Reporting: A mandated professional reports suspected child maltreatment to reporting hotline

Step 2: Screening: Caseworkers gather information and determine whether report meets guidelines and whether prior reports have been made. Calls that do not meet guidelines are screened out or referred to other agencies that can better meet a family's needs. If a report meets guidelines, it is triaged in terms of response time (i.e., within 24 hours) based on severity of abuse/vulnerability of the child

Step 3: Initial Investigation/Family Assessment: CPS conducts an initial assessment to determine safety and risk. During this time they will generally contact the treatment provider directly, meet with family members at the home, meet with the victim in the home or school setting, and talk with other involved parties, such as the school or agencies. The initial assessment may be extended if there is a determination of risk.

If the initial investigation does not yield safety or risk concerns, the case is then closed, but a record of this contact is kept.

If the child is in immediate danger, the child welfare worker may place him or her under emergency protective services, which may include in-home support and supervision or the temporary removal of the child to a safe alternative environment (e.g., with other family

members or in foster care). If the child is removed from the home under these circumstances, the court and family must be notified and an emergency/temporary custody review hearing must be held, typically within 48 to 72 hours.

Step 4: Planning: If the child welfare worker determines that there are safety concerns, but it is safe to leave the child in the home, the worker is responsible for creating a plan to keep the child safe in that environment and for organizing or providing any needed support for the child and the family. Support may come from a variety of sources, including extended family, local community organizations and child protective services.

Step 5: Service Provision: CPS or the agencies involved help the family to implement the plan.

Step 6: Evaluation of Family Progress: The CPS worker continues to evaluate progress.

Step 7: Case Closure: Cases can be closed in various ways. If the child remains in the home and is considered safe, the case will be closed to CPS. If the child was removed from the home and is now considered safe, reunification (reuniting the child with the parents) can take place.

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Office Phone: (509) 420-3442
Fax: (858) 521-8173

Progress/Program Supervision Clinic Note

A. Patient and meeting information

Patient: ☐ Date: ☐ Others Present: ☐

Start ☐ End: ☐ ☐No Show ☐Cancelled/rescheduled: ☐

Location: ☐Office ☐School ☐Patient's home ☐Community Location: ☐

Modality: ☐Individual ☐ ☐ ☐Supervision

We check the areas we targeted during the session. Our raw data for each program, procedure, or protocol is kept on a separate sheet or electronic data system.

B. Areas Targeted	C. Treatments/i
☐Social Communication	☐Behavioral* ☐
☐Behavioral Problems	
☐Sensory/Flexibility Issu	
☐Learning/Attending/D	
☐Leisure Development	
☐Self-Care	
☐Parenting	☐Parent's Homework Assignments(other communication)
☐Other	

We state or list the procedures, programs, protocol, or interventions used. (e.g., token system, visual schedule...etc.)

*Specify Programs

D. Assessmen

We indicate the response of the client to programs or interventions both behavior reduction and skill acquisition.

1.Treatment participation/Compliance		☐ onsive	☐Variable	☐Minimal	☐Resistant	☐None
2. Response to Treatment	☐As expected	☐Better than expected	☐Much better	☐Poorer	☐Very Poor	☐Did not respond

E. Symptoms

Change since last evaluation (enter a ✓)

Target symptoms/concerns/complaint	Current severity rating	Much worse	More severe	No change	Less severe	Much improved

*Rate from 0-10 as follows: 0=resolved problem 5=distressing/limiting 10=disrupting, harm/risk

3. Other observations/evaluations ☐

4. Crisis Issues (attached additional information): ☐Yes ☐No 5. Medication Change: ☐No ☐ Yes: ☐

6. Major Changes (health, family, etc.) ☐

7. Major changes or issues addressed by: ☐ "

We indicate the variables or changes that may have effected the client's response

F. Changes to treatr ☐ N

We indicate the changes made to the programs or treatment under the direction of the supervisor for the client.

G. Follow-up: ☐

H. Progress towards goals & objective: ☐

A simple statement indicate overall progress or regression towards goals.

I. Clinician's Signature: **Date:**

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law

Child Enrichment Center
Every child deserves a bright future

www.childenrichmentcenter.org
Email: childenrichmentcenter@gmail.com
Fax: (858) 521-8173

we use this form to report and incident where a client, staff or other therapy participants have been injured during a session.

Incident Report Form

____

Date & Time of Incident: ____

Was illness or injury involved (if yes, describe below)? ______________________

Description of Incident (Please include names of individuals involved, nature of the incident, if injury or illness give name of physician/hospital used names and address of witnesses, and narrative of what occurred)

____

____

The staff person will describe the situation in full. including a sequence of events of what happened prior, during and after the

____

____

Final Disposition (how you intend to handle the incident, any next steps required, or likely outcomes)

____

____

____

____
Signature of Person Reporting Incident Date

____
Signature of Supervisor Date

NOTE:

Fax: (858)521-8173
Email: childenrichmentcenter@gmail.com
www.childenrichmentcenter.org

Sentinel Event Reporting Form Instructions

Unexpected occurrence involving death or serious physical or psychological injury that occurs in the course of a patient receiving behavioral health treatment.

1. **Fill out child information completely. Demographics, Address, Date of Birth, person's name reporting and dates, Diagnosis and medical condition,….etc.**

2. **List all services child was receiving from Child Enrichment Center LLC including the list of therapist/tutors working with the child on a consistent bases.**

3. **Describe the event. Provide detailed information about the sentinel event: What happened, when it happened, and how it happened.**

4. **Witnesses to the sentinel event: Provide a full name and phone number of all the known witnesses to the sentinel event.**

5. **Provide the date of the scheduled Sentinel Event Review**

6. **Outline the action plan**

7. **Signatures of Reporting Person(s), Supervisor, Parent or Legal Guardian of child.**

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Email: childenrichmentcenter@gmail.com
www.childenrichmentcenter.org

Sentinel Event Reporting Form

Date: ____________________ Time: ______________________ Date Reporting: ________________

Date of Sentinel Event: _____________ Reported by: _________________ Relationship: ____________

Name of Child: _______________________ DOB: _________ Location: ____________________

Address: ____

Diagnosis: _______________________ Medical Condition: ________________________________

Services: (list all of the services the child was or is receiving, if case is recently closed)

____

____

____

Describe the Event:

____

____

____

Witnesses to Sentinel Event and Phone Number(s):

____

____

____

Date of Review: ___________________________

Action Plan:

____

____

____

____ ________________________

Reporting Person's Signatures Date

____ ________________________

Supervisor Signature Date

____ ________________________

Parent/Legal Guardian's Signature Date

Please write additional information about sentinel event on the back of the form and return within 24 hours to BCBA Supervisor.

Instructions for providers:

- Create a new document on your own letterhead
- Retitle your document
- Determine your own bulleted list based upon the needs of your practice, using this statement as a starting point
- Remove the disclaimer below before distributing to patients
- Communicate your revised statement of rights and responsibilities to your patients, and document in their medical records that you have done so

Disclaimer: this Suggested Provider Statement of Patient/Client Rights and Responsibilities serves as an example, not as a recommended template for your specific situation. Please consult with your own advisors, including legal counsel, for assistance in creating your own Rights and Responsibilities Statement.

Suggested Provider Statement of Patient/Client Rights and Responsibilities

• Patients/Clients have the **right** to be treated with dignity and respect.
• Patients/Clients have the **right** to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
• Patients/Clients have the **right** to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
• Patients/Clients have the **right** to access care easily and in a timely fashion.
• Patients/Clients have the **right** to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
• Patients/Clients have the **right** to share in developing their plan of care.
• Patients/Clients have the **right** to the delivery of services in a culturally competent manner.
• Patients/Clients have the **right** to information about the organization, its providers, services, and role in the treatment process.
• Patients/Clients have the **right** to information about provider work history and training.
• Patients/Clients have the **right** to information about clinical guidelines used in providing and managing their care.
• Patients/Clients have a **right** to know about advocacy and community groups and prevention services.
• Patients/Clients have a **right** to freely file a complaint, grievance, or appeal, and to learn how to do so.
• Patients/Clients have the **right** to know about laws that relate to their rights and responsibilities.
• Patients/Clients have the **right** to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.

• Patients/Clients have the **responsibility** to treat those giving them care with dignity and respect.
• Patients/Clients have the **responsibility** to give providers the information they need, in order to provide the best possible care.
• Patients/Clients have the **responsibility** to ask their providers questions about their care.
• Patients/Clients have the **responsibility** to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
• Patients/Clients have the **responsibility** to let their provider know when the treatment plan no longer works for them.
• Patients/Clients have the **responsibility** to tell their provider about medication changes, including medications given to them by others.
• Patients/Clients have the **responsibility** to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
• Patients/Clients have the **responsibility** to let their provider know about their insurance coverage, and any changes to it.
• Patients/Clients have the **responsibility** to let their provider know about problems with paying fees.
• Patients/Clients have the **responsibility** not to take actions that could harm others.
• Patients/Clients have the **responsibility** to report fraud and abuse.
• Patients/Clients have the **responsibility** to openly report concerns about quality of care.
• Patients/Clients have the **responsibility** to let their provider know about any changes to their contact information (name, address, phone, etc).
• Patients/Clients have the **right** and the **responsibility** to understand and help develop plans and goals to improve their health.

I have read and understood my rights and responsibilities.

____

Patient/Client Signature Date

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office.childenrichmentcenter@gmail.com
(858) 521-8173

CLIENT RIGHTS & RESPONSIBLITIES

Name of Child: ________________ Date of Birth: ________________

Parent/Guardian Name (completing this form): ________________________________

CLIENT RIGHTS

1. Be treated with respect, dignity and privacy;
2. To receive services in the least restrictive, feasible environment.
3. To be informed of available program services
4. To participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it;
5. Develop a plan of care and services which meets your unique needs;
6. The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies or photographs.
7. The services of a certified language or sign language interpreter and written material and alternate format to accommodate disability consistent with Title VI of the Civil Rights Act;
8. Refuse any proposed treatment, consistent with the requirements in chapter 71.05 and 71.34
9. Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language age, disability, and sexual orientation;
10. Be free of any sexual exploitation or harassment;
11. Review your clinical record and be given an opportunity to make amendment or corrections.
12. Receive an explanation of all clinical recommendations, including expected effect and possible side effects;
13. Confidentially, as described in chapters 70.02, 71.05 and 71.34 RCW and regulations.
14. All research concerning consumers whose cost of care is publicly funded must be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects as specified in chapter 388-04 WAC.
15. Make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;
16. As a parent of a minor patient, observe any and all ABA sessions with your child, ask questions about any intervention or procedure;
17. As a parent of a minor patient, to terminate any procedure which you might object to, such intervention will not be reinstated without your approval;
18. Receive a treatment plan and verbal explanations of our interventions in language you can understand, free of professional or academic terms and

language not understandable to the lay person.

19. Ask for an administrative hearing if you believe that any rule in this chapter was incorrectly applied in your case.
20. The right to be informed of the reason(s) for denial of a service
21. The right to know the cost of services.
22. The right to be informed of all client rights.
23. The right to exercise any and all rights without reprisal in any form including continual

Any client who has reason to believe that he/she has been mistreated, denied services, or discriminated against in any aspect of services because of disability may file a grievance with the Section 504 Coordinator: Valerie Moyer Ph.D., P.O. Box 29, Bowling Green, Ohio 43402; 419-352-5387.

All other grievances, if not resolved with a staff member and/or supervisor, can be filed with the Client Advocate (Christopher Pryor) or the Client Rights Officer (Valerie Moyer, Ph.D.), if the grievance concerns clients' rights). During business hours, the Client Advocate or the Client Rights Officer can be reached by calling 419-352-5387 or 419-872-2419 and asking for the Client Advocate or the Client Rights Officer.

CLIENT RESPONSIBLITIES

1. Clients who are using the service have a responsibility to:
2. Respect as individuals everyone involved in the service.
3. Respect the rights of others including their rights to confidentiality and privacy
4. Inform staff of support needs
5. Read, understand and agree to the Parent Agreement/Contract agreement before signing
6. Honoring agreements made with CEC about services provisions and care.
7. Respect Child Enrichment Center's property.
8. Let the service know if they are not available for an appointment.
9. Ensuring that you are not under the influence of alcohol or other drugs, and/or behaving in a way which makes delivery of service difficult or dangerous
10. Act in a way which respects the rights of other clients and staff.
11. Take responsibility for the results of any decisions they make.
12. Seek a fair resolution of any complaints.

____ _______________
Parent/Guardian Signature Date

____ _______________
Child Enrichment Center Representative Signature Date