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LEGAL AND ETHICAL ISSUES IN COUNSELING CHILDREN AND ADOLESCENTS

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Data on children and young people have proliferated in the past 30 years, but not enough to eliminate some of the most glaring and egregious gaps in knowledge on children's rights.

—UNICEF (2019, p. 45)

INTRODUCTION AND PURPOSE

Counselors serving children and adolescents are called to balance the simultaneous and sometimes competing responsibilities to protect children and adolescents, appropriately communicate and collaborate with the adults in children and adolescents' lives to enhance their development across the life span, and promote their autonomy in developmentally appropriate decision-making related to counseling (American Counseling Association [ACA], 2014). The federal statutes and state-level laws guiding this work can vary and be further complicated by the profession-specific ethical principles and guidelines, as well as the policies and practices of the counseling context itself. Given the population's needs and the intricacies within the legal and ethical obligations, which almost always necessitate providers to work with parents, familial guardians, and/or other custodial adults as part of the community of care (Ensher et al., 2020), it is widely recognized that legal and ethical issues arise more frequently when counseling children and adolescents than adults. Unlike counselors working with adults, counselors working with children and adolescents frequently need to assimilate information from families, schools, and other community care providers when making clinical decisions for their child and adolescent clients who definitionally have limited legal rights. It is therefore surprising that so few resources beyond the ACA Code of Ethics (2014) exist to proactively support counselors in navigating the legal and ethical dimensions of their work with vulnerable children and adolescents.

Counselors working with children and adolescents require a specialized skill set and they should not approach the laws and ethical principles associated with the work as they would with adult clients (Ensher et al., 2020). As a division of the ACA, the Association of Child and Adolescent Counseling (ACAC) recognizes this and is described as “a support and information network for counselors who work with children and adolescents”

(<http://acachild.org/about-us/>). Given the complexity of the distinctive needs of this often-underserved population, ACAC acknowledges that counselors serving children and adolescents commonly face unique experiences and challenges. As a result, they have published a number of position statements and other resources to support counselors in navigating these. To date, however, neither ACAC nor any of the other ACA divisions have developed comprehensive material to assist counselors in identifying legal and ethical principles unique to work with children and adolescents or to navigate the particular concerns within resultant ethical dilemmas and decision-making with children and adolescents.

The gap between need and supporting resources underscores the criticality of counselors' continued examination of how their own values and beliefs shape their case formulation and interventions with children and adolescents (Gilbride et al., 2016), including but not limited to the ways their cultural, religious, and worldview (CRW) factors may conflict with that of their clients, their clients' family and community, as well as that of the context within which the counseling services are provided (Luke et al., 2017). As part of their reflective practice, counselors working with children and adolescents can benefit from asking themselves the following questions:

- What is my relationship with and professional obligation to the child or adolescent client?
- What is my responsibility to the child or adolescent's parent, familial guardian, and/or custodial community of care?
- How do my own experiences as a child or adolescent inform my understanding of my client and their presenting concerns?
- In what ways does my perspective as an adult and other privileges influence my view of the client, case, and my potential decision-making?
- How does the view change if I take the perspective of my child or adolescent client or that of their parent, familial guardian, and/or custodial community of care?

In the remainder of this chapter, we overview and discuss the wide-ranging legal and ethical issues pertaining to counseling children and adolescents. To do so, we provide a synthesis of the contemporary literature and offer case illustrations and guided examples to assist in applying the concepts across different child and adolescent client presentations and a variety of counseling contexts. At the conclusion of this chapter, the reader will be able to

- identify federal and state legal statutes that apply to counseling minor children and adolescent clients across school and clinical contexts;
- distinguish ethical standards and guidelines for counseling minor children and adolescent clients across school and clinical contexts (e.g., ACA, 2014; American Mental Health Counselor Association (AMHCA), 2020; American School Counselor Association (ASCA), 2016b);

- recognize and apply ethical practices, such as informed consent and assent;
- understand and implement ethical decision-making models that integrate knowledge of legal statute, ethical practice, and counseling context policy; and
- cite professional organizations related to counseling children and adolescents.

Guided Exercise 2.1 helps you get started learning about ethics and legal issues in counseling children and adolescents by interviewing a counseling professional.

GUIDED EXERCISE 2.1

Getting Started

Interview a counseling professional about their perspectives and experience regarding legal and ethical issues when working with children and adolescents. You may ask some of the following sample interview questions:

- Tell me about your experiences with ethical dilemmas. Is there a particular incident that comes to mind?
- What steps did you follow?
- How do your action(s) align with your professional code of ethics and the policies and procedures of your organization?
- To what degree did your client's, your institution's, and your personal culture, religion, and worldview influence your work?
- What did you learn from working through this ethical and legal dilemma?

Then, in a small group, discuss themes that emerged during your interview and the extent to which you agree with how they approached the situation and what you might do differently if faced with a similar situation.

THE CHILD AND ADOLESCENT COUNSELOR AND THE LAW: WORKING WITHIN THE LEGAL SYSTEM

Each of US states and territories has their own set of laws and governing entities overseeing child welfare, and review of each is beyond the scope of this chapter. Counselors have the responsibility to familiarize themselves with the laws and legal codes of the state or territory within which they practice, particularly related to what constitutes informed consent, the bounds of confidentiality, and the parameters under which disclosure is permitted; the definition of child abuse and neglect; the age of sexual consent and what defines statutory rape; and minors' access to health services (e.g., reproductive, substance abuse, and other mental health concerns) as these vary widely. The United States Department of Health and Human Services provides guidance on the statutes and how these apply across location through an online database that is searchable

by state or territory and topic and can be easily downloaded as a PDF. For more information, counselors should explore the laws and statutes of their state or territory before working with their clients through the Child Welfare Information Gateway website <https://www.childwelfare.gov/topics/systemwide/laws-policies/state/>.

In the following section, we identify key legal issues in counseling children and adolescents and provide a synthesis of pertinent resources beginning with federal statutes. We include discussion of topics that counselors have identified as historically germane such as parental rights and mandated reporting, as well as more recent legislation related to bullying, cyberbullying, and sexting. In addition to referencing prior publications, we include a range of online resources that presumably will be more regularly updated as the important information is revised. In Guided Exercise 2.2, read and discuss children's rights.

GUIDED EXERCISE 2.2

Children's Rights

Read "The Convention on the Rights of the Child" published by the United Nations Commission on Human Rights at <https://www.ohchr.org/en/professionalinterest/pages/crc.aspx> and respond to the following discussion prompts:

- Are there any rights not listed that you believe should be considered?
- What do you believe might be the most difficult rights for caregivers to provide their children?
- What are the possible implications of these rights on your work with children and their families?

Review "Definitions of Child Abuse and Neglect" at the Child Welfare Information Gateway, <https://www.childwelfare.gov/topics/can/defining/>, which includes differing criteria related to the use of corporal punishment. After reviewing your state's laws related to caregivers' use of corporal punishment, consider how you might respond to the following:

- A caregiver discloses the use of a behavior management strategy that you believe is developmentally inappropriate (e.g., forcing a toddler to sit in a corner for multiple hours).
- A caregiver discloses use of corporal punishment (i.e., spanking a child without leaving marks) and suggests this practice has been helpful in changing the child's behavior.
- A caregiver directly asks the counselor how they parent/discipline their child.

Federal Privacy Laws: HIPAA and FERPA

Federal laws safeguarding clients' right to privacy and confidentiality are central to the care and integrity of counseling children and adolescents. The Health Insurance Portability and

Accountability Act of 1996 (HIPAA; U.S. Department of Health and Human Services, Office of Civil Rights, n.d.) and the Family Educational Rights and Privacy Act of 1974 (FERPA; 20 U.S.C § 1232g; 34 CFR Part 99) are two significant regulations that counselors should be familiar with to ensure their service delivery is in compliance. HIPAA is a federal statute that outlines standards for the use, storage, and disclosure of clients' protected health information (PHI; Rousmaniere et al., 2016). PHI can be described as individually identifiable information in any form (i.e., written, oral, or electronically transmitted information). In certain cases, counselors might withhold a minor child or adolescent client's health records from the parent/guardian if they determine that access to this information might have a detrimental effect on the professional relationship with the client or the minor's psychological well-being or physical safety (National Center for Youth Law, 2018). Further information regarding minors' legal consent and confidentiality can be found in later sections.

FERPA protects the privacy of students' educational records. This statute applies to all PK-12 schools and postsecondary institutions that receive federal funding from the U.S. Department of Education (U.S. Department of Education, 2018). It also provides parents/guardians with various rights, unless there is evidence of a court order, concerning their student's educational records. These rights involve providing the parent/guardian or eligible student with a copy of requested records or allow them to inspect and review the educational records. Not only does this act allow parents/guardians to access their child's educational records but they can also determine "what, when and with whom the data in these records is shared" (Wehrman et al., 2010, p. 13). Therefore, educational institutions generally cannot disclose identifiable information from a student's educational records without the parent/guardian or eligible student providing written consent. There are 11 instances of exceptions to this rule, which can be found at the U.S. Department of Education's website (<https://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html>).

According to FERPA, if nonconsensual disclosure of educational records is reported by the parent/guardian of a student or the eligible student themselves, the U.S. Department of Education will review and investigate the alleged violation. Similarly, according to HIPAA, disclosure of a child or adolescent client's PHI without signed documentation can be reported and investigated by the U.S. Department of Health and Human Services. In both instances, if a violation has been found, hefty fines and consequences may ensue, with a maximum penalty of 1.5 million per year for each violation (HIPAA) or termination of federal funding (FERPA; https://nces.ed.gov/pubs97/p97527/Sec6_txt.asp).

Minors' Legal Consent

Legal and ethical frameworks for minor consent vary from state to state. These legal and ethical guidelines also indicate specific circumstances (e.g., serious mental health concerns, drug- and alcohol-related problems) in which a minor, generally under the age of 18 years, can receive treatment on their own accord. In most cases, however, a parent or guardian with appropriate legal authority must provide consent for a minor to receive healthcare services, though it is recommended to also obtain the minor's assent where possible as well. States enact varying statutes regarding minor consent that are commonly grouped into one of two overarching categories: (1)

laws that are based on status of the minor (e.g., age of majority, emancipated, living apart from parents) and (2) laws that are based on the type of care (e.g., drug/alcohol treatment, outpatient mental health services) they are pursuing.

In most states, minors are permitted to consent for care related to use of drugs and alcohol, with variations regarding age limit and restrictions on type of care provided (Kerwin et al., 2015). Yet, the percentage of states that permit minor consent to outpatient mental health treatment is less. It is unclear why states provide more autonomy to minors seeking drug and alcohol treatment compared to mental health treatment; however, it has been suggested that parents and other caregivers might be more likely to discipline their minor child for substance use compared to mental health issues (Kerwin et al., 2015). This may allow minors access to needed care for substance use disorders, privately, without disclosure to parents/guardians, which could put the adolescent at an increased risk for harm; however, minors rarely seek treatment at their own discretion (Kerwin et al., 2015). There remains ongoing controversy regarding the role of parent/guardian and minors' cognitive ability to make decisions affecting their short- and long-term well-being. Additional ethical issues arise when considering the developmental ability of minors to access services without parent/guardian knowledge and involvement. This becomes even more complex when considering the critical period of psychological and social development and the negative effects of substance use on executive functioning, attention, and motivation (Nock et al., 2017). Thus, numerous ethical considerations might arise for professional counselors such as the following: How successful will the child's recovery be without the parent/guardian's knowledge and support? What if the child is unable to maintain consistent, ongoing participation in treatment or is engaging in risky sexual behavior without contraceptives (Erford, 2017)? And what if the child's condition requires medication?

Although laws directing consent for health care, including counseling, are largely state directed, clinicians should also be familiar with their institution's policies concerning consent. For example, state law might indicate that counselors can address minor issues related to substance abuse without parent/guardian consent or involvement; however, agency policy might not allow it. Given limitations on their legal rights, many minors are mandated clients (Goodrich & Luke, 2015). Further information about minor's legal consent can be accessed on the Center for Adolescent Health & the Law website (<https://www.cahl.org>).

Counseling Youth With Disabilities: IDEA and Section 504

The Individuals with Disabilities Education Act (IDEA) of 1975 and Section 504 of the Rehabilitation Act of 1973 are two federal laws that counselors working with child and adolescent clients should be familiar with, particularly those working in school settings. Both federal statutory acts are designed to protect the rights of individuals with disabilities. These statutory frameworks authorize that qualified students receive a free appropriate public education and that they obtain the necessary services that fulfill their developmental and educational needs (IDEA, 2004). Individualized Education Programs or Plans (IEPs) are to IDEA as 504 Plans are to Section 504. A comparison chart depicting an overview of similarities and differences

between these plans can be found on the Understood website (<https://www.understood.org/en/school-learning/special-services/504-plan/the-difference-between-ieps-and-504-plans>).

Individuals With Disabilities Education Act

The IDEA indicates that children who are classified as having at least one of the 13 disability categories are eligible for additional educational and mental health services (Congressional Research Service, 2019). According to the Act, “public schools are financially responsible for all assessments related to the identification of disabilities addressed by IDEA” (Auger, 2012, p. 264). Further information regarding federal efforts to support the education of individuals with disabilities can be found on the Congressional Research Service website (e.g., *Laws Affecting Students with Disabilities: Preschool Through Postsecondary Education*; <https://crsreports.congress.gov>).

Counselors who work in schools provide both direct and indirect services related to IDEA, ranging from delivering core curriculum and individual and/or group counseling to collaborating with other school personnel to implement students’ IEPs. Given that students with disabilities may require additional social and emotional support, counseling services may be incorporated into their IEP. Counselors who provide these mandated services establish counseling goals to help students develop skills that they can use during both instructional and noninstructional time, such as at home or in the community. Sample counseling goals might include the following: *(1) In the classroom environment, the student will use self-control by raising their hand and wait to be called on by the teacher in four out of five trials, as measured by teacher observation; (2) In counseling sessions, the student will identify feelings and practice coping strategies (e.g., deep breathing, take a break) in three out of four instances, as measured by charted data; and (3) When the student becomes frustrated, they will use a self-regulation strategy (e.g., movement break, engage in positive self-talk) in two out of three trials, as measured by observation and documentation.* Counseling goals are determined according to student needs and informed by data as indicated by both formal (e.g., observation charts, behavioral data) and informal (e.g., parent and teacher feedback) means. If warranted by the school’s multidisciplinary team, the counselor may need to work closely with other personnel (e.g., school psychologists, teachers, parents) to conduct a functional behavioral assessment (FBA) to inform the development of a student’s behavior intervention plan (BIP). According to the regulations for Part B of the IDEA (2009):

FBA and BIPs are required when the LEA, the parent, and the relevant members of the child’s IEP Team determine that a student’s conduct was a manifestation of his or her disability under 34 CFR §300.530(e). If a child’s misconduct has been found to have a direct and substantial relationship to his or her disability, the IEP Team will need to conduct an FBA of the child, unless one has already been conducted. Similarly, the IEP Team must write a BIP for this child, unless one already exists. If a BIP already exists, then the IEP Team will need to review the plan and modify it, as necessary, to address the behavior.

An FBA focuses on identifying the function or purpose behind a child’s behavior. Typically, the process involves looking closely at a wide range of child-specific factors

(e.g., social, affective, environmental). Knowing why a child misbehaves is directly helpful to the IEP Team in developing a BIP that will reduce or eliminate the misbehavior.

For a child with a disability whose behavior impedes his or her learning or that of others, and for whom the IEP Team has decided that a BIP is appropriate, or for a child with a disability whose violation of the code of student conduct is a manifestation of the child's disability, the IEP Team must include a BIP in the child's IEP to address the behavioral needs of the child (pp. 14–15).

Counselors should consult their state's Department of Education's website for further guidance regarding the use of FBAs or BIPs.

Though it is inappropriate for school counselors to provide long-term therapy, they can assist with codeveloping postsecondary, transition and academic plans and/or short-term, solution-focused counseling, as appropriate (ASCA, 2016b). Similarly, although counselors who work in clinical settings may not be directly involved with the implementation of the children's IEPs, being familiar with state and federal statutes and family rights may allow them to better collaborate with other related support professionals to more effectively advocate and assist their clients. For example, counselors can reframe any associated behavioral issues as characteristics of the disability rather than the student intentionally acting out (Auger, 2012). Further information can be accessed at the United States Department of Education's website (<https://sites.ed.gov/idea/regs/b/a/300.34>).

Section 504

Individuals eligible under Section 504 must have a mental or physical impairment that significantly limits one or more major life activities (e.g., speaking, learning) or have a history of such an impairment but cannot also qualify for special education services for this disability under IDEA. After it is determined that a student should receive such classification, elementary and secondary schools can establish reasonable accommodations for the students to address barriers to learning in the educational environment. For example, a student with a 504 may receive preferential seating or have extended time on tests and assignments. Counselors, particularly those working in school settings, should remain current with Section 504. Counselors working in school settings can be held legally responsible for violating young people's civil rights to learning accommodations, including those outlined in the delivery of 504 services (Goodman-Scott & Boulden, 2020). More information concerning Section 504 and disability-related issues can be accessed at the National Information Center for Children and Youth website (<https://www.washington.edu/doi/>).

Additionally, counselors and particularly those working in school settings should serve on multidisciplinary teams and support decision-making around the development and delivery of 504 plans. This may allow them to provide information to their clients and colleagues regarding available programs and services that might assist the student in their current educational environment or their preparation for postsecondary educational settings. Professional counselors should seek out and receive relevant professional development, mentorship, and supervision

to foster a more in-depth knowledge base and delivery of the 504 process (Goodman-Scott & Boulden, 2020).

Also, although states and territories have put policies and procedures in place to prevent the inappropriate overidentification or disproportionate representation by race and ethnicity of students with disabilities, this remains an ongoing issue. Emerging research suggests that overidentification of students of color and those from other historically marginalized groups may be partially due to preventable misidentification (e.g., Sullivan & Osher, 2019; Sullivan & Proctor, 2016). For instance, English language learners (ELLs) are overrepresented in special education, particularly at the secondary level. There are also issues concerning the underidentification among minority groups. For example, while ELLs are overrepresented in special education at the high school level, they are underrepresented in special education overall and across most disability categories (Umansky et al., 2017). For additional information regarding disproportionality, visit the Office of Special Education and Rehabilitative Services website (<https://www2.ed.gov/about/offices/list/osers/index.html>). Search for Racial and Ethnic Disparities in Special Education. For state-specific information regarding regulations, consult your state's Department of Education.

Counselor Advocacy for Children With Disabilities

Before professional counselors can effectively serve students with disabilities and provide consultation and support to families, they must first examine their beliefs, attitudes, and awareness of the disability and how it may differ from those of the child and their family (Ennis-Cole et al., 2013). Counselors can use empowerment strategies to explore the students' and their families' culture, which may inform how various cultural identities intersect and impact students (Ennis-Cole et al., 2013). Underrepresented cultural groups might have a negative history with mainstream health care, as a result of discrimination, unjust treatment, and undervalued perspectives. Counselors should be aware of how these sociocultural and political factors might influence family beliefs about seeking and receiving treatment for their child and tailor their approach accordingly.

After establishing a positive therapeutic relationship with the family, professional counselors can help to identify and connect them with essential resources. Additionally, families can be empowered to learn about their legal rights and obligations.

Parental Rights and Custody

Over the course of a counselor's career, they will directly and indirectly work with children, adolescents, and families experiencing high-conflict divorce, separation, and custody-related issues.

Professional counselors should be prepared to navigate subpoenas, to testify in court, and on how to respond to clients' lawyers requesting them to share their opinion or recommendations regarding the child, parental fitness and ability, domestic violence, or abuse. Generally speaking, counselors should report only factual information (e.g., descriptive, observable, concrete), both in their notes and in any correspondence responding to legal matters. Counselors should also be aware of disadvantages associated with custody disputes including potential threats to

confidentiality, counselor biases, impacts on the therapeutic alliance, and unexpected results of the counselor's testimony. Although experiences with legal proceedings can elicit a number of internal reactions for counselors such as disarray and panic (DeCinco et al., 2017), their extensive knowledge of the family can play a crucial role in ensuring the child's welfare.

Guided Exercise 2.3 focuses on legal and ethical issues related to parental rights and custody.

GUIDED EXERCISE 2.3

Parental Rights and Custody

- A. You are providing weekly out-patient counseling services to a 13-year-old biracial cisgender male client named Beau, whose presenting concern relates to generalized anxiety that reportedly developed following a parental separation. Beau was referred to counseling by his mother Natoya, who reported at intake that she has full custody of Beau and signed the informed consent. She has since provided third-party insurer billing information for Beau's treatment through a policy under her name. After six months of counseling, Beau's presenting anxiety symptoms have decreased and his treatment goals have progressed to include developmental tasks related to individuation; however, you recently received a request for a treatment report from Beau's father Blake's attorney as part of a contested custody suit. The attorney has provided information to document that although Beau's mother, Natoya, has primary physical custody, Beau's father, Blake, has joint legal custody. Access online information about your state or territory's regulations related to type of parental custody and access to HIPAA-related minor client information and discuss with a partner how you would respond to the situation and why.

Counseling practitioners may access the wealth of online resources (e.g., American Bar Association: Center on Children and the Law, U.S. Department of Justice's Uniform Child-Custody Jurisdiction and Enforcement Act) that exist on family law.

Child Abuse and Neglect and Mandated Reporting

All 50 states and the District of Columbia have designated mandatory reporting laws that include how child abuse and neglect is defined, necessary information to elicit a report, professionals who are mandated to report, procedures of reporting, penalties for failing to report, and guidelines for confidentiality and immunity for reporters (Child Welfare Information Gateway, n.d.). In 44 states, counselors are designated as mandated reporters (MRs; Kenny et al., 2018). The remaining states specify that all persons who suspect child abuse or neglect are required to report (Child Welfare Information Gateway, n.d.).

According to the Federal Child Abuse Prevention and Treatment Act (Child Welfare Information Gateway, 2019a) enacted in 1974, and many reauthorizations since, child abuse and neglect is defined as "any recent act or failure to act on the part of the caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation ... or an act or failure to act which presents an imminent risk of serious harm" (42 U.S.C. 5101, § 3). In

addition, each state is required to provide its own classifications of child abuse and neglect (Child Welfare Information Gateway, 2019b). As such, counselors should familiarize themselves with the policies and referral procedures concerning state law and reporting sanctions and any internal procedures at the institution in which they serve. Institutional guidelines may designate documentation procedures, the official reporter, and individuals who may need to be notified that a report has been made (Tuttle et al., 2019).

Most state reporting laws do not provide a clear definition of *reasonable suspicion* or other related terminology. Therefore, counselors should remember that if they simply suspect child abuse or neglect, a report should be made. It is the investigative agencies' responsibility to determine whether or not there is proof. Additionally, in the majority of states, there is an MR hotline where counselors may call to seek consultation prior to formally initiating a report. All 50 states including the District of Columbia provide immunity to professionals who report suspected abuse in good faith. In other words, as long as the individual making the report has reason to believe that the child in question is being abused or neglected, he or she cannot be held liable for any damages that may come from the report.

While the timeframe for reporting varies across states, it is typically recommended that reporting is done immediately or as soon as possible. For more information about what happens when possible abuse or neglect is reported, please visit the Child Welfare Information Gateway website (<https://www.childwelfare.gov>) (Table 2.1).

In Guided Exercise 2.4, explore resources at childwelfare.gov and discuss in small groups.

GUIDED EXERCISE 2.4

Child Abuse and Neglect/Mandated Reporting

At childwelfare.gov, you can access a number of resources concerning child abuse and neglect. Go to <https://www.childwelfare.gov/topics/can/and> select and review "What is Child Abuse and Neglect? Recognizing the Signs and Symptoms."

Then, in small groups, discuss what information you would like to access and prioritize after a child exhibits potential signs of abuse or neglect. In what ways might state law and organizational and/or institutional policy be relevant here. Describe how you might access this information? What are - the two to three resources that you could access from the website to incorporate into your work with the child. Discuss with your instructor where you would start and why.

Juvenile Justice and Other Residential Treatment

Provision of counseling to children and adolescents within the juvenile justice system or within other residential treatment contexts provides opportunities for great reward, but it can also involve many challenges. Reflecting the racial biases in the larger U.S. system of justice, African American and Hispanic youth are significantly overrepresented in both arrests and juvenile justice placements (Carrola & Brown, 2018). Although children and adolescents can enter

TABLE 2.1 ■ Resources for Navigating Cases of Suspect Child Abuse and Neglect

Institution	Resource Available	URL or Telephone
Childhelp	This site includes preventative, intervention, and treatment programs for child abuse and the educational resources for parents and educators.	https://www.childhelp.org (1-800) 4-A-CHILD or (1-800) 422-4453
Child Welfare Information Gateway	This site provides information about child welfare, abuse and neglect, adoption, and related information.	https://www.childwelfare.gov/topics/preventing/overview/federal-agencies/ (1-800) 394-3366
CyberTipline	This site is the centralized reporting system for the online exploitation of children.	https://www.missingkids.org/gethelpnow/cybertipline (1-800) 843-5678
Futures Without Violence	This site offers educational resources to teach about and address childhood violence.	https://www.futureswithoutviolence.org (415) 678-5500
National Domestic Violence Hotline	This resource provides general welfare information including identifying characteristics of abuse, safety planning, and supporting others.	https://www.thehotline.org (1-800) 799-SAFE (7233) or (1-800) 787-3224
RAINN (Rape, Abuse & Incest National Network)	This resource includes information on sexual violence, safety, and prevention; opportunities to get involved; public policy information; media; and other resources and opportunities for consultation and training.	https://www.rainn.org (1-800) 656-HOPE (4673)

Source: Adapted from Valkyrie et al. (2008). Mandatory reporting and school counselors: Reporting laws, obstacles, and solutions. *Alabama Counseling Association Journal*, 34, 18-33.

residential treatment contexts as a result of similar delinquent or criminal offenses, they may also enter residential treatment as a result of mental health issues. Lesbian, gay, bisexual, and transgender youth are also disproportionately represented in both juvenile justice and other residential treatment contexts, with estimates ranging between 4% and 10% of residents (Goodrich & Luke, 2015).

The majority of children and adolescents within juvenile justice and many residential treatment contexts have experienced proportionately more adverse childhood experiences than their non-out-of-home placed peers (Centers for Disease Control and Prevention & Kaiser Permanente, n.d.). As any out-of-home placement has the potential to be compound and even retraumatize the youth (Goodrich & Luke, 2015), attention to trauma-informed counseling practice is often employed in juvenile justice and residential treatment settings. Counselors working in these settings should seek out additional education in trauma treatment modalities.

As a result of the *in loco parentis* in reference to the adult responsible in absence of the parent, counselors can experience a heightened sense of concern for child and adolescent clients' welfare, which can lead to increased occasion for boundary crossing. As such, counselors and other treatment providers working with children and adolescents need to engage in a high level of communication to ensure treatment fidelity and to inhibit the potential for *splitting* across providers, wherein a child or adolescent not wanting to accept a limit imposed by one provider attempts to circumvent and obtain permission from another provider.

Recent Legislation to Bullying, Cyberbullying, and Sexting

In the past two decades, youth aggression and bullying have become regarded as an urgent public health issue and, as a result, the laws of all 50 states and U.S. territories address bullying in some capacity (Modecki et al., 2014; Tinstman Jones et al., 2020). An overview of these commonalities and comparisons between states can be accessed at the StopBullying.gov website (<https://www.stopbullying.gov/resources/laws>).

Although there are no federal laws that specifically address instances of bullying, there are civil rights and antidiscrimination laws that safeguard particular groups of people who have historically been targets of harassment and discrimination. For instance, while Title IX of the Education Amendments Act of 1972 and Title VI of the Civil Rights Act of 1964 do not prohibit discrimination based exclusively on sexual orientation, they do protect students who identify as LGBTQ from gender- and sex-based harassment.

There are typically three overarching elements that are embedded in laws, regulations, and policy guidance at the local and state level: (1) enumerated protections—protections to specific groups, such as gender and sexual identity and race; (2) professional development—mandatory training for staff about harassment and bullying; and (3) accountability—mandated to report instances of bullying (Kull et al., 2015). However, in a large-scale study of 13,181 districts across the nation, Kull et al. (2015) found that only 3% of district policies included all three categories, 18.9% of districts required training for staff on addressing bullying and harassment, 26.8% of districts required instances of bullying and harassment be reported to the district level, and only 9.9% of districts with LGBT-inclusive antibullying policies.

Abreu et al. (2016) highlighted six distinct strategies that school counselors should engage in to address and prevent LGBTQ bullying and harassment in school. These strategies have been slightly modified to expand the scope to counselors in a variety of settings:

- Counselors should advocate for youth by asking their institution to review and update their organization's mission and policies to include sexual minorities and gender-expansive youth. Specifically, counselors should ask that the institution provide (a) a detailed definition of what constitutes sexual minority and gender-expansive bullying, (b) ideas and mandates on reporting, and (c) anticipated consequences for violators of LGBTQ antibullying policies.
- Counselors should advocate and collaborate with their supervisor or director to make it mandatory for other staff to address LGBTQ bullying as part of their practice.

- Counselors should help design institution-wide procedures to address LGBTQ bullying. For instance, counselors could request that their supervisors or directors designate one day each quarter of the year for staff to discuss different social justice issues and make sure that LGBTQ bullying and harassment are part of this discussion.
- Counselors should establish and lead an institution-wide LGBTQ-bullying taskforce to assess their organization's LGBTQ-bullying climate and develop and implement programs to protect sexual minority and gender-expansive youth. This taskforce should comprise at least the following members: (a) counselor, (b) supervisor/director, (c) staff from different areas, (d) parents/guardians, and (e) community partners.
- Counselors should build relationships with local community organizations that specifically work with LGBTQ youth. For example, counselors could coordinate guest speakers and workshops to address LGBTQ bullying and harassment.
- Counselors should create safe methods of reporting LGBTQ bullying by both youth and families and staff. Also, counselors should develop a plan for documenting and addressing these reports (adapted from Abreu et al., 2016, pp. 331–332).

In Guided Exercise 2.5 use resources from StopBullying.org and imagine how you might advocate with a family whose young son faces bullying at school.

GUIDED EXERCISE 2.5

Bullying

The mother of a 9-year-old client that you are working with expresses a concern about her child being bullied at school. The client's mother suggests that the school is not doing anything to resolve the issue. What are some of the ways in which you might respond? How might the context of your counseling of the client impact your next steps?

Using StopBullying.gov, what are three resources that you might provide to empower the mother's advocacy. How can you incorporate – two to three resources into your own work with the child? How can you support the parent while maintaining an understanding that the child is your client?

Cyberbullying

Cyberbullying can be defined as “willful and repeated harm inflicted through the use of computers, cell phones, and other electronic devices” (Cyberbullying Research Center, n.d.). Although traditional forms of bullying are almost twice as prevalent as cyberbullying, they are highly correlated constructs (Modecki et al., 2014). Other findings suggest that cyberbullying impacts between 25% and 75% of secondary students (Waasdorp & Bradshaw, 2015). Thus,

organizations should review language of state law and recent court cases to address and enforce instances of harassment, intimidation, and bullying (Hinduja & Patchin, 2015). A synopsis of laws and policies enacted in each state regarding bullying and cyberbullying can be accessed at the Cyberbullying Research Center website (<https://cyberbullying.org/cyberbullying-laws>).

It has been reported that LGBTQ youth are nearly twice as likely to be cyberbullied compared to their heterosexual counterparts (36.1% compared to 20.1%; Hinduja & Patchin, 2020). Institutions that promote an environment that embraces a climate of diversity and has explicit policies concerning bullying perpetrated against LGBTQ youth are more likely to experience a decreased rate of victimization related to sexual orientation (Kosciw et al., 2014). Further information regarding cyberbullying and LGBTQ youth can be accessed on the ConnectSafely website (<https://www.connectsafely.org/lgbtq/>).

Cyberbullying, particularly for schools, can be problematic considering it often occurs off campus or outside of the institution; however, past court rulings have acted in favor of schools disciplining students who engage in cyberbullying when their behavior results in a disruption to the school learning environment (Hinduja & Patchin, 2015). Schools with evidence-based, practical, and detail-oriented cyberbullying policies have less instances of bullying (Steele et al., 2016). Below, we provide an adapted three-tiered model from Davis and Schmidt (2016) that can be used to prevent and intervene with instances of cyberbullying and cyber abuse (Table 2.2).

Sexting

Sexting, while a relatively new adolescent phenomenon, is thought to be a potentially normal aspect of teens' behavior, sexual self-expression, and sexual agency (Holoyda et al., 2018). Unfortunately, sexting can be used to coerce or blackmail the victim, distributed out of revenge, and forwarded or shown to others without consent (Van Ouytsel et al., 2017). Additionally, youth who are caught engaging in sexting or distributing such messages can experience a myriad of legal, criminal, and emotional repercussions. For instance, minors can be charged with a misdemeanor, delinquent offense, or felony, which might require the convicted minor to register as a sex offender (Holoyda et al., 2018). In recent years, states have begun adopting sexting-specific and revenge pornography laws, to better protect children, prevent abuse and exploitation, and decrease the number of minors who are prosecuted (Lorang et al., 2016). An overview of sexting laws by state can be accessed on the Cyberbullying Research Center's website (<https://cyberbullying.org/sexting-laws>).

Counselors should assess each case individually to understand the scope and circumstances around the issue and determine age and maturity appropriate and case-specific interventions. Additionally, they should familiarize themselves with relevant laws in the jurisdiction in which they practice and assess for the level of need the family may require to support the child's overall well-being. For more information about how to support victims and families who have experienced coercion and cyberbullying as a result of sexting, visit the National Center for Missing & Exploited Children websites (<https://www.missingkids.org/theissues/sextortion>; <https://www.missingkids.org/netsmartz/resources#overview>).

TABLE 2.2 ■ Supporting Youth and Responding to Instances of Cyberbullying

I. Universal or Primary		
<i>Provided to all stakeholders</i>		
Children/Adolescents	Caregivers	Staff
<ul style="list-style-type: none"> ● Provided socioemotional and Internet safety training and education (e.g., building empathy, conflict resolution). ● Screened for potential concerns. 	<ul style="list-style-type: none"> ● Provided information (e.g., parent workshop, letter home) about cyberbullying including its characteristics and consequences of youth who engage in cyberbullying. 	<ul style="list-style-type: none"> ● Receive training on reporting and navigating instances of cyberbullying.
II. Targeted or Secondary		
<i>Supplemental small group</i>		
Youth At Risk of Cyberbullying	Youth At Risk of Cybervictimization	
<ul style="list-style-type: none"> ● Receive additional small group learning opportunities addressing socioemotional development topics such as healthy and unhealthy relationship behavior, appropriate Internet behavior, self-management skills, conflict resolution, and other social skills. 	<ul style="list-style-type: none"> ● Receive additional small group learning opportunities focused on socioemotional development topics including advocacy skills, resiliency, self-esteem, self-worth, and Internet safety. 	
III. Intensive or Tertiary		
<i>Tailored for individual child/adolescent</i>		
Youth Engaging in Chronic Cyberbullying	Youth Experiencing Chronic Cybervictimization	
<ul style="list-style-type: none"> ● Receive individual support focused on skill development in areas such as anger management, compassion, empathy, and self-esteem. 	<ul style="list-style-type: none"> ● Receive individual support on areas including safety planning, depression and anxiety management, resiliency, and advocacy skills. 	

Source: Adapted from Davis, N., & Schmidt, C. (2016). Cyberbullying and cyber abuse intervention: The three-tiered model for schools. *Journal of Creativity in Mental Health, 11*, 366–377.

Malpractice

All counselors should carry professional liability insurance in addition to the separate liability protections held by their employers. Although most counselors will not ever be in a position to make a claim, all counselors should be familiar with malpractice. The definition of malpractice hinges on a violation of a customary professional standard of care. The standard of care has been judged according to what is consistent with or should be expected given the prevailing learning, skill, and ethics within the professional community (e.g. ACA, AMHCA, ASCA, state licensing or certification boards). There is a difference between a counselor providing the minimum quality

of counseling services or even making a misstep than failure to meet standards of care, in that the latter involves negligence or wrongful action that results in harm to the client. Given the additional scope of responsibilities for counselors working with child and adolescent minor clients, counselors need to understand the professional standards at the federal, state, and local levels and be aware that violations can be considered and sanctioned as malpractice. Counselors are encouraged to examine the websites of professional counseling licensing and certification boards in their state, as well as the website of the National Board for Certified Counselors for a comparison of national counselor certification and state licensure at <https://www.nbcc.org/certification/licensure> and the ASCA's website for up-to-date state certification requirements at <https://www.schoolcounselor.org/school-counselors-members/careers-roles/state-certification-requirements>.

ETHICS OF COUNSELING CHILDREN AND ADOLESCENTS— BEST PRACTICES AND DECISION-MAKING

In the following section, we discuss relevant counseling competencies when working with children and adolescents, ethical and legal considerations of informed consent and confidentiality, and models for ethical decision-making. We outline interventions that counseling practitioners can employ to minimize potential harm, with careful attention toward counselors' *standard duty of care*. Lastly, we provide an overview of the Intercultural Model of Ethical Decision Making (IMED) model (Luke et al., 2013a) and highlight considerations that counselors should heed attention to when navigating ethical dilemmas.

Counselor Competence

When counseling minors, counselors must strive to “balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf” (ACA, 2014, p. 4). Careful consideration must be given to both the counselor and client's social identities and the environments in which they are embedded. Ratts et al. (2016) proposed the following aspects as being crucial to counseling practice: (1) understand the complexities of diversity and multiculturalism in the counseling relationship; (2) recognize the negative influence of oppression on mental health and well-being; (3) understand individuals in the context of their social environment; and (4) integrate social justice advocacy into the various modalities of counseling. Further information concerning competencies to guide counselors' multicultural responsiveness when working with diverse clients can be accessed on the Association for Multicultural Counseling and Development website (<https://multiculturalcounselingdevelopment.org/resources/>) and throughout this text.

Informed Consent and Confidentiality

There are limited cases in which minors have the legal ability to consent for counseling services. However, counselors should still request the minor client's assent and use clear and developmentally appropriate language to explain the counseling process. Assent can be described as “an agreement when a person is otherwise not capable or competent to give formal consent (e.g., informed consent)

to a counseling service or plan” (ACA, 2014, p. 20). Typically, providing any form of counseling or treatment to a minor requires parent/guardian consent. This requirement may be different for school counselors who provide counseling-based services (e.g., individual counseling, group counseling) as part of the school’s educational programming. In other words, school counselors generally do not need parental/guardian consent to meet with their minor child as part of their educational programming, though it can be helpful to have an open line of communication to ensure adequate support is provided to the child. When navigating these conversations, counselors should respect the confidential nature of the counseling relationship with the minor child while also acknowledging that parents/guardians have legal rights to counseling information (ACA, 2014).

Upholding confidentiality has been documented as being a crucial aspect of providing care in an array of mental health professional codes of ethics (e.g., ACA, ASCA, American Psychological Association [APA]). Experienced counselors know that adolescents highly value confidentiality during treatment and that when treatment providers offer explicit assurances concerning confidentiality, they are more likely to disclose pertinent and sensitive information. Sharing information about a client, even unintentionally, can compromise the counselor’s trust, respect, and working relationship. In other words, although counselors are expected to uphold confidentiality concerning their clients, there are limitations that can cause them to breach confidentiality.

These exceptions or limitations to confidentiality occur when there is serious and foreseeable harm to the client or others, or the counselor is otherwise legally required to reveal such information (ACA, 2014). Confidentiality is often discussed in a binary matter (breach/not breach), and confidentiality decision-making options can exist on a continuum, ranging from full confidentiality being maintained (high level of autonomy) to disclosure of information without the child’s consent or knowledge (lowest degree of autonomy; Duncan et al., 2015). When navigating these decisions, careful consideration should be given to immediate and future risk of harm, the best interest of the client, and standard duty of care (Duncan et al., 2015). Duncan et al. (2015) established a framework that mental health professionals can use to minimize harm in relation to confidentiality with minor clients. This framework has been adapted and is provided below in Table 2.3. Further information about minor consent and confidentiality can be accessed through the ACA Code of Ethics (2014) and the National Center for Youth Law website (<https://youthlaw.org>).

Guided Exercise 2.6 asks you to role-play how to talk about informed consent and confidentiality with parents and young clients.

GUIDED EXERCISE 2.6

Informed Consent and Confidentiality

- A. In groups of three, role-play one of the two options outlined below:
- Option 1: Practice an informed consent statement, regarding rights and explanations of limitations to confidentiality, with a caregiver. For example, one individual can play the role of a counselor, another as a parent/caregiver, and the third as a process observer. Consider the questions below to guide your role-play and discussion.

- How do you inform caregivers about their child's rights to confidentiality?
- How might you proactively address a parent's request to be informed? What factors might influence your response?
- How do you discuss the ethical responsibility for privacy while also balancing caregivers' investment to be part of the treatment?
- Option 2: Practice an assent statement (assent—"to demonstrate agreement when a person is otherwise not capable or competent to give formal consent to a counseling service or plan" [ACA, 2014, p. 20] regarding rights and explanations of limitations to confidentiality with a child or adolescent client. Consider the questions below to guide your role-play and discussion.
 - How do you make a child assent developmentally appropriate and create a safe therapeutic alliance for children to disclose sensitive information?
 - How might you proactively address the possible question, "Are you going to tell my parents what I say?"
 - How do you understand the differences between informed consent and assent?
- B. You are facilitating a group with six adolescents who experienced changes in their family structure due to child custody arrangements. As part of the initial informed consent, you explained adolescents' rights to confidentiality in your role as a counselor as well as limitations to their confidentiality. You also clearly articulated to all group members, honoring "what is said in group, stays in group." In the middle of the eighth session, two group members confront a third member indicating that information shared in the past session by another group member was discussed in a Facebook group chat with non-group members. In response, you recognize that there are relevant legal and ethical concerns as well as potential impacts on both clinical and group developmental factors. Using the chart below, list the legal and ethical issues and potential impact on clinical and group developmental factors. How might each of these factors intersect with each other?

LEGAL AND ETHICAL ISSUES CLINICAL AND DEVELOPMENTAL GROUP FACTORS

Ethical Decision-Making Models

Counselors are expected to make decisions that are not straightforward and may not be addressed by state and federal legislation or organizational policy (Luke et al., 2013a, 2017). Therefore, practitioners should consider using an ethical decision-making framework to access additional information and resources to more effectively, ethically, and respectfully navigate complex and multicultural dilemmas.

Given that the counselors need to account not only their own CRW but also that of their clients and other important stakeholders (e.g., supervisors, families, teachers) and how these various factors influence decision-making, we recommend Luke et al.'s (2013a) seven-step IMED model. The general steps of the IMED are outlined below:

1. Recognize that CRW factors are present within a potential ethical situation.
2. Outline the client's and other stakeholders' CRW factors relevant to the dilemma.

TABLE 2.3 ■ Interventions to Minimize Potential Harm in Relation to Confidentiality With Minors

Type of Intervention	Specific Intervention
Risk assessment	<ul style="list-style-type: none"> ● Conduct a risk assessment and decide the extent to which confidentiality may need to be breached.
Maintaining the therapeutic alliance	<ul style="list-style-type: none"> ● Discuss confidentiality and its limitations at the onset of and throughout the counseling process. ● Elicit trust and confidence through relatively less impactful disclosures. ● Openly provide an explanation for breaching confidentiality and support the client throughout the process. ● Limit disclosures to a “need to know” basis.
Empowering the client	<ul style="list-style-type: none"> ● As much as reasonably possible, involve the client in decision-making about the timing of the disclosure, what information is shared, and who to disclose to. ● Provide an opportunity for the minor client to disclose information to caregiver(s) themselves or to be present when the counseling practitioner makes the disclosure.
Supporting the family	<ul style="list-style-type: none"> ● Provide support to caregivers concerning the disclosure. ● Discuss and model appropriate ways to react to the minor’s disclosure.
Other	<ul style="list-style-type: none"> ● Seek out and receive supervision. ● Consult with trusted colleagues. ● Document the incident and decision-making process in detail.

Source: Adapted from Duncan, R., Hall, A., & Knowles, A. (2015). Ethical dilemmas of confidentiality with adolescent clients: Case studies from psychologists. *Ethics & Behavior, 25*, 197–221.

3. Review and identify applicable organizational policies and procedures.
4. Determine whether external consultation is required.
5. Document, in detail:
 - a. potential processes of action needed to make an ethical decision.
 - b. possible courses of action to resolve the situation.
6. Identify and analyze CRW factors in each process and decision from previous step. Subsequently, explicitly list CRW factor(s) that support or conflict with each action or decision, including corresponding ACA and ASCA ethical standards.
7. Select, record, and assess the course of action that best resolves the dilemma.

These steps may serve as an integrative framework and “flexible cognitive frame” (Luke et al., 2013b, p. 223) through which counselors can draw attention toward their own CRW beliefs and perspectives and how they converge with, and perhaps diverge with, the CRW factors of their clients and other stakeholders. This is especially important in litigious and political environments (Luke et al., 2017). For instance, counselors may encounter instances where “they are asked to provide information about and access to services for adoption or abortion; to negotiate decisions involving an awards committee, gender equity, and access to higher education; or to provide input on stakeholder policies based on knowledge accessed through PSC activities with students” (Luke et al., 2017, p. 3).

In Guided Exercise 2.7, reflect on your own values and ethical decision-making.

GUIDED EXERCISE 2.7

Counselor Competence and Ethical Decision-Making

- A. Identify a personal/moral dilemma you might encounter when working with a client and how you might navigate the situation. What are some measures you could take to bracket these biases and values so that they may not cause undue harm to the client and your continued practice as a counselor?
- B. Research indicates that upward of 50% of counselors fail to identify a potential ethical dilemma (Luke et al., 2013a), interfering with their ability to enact an ethical decision-making model. Often, the largest contributing factor interfering with such identification is that the counselor and client/family/parents/caregivers are operating from different CRW backgrounds. Identify one instance where this has occurred in your own experiences and respond to each of the following:
 - What were the CRW factors of the parent/caregiver?
 - What were the CRW factors related to yourself?
 - What were the CRW factors of the organization/institution in which you were working?

Draw a Venn Diagram that identifies CRW factors of each stakeholder and how they are distinct and where they might overlap.

SUPERVISION

As we have noted elsewhere in this chapter and is emphasized across other chapters within this book, counseling children and adolescents requires a specialized skill set and unique competencies. However, counselors often begin their work with children and adolescents with minimal education and training specific to this population. Supervision is key to learning effective strategies for working with this population. In addition, supervision can ensure professional gatekeeping and quality control over the counseling services provided.

Supervision can also help ameliorate the potential for emotional exhaustion, depersonalization, and burnout that frequently are associated with the delivery of intense and demanding

quality of care to children and adolescents. Given the growing use of telecounseling with children and adolescents across school and clinical contexts, it may be particularly important for counselors to access consultation and supervision of this work. In a recent study, Williams et al. (2019) examined the impact of a four-month reflective supervision training and found that participants found it “effective and impactful, especially the experiential components” (p. 158).

In Case Illustration 2.1, read the case of Mark, a counselor who faces an ethical dilemma while working with 11-year-old Josefina in group counseling. Consider ethical-decision making based on what you’ve learned in this chapter. Then, read the case navigation applying IMED.

CASE ILLUSTRATION 2.1

Putting It All Together

Mark has consistently received positive reviews from his clinical supervisor, who highlights his ability to establish positive working relationships with adolescent clients and their families and his strong connections to community organizations including the local interfaith counseling agency where he volunteers. Mark has organized and implemented several psychoeducational counseling groups for children and adolescents at the site. Accordingly, Mark facilitates an after school mixed-gender group for preteen clients aged 9–12 years focusing on identity development, values clarification, and communication skills.

Josefina is an 11-year-old Latinx sixth grade girl referred to individual counseling last year by her school counselor for symptoms of generalized anxiety. Josefina has responded well to individual counseling with another clinician named Tricia. Recently, Tricia recommended reduced frequency of individual counseling to every other week and for Josefina to add bimonthly group counseling in the off weeks. For the past two months, Josefina has attended Mark’s afterschool psychoeducational group that meets on the first and third Wednesday each month. Although Josefina’s mother Isa is supportive of her ongoing counseling, Josefina’s stepfather Manuel is not. Manuel is upset that the afterschool group interferes with Josefina participating in church-related activities on Wednesday.

In a recent group session, Josefina disclosed that she overheard her mother and stepfather arguing and she is worried that some of the conflict is because of her. Josefina shared her worry that her stepfather is taking out his anger on her mother and is considering dropping out of the afterschool group so she can attend church on Wednesday. Several group members validated Josefina’s experience of the parental conflict, while others challenged her proposed decision by saying that it was “sacrificing herself” and encouraging Josefina to “differentiate” her thinking from the “family scripts.” One group member offered to have his father speak to Josefina’s stepfather at church this coming Sunday.

Mark was tempted to intervene in the group during the exchange, but he was torn about how to do so. On one hand, Mark recognized the importance of church-related activities as formative in youth development while also respecting the stepfather as head of household, particularly in Latinx family dynamics. On the other hand, Mark was also aware that group members were appropriately applying many of the concepts from past group sessions as they interacted with Josefina. Mark has a potential ethical dilemma and must decide (a) how to address the situation within the group and (b) whether to discuss with Josefina’s mother within a parent consultation.

Case Navigation—Applying IMED

In alignment with the IMED (Luke et al., 2013a), Mark should first recognize CRW factors that are present. In Mark's case, it seems that he already recognizes that there are a number of ethical dilemmas present and simultaneously interacting CRW factors at play. Notably, (a) Josefina's considerable worry about her stepfather "taking out his anger" on her mother and (b) how Mark's religious affiliation, beliefs, and treatment goals may be affecting his work with Josefina. There seem to be other CRW factors that may be relevant, such as the counselor and/or client's gender, religious identification, culture, family role, diagnosis, dynamics of the psychoeducation group and individual backgrounds, and the small rural/regional contextual factors (e.g., dual relationships).

The second step of ethical decision-making model suggests that Mark should identify relevant CRW factors. In Josefina's case, she is experiencing internal and external (e.g., peers, caregivers) conflict regarding her continued participation in the afterschool psychoeducational group and its impact on her ability to attend church-related activities. In addition, the counselor's understanding of Latinx culture, gender, and family roles as well as his religious affiliation and beliefs may be diverging with those of Josefina and her family. The third step of the IMED indicates that Mark should identify relevant institutional policies and procedures. Mark should investigate Josefina's concern related to her stepfather taking out his anger on her mother and what this might mean because this information would have implications on how to proceed from a legal and ethical perspective. Mark would also need to determine what, if any, agency policies may relate to this case. For instance, his organization may have clearly articulated policies, procedures, or guidelines related to disclosure of information. Relatedly, state regulations and laws might provide detailed procedures to address specific issues that may be relevant after further information about the family circumstances is obtained.

The fourth step suggests that Mark should consult with cultural experts to ensure that he has clearly and accurately identified key CRW factors. Mark might communicate with Tricia, if releases have been signed, to identify how they might be able to individually or jointly approach the situation. He might also seek consultation from his clinical supervisor, consult with other mental health counselors and school counselors, child protective services, and culturally relevant resources (e.g., religious leaders, cultural center), as well as review the literature including Latinx culture, gender, and family roles; religion; and Association for Specialists in Group Work best practice documents (e.g., Best Practice Guidelines, Multicultural and Social Justice Competence Principles for Group Workers).

The fifth step of the IMED involves listing courses of action. In a group session, Mark might first acknowledge group participants' care and concern toward Josefina's situation. With concern for clinical and group development dynamics, Mark might facilitate a formal discussion about confidentiality and its limits, as well as the importance of the ground rule that *what is discussed in group should stay in the group*. Mark might try to speak with Josefina further to understand her situation and concern of her father "taking out his anger" on her mother. Depending on the content of the discussion, Mark might talk with Josefina about consulting with her mother. Mark might consult with his clinical supervisor about the various CRW factors present and about relevant agency protocols and procedures and decide on plans of action. Mark might consult relevant religious practitioners and cultural centers to gain insight of how his religious beliefs and understanding

may converge or diverge from that of Josefina and her family. If there is a signed release, Mark and Tricia might consider how to individually or jointly consult with Isa, with or without Josefina. Depending on the information obtained, Mark could consult with child protective services and then identify various ways in which he could work with the family to better support them.

The sixth step will involve Mark analyzing the relationship between potential courses of action and the consistency of each CRW factor. His analysis will require a careful examination and explication of possible CRW factors related to process actions at the agency, community, family, and individual levels and for him to label the full range of decisions involved, with corresponding ACA ethical standards. Importantly, Mark will first need to acquire more information before engaging in any decision-making. It is critical that Mark seek consultation and resources of multiple perspectives to appropriately determine the best course of action.

The last IMED step (Luke et al., 2013a) involves Mark selecting, documenting, and evaluating the course of action that best meets the needs of Josefina and her family within a cultural and religious context. After that has been completed, Mark may want to continue to follow-up with Josefina and her family intermittently even after the present situation is resolved.

Professional Development

Given that counseling practitioners work in a variety of settings that will require them to consult with clinicians from other helping professions around ethical issues, it's important to be

TABLE 2.4 ■ Professional Organizations' Ethical Codes and Position Statements

Organization	Code of Ethics	Position Statements
American Counseling Association (ACA)	https://www.counseling.org/knowledge-center/ethics/code-of-ethics-resources	—
Association for Child and Adolescent Counseling (ACAC)	—	http://acachild.org/resources/
American School Counselor Association (ASCA)	https://www.schoolcounselor.org/school-counselors-members/legal-ethical	https://www.schoolcounselor.org/school-counselors-members/publications/position-statements
American Psychological Association (APA)	https://www.apa.org/ethics/code/	https://www.apa.org/news/press/statements/
National Association of School Psychologists (NASP)	https://www.nasponline.org/standards-and-certification/professional-ethics	https://www.nasponline.org/research-and-policy/policy-priorities/position-statements
National Association of Social Workers (NASW)	https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English	https://www.socialworkers.org/Advocacy/Sign-On-Letters-Statements

aware of relevant professional organizations' codes of ethics. It is prudent of counselors to be well-acquainted with the ACA Code of Ethics (ACA, 2014) and the ASCA Ethical Standards for School Counselors (ASCA, 2016a) and also allied professions' code of ethics. Valuable resources are available from these organizations to help counselors navigate ethical issues. Below links are provided to relevant code of ethics and position statements from ACA, ACAC, ASCA, APA, and the National Association of School Psychologists (Table 2.4). Each organization also has state and provincial divisions to provide additional resources and state-level information. In Guided Exercise 2.8, explore ethical codes of different professional organizations and working together with other mental health professionals.

GUIDED EXERCISE 2.8

Professional Organizations

- A. Across work settings, professional counselors must often work directly and indirectly with professionals (e.g., social workers, psychologists) from other allied helping professions who are guided by different ethical codes and guidelines. Relatedly, institutional protocols and procedures may sometimes conflict with counselors' code of ethics. What are the potential implications of navigating ethical issues (e.g., breaking confidentiality, boundary issues) when working with other helping professionals? How might you navigate situations where there is a conflict between your code of ethics and institutional policies and procedures?
- B. You are coleading a parenting group with a clinical psychologist. The five-session closed psychoeducation group is composed of three sets of parents (six people) of elementary age children. In between the second and third sessions, you and your coleader are discussing group dynamics and developing ideas on how to approach parent members about diagnosis. As a professional counselor, you are drawing on your understanding of your role in a preventive, developmental, and strength-oriented profession. As a clinical psychologist, your coleader is approaching this more from a medical model perspective. How might you collaboratively approach differing perspectives in the preparation of broaching the conversation of diagnosis in the context of this psychoeducational intervention for parents? What are the pros/cons of each potential course of action?

COUNSELING KEYSTONES

- Counseling children and adolescents is a distinct specialty area, and counselors should be knowledgeable of the broad range of capacities of children (e.g., age, psychological maturity) and determine developmentally appropriate, case-specific interventions.
- HIPAA and FERPA are the two federal statutes associated with minor clients' privacy. FERPA protects the privacy of minor clients' educational records, while HIPAA primarily deals with PHI.

- Counselors should be familiar with legal statutes and ethical considerations associated with child custody and parental rights, as well as maintain knowledge of court terminology and procedures.
- An effective, competent, and socially just counselor recognizes that CRW factors are embedded in all ethical dilemmas and therefore seek out relevant information including resources, consultation and supervision, policies and procedures, ethical standards, and legislation.
- Counselors should gain minor client's assent to treatment and respect the confidential nature of the therapeutic relationship, while also recognizing that caregivers have legal rights to counseling information.
- Counselors should familiarize themselves with their state's laws and institution's policies regarding bullying and cyberbullying and provide education to clients and stakeholders about navigating these issues in various settings (e.g., school, online).
- In most states and jurisdictions, professional counselors are designated as MRs. If child abuse or neglect is suspected, the counselor should make a report.
- When issues of confidentiality arise, professional counselors are aware that confidentiality decision-making options exist on a continuum, ranging from full confidentiality being maintained to disclosure of information without the child's consent or knowledge. As such, clinicians should employ interventions that seek to minimize potential harm when breaching confidentiality.
- It is counselors' responsibility to advocate with and on behalf of children and adolescent clients and position themselves as change agents to tackle issues of discrimination and oppression that clients might experience as a result of their sexual orientation, race/ethnicity, and other individual and cultural differences.

ADDITIONAL RESOURCES

In Print

Adkison-Johnson, C., Terpstra, J., Burgos, J., & Payne, E. (2016). African American child discipline: Differences between mothers and fathers. *Family Court Review, 54*, 203–220.

Barrett, K., Lester, S., & Durham, J. (2011). Child maltreatment and the advocacy role of professional school counselors. *Journal for Social Action in Counseling & Psychology, 3*, 86–103.

Beck, M., Rausch, M., & Wood, S. (2014). Developing the fearless school counselor ally and advocate for LGBTQIQ youth: Strategies for preparation programs. *Journal of LGBT Issues in Counseling, 8*, 361–375.

Brown, T., Armstrong, S., Bore, S., & Simpson, C. (2017). Using an ethical decision-making model to address ethical dilemmas in school counseling. *Journal of School Counseling, 15*, 1–30.

Clark, B., Canadian Paediatric Society, & Mental Health and Developmental Disabilities Committee. (2013). Supporting the mental health of children and youth of separating parents. *Paediatrics & Child Health, 18*, 373–377.

De Riggi, M., Moumne, S., Heath, N., & Lewis, S. (2017). Non-suicidal self-injury in our schools: A review and research-informed guidelines for school mental health professionals. *Canadian Journal of School Psychology, 32*, 122–143.

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Center on Children and the Law: https://www.americanbar.org/groups/public_interest/child_law/

Center for Law and Education: <https://www.cleweb.org>

Center for Parent Information & Resources: <https://www.parentcenterhub.org/schoolage/>

Child Welfare Information Gateway: <https://www.childwelfare.gov>

- Children's Defense Fund: <https://www.childrensdefense.org>
- Children's Rights Council: <https://www.crckids.org>
- Council for Exceptional Children: <https://www.cec.sped.org>
- Crimes Against Children Research Center: <http://unh.edu/ccrc/>
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- FindLaw: <https://family.findlaw.com/child-custody.html>
- Futures Without Violence: <https://www.futureswithoutviolence.org>
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- National Center for Learning Disabilities: <https://www.nclld.org>
- National Center for Missing & Exploited Children: <https://www.missingkids.org/home>
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- UK Safer Internet Centre: <https://www.saferinternet.org.uk/advice-centre/teachers-and-school-staff/teaching-resources/sexting-resources>
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- Unaccompanied Alien Children Information: <https://www.hhs.gov/programs/social-services/unaccompanied-alien-children/index.html>
- U.S. Department of Justice
- Child Exploitation and Obscenity: <https://www.justice.gov/criminal-ceos>
- Office of Juvenile Justice and Delinquency Prevention: <https://ojjdp.ojp.gov>

Youth.gov: <https://youth.gov>

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