

## Legal and Ethical Implications of Working with Minors in Alabama: Consent and Confidentiality

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### Abstract

Until recently, there has been little guidance in the professional literature with respect to counseling minors outside of the school setting. Although most authors suggest referring to state statutes for legal limits of counseling practice, little research exists describing these requirements in Alabama. The purpose of this literature and statutory review is to increase school and mental health counselors' awareness of accepted practice and the possible legal limitations of working with minors in the State of Alabama.

Ethics refers to decisions of a moral nature about people and their interaction in society (Kitchener, 1986). Needs to be added to the references. Law refers to legal standards for behavior developed by legislators and interpreted by judges (Remley, Hermann, & Huey, 2003). Needs to be added to the references As most counselors know, sometimes the distinctions between these two, as well as their relationship to each other, are ambiguous. Until recently, there has been little guidance in the professional literature with respect to counseling minors outside of the school setting. Lawrence and Kurpius (2000) found little research or professional literature concerning appropriate legal and ethical procedures for service provision to minors in the community agency setting. In fact, their exploration of the *Journal of Counseling and Development* between 1995 and 2000 failed to discover any articles on this subject. A subsequent search of available databases for relevant articles from 2000 to 2008 produced similar results. The purpose of this literature and statutory review is to increase school and mental health counselors' awareness of accepted practice within the profession and the possible legal limitations of working with minors in the State of Alabama.

### Models for Ethical Practice

A number of authors have provided general guidelines that are useful in understanding the issues of counselor competence, confidentiality, parental rights, record keeping, collaboration, touch, and multicultural approaches in working with this population (Bergin, Hatch, & Hermann, 2004; Lawrence & Kurpius, 2000; Sori & Hecker, 2006; Stone, 2005). Specifically, Lawrence and Kurpius (2000) propose the following seven best practices in working with minors: (1) practice within the educational, training, and supervisory limits of your abilities; (2) be familiar with state statutes; (3) a written statement of policies concerning confidentiality should be discussed with both parents and child at the outset of the counseling relationship; (4) acquire written informed assent from minor clients if choosing not to gain parental consent for treatment; (5) keep precise records of all counseling sessions; (6) maintain adequate liability insurance; and (7) collaborate with colleagues or obtain legal counsel if uncertain as to the proper course of action.

Similarly, Stone (2005) describes the STEPS model for ethical decision making for school counselors that includes the following: (1) Define the problem emotionally and intellectually; (2) Review pertinent codes and laws; (3) Consider client's chronological and developmental levels; (3) Consider setting, and rights of both parents and minors; (4) Apply moral principles; (5) Identify possible actions and their consequences; (6) Evaluate the possibilities; (7) Consult with knowledgeable colleagues; (8) Implement plan and evaluate outcomes.

Models for ethical practice such as these two provide some guidance for counselors who are uncertain about what course of action to take when working with minors. Following such guidelines is consistent with what Reamer (2005) refers to as procedural standard of care – the way an ordinary, reasonable, and prudent professional would act under the same or similar circumstances. Failure to maintain accepted standards of care may represent unethical behavior and establish liability for malpractice. In addition to the practices mentioned by Lawrence and Kurpius (2000) and Stone (2005), Reamer (2003) suggests that professionals should document their decision-making steps. In the following sections, specific ethical and legal issues will be presented along with guidance from the field about how to respond. We encourage you to think through the issues presented using the suggestions of one or more of the authors above as a framework to guide your own decision-making.

### Common Dilemmas

#### Consent and Assent

In the State of Alabama, the age of majority is designated as 19 years (Alabama Code § 26-1-1, 1975). However, in working with minors in a clinical setting, Alabama Code, Section 22-8-6 (1971) states

“Any minor may give effective consent for any legally authorized medical, health or mental health services to determine the presence of, or to treat, pregnancy, venereal disease, drug dependency, alcohol toxicity or any reportable disease, and the consent of no other person shall be deemed necessary.” (p. 3681)

Furthermore, Section 22-8-7 (1971) protects mental health professionals who act in good faith to assist a minor client “who professes to be, but is not, a minor whose consent alone is effective to medical, dental, health or mental health services...” and as such, the mental health counselor “shall not be liable for not having consent” (p. 3681).

The *ACA 2005 Code of Ethics* (Code), in relation to confidentiality, states in Section A.2.d that counselors acknowledge “the need 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.” (p.?) The Code further states in Section B.5.b that “Counselors inform parents and legal guardians about the role of counselors and the confidential nature of the counseling relationship” and to be “sensitive to the cultural diversity of families and respect the inherent rights and responsibilities of parents/ guardians over the welfare of their children/charges according to law.” (p. ?) As such, counselors should work to establish collaborative relationships with parents or guardians when possible.

Relying on ACA, the American School Counselor Association (ASCA), and the Association of Specialists in Group Work (ASGW) ethical standards as well as legal precedent, Bergin et al. (2004) discuss the issue of informed consent as it relates to minors within the school setting. They suggest that at the beginning of the academic year, schools should notify parents as to the existence of school counseling services provided to their children. Parents should then be instructed to contact the school in writing if they do not wish for their child to participate in counseling sessions. However, before counseling groups are initiated concerning sensitive topics (e.g., divorce, substance abuse, risky sexual behaviors, etc.); the counselor must gain permission from the parents or guardians. If there is joint custody in the case of divorce, both parents must be notified. The counselor should then directly contact each parent by phone, inform them that their child is enrolled in a counseling group, and gain both verbal and later written approval for the child’s participation (Bergin et al.).

Salo and Shumate (1993) found that few states have passed laws requiring parental or guardian consent prior to initiating a counseling relationship with a minor in either the school or community agency setting. However, the counselor must be aware of the expected community standards of behavior or applicable school board policies (Ledyard, 1998). If the minor client is unable to give consent, the counselor should clarify the therapeutic process and attempt to protect his or her best interest (Ledyard, 1998).

Furthermore, it is the counselor's ethical responsibility to include the client in the decision to release information, or informed assent, whenever possible (Herlihy & Corey, 1996). Presenting feedback on a child's progress in therapy is expected but may be performed without divulging specific content of sessions (Corey, Corey, & Callanan, 2007). Lawrence and Kurpius (2000) state that "minors over the age of 7 years can give informed assent to be involved in counseling or research. Although this is not legally recognized, it demonstrates respect for the minor and signals that the minor has agreed to participate" (p. 134). Likewise, the Association of Specialists in Group Work (ASGW) *Best Practices Guidelines* (1998), Section A.7.c., requests that group workers "obtain the appropriate consent/assent forms with minors and other dependent group members."

### Confidentiality

Confidentiality is another issue that lacks clarity when counseling with minors. Salo and Shumate (1993) state that courts have generally ruled that the privacy rights of minors are an extension of parental privacy rights and therefore counselors have legal obligations to the parent or guardian. Additionally, most legal jurisdictions do not consider minors to have the ability to give informed consent (Ledyard, 1998) and as such, the issue of gaining children's consent prior to treatment is seldom considered (Hall & Lin, 1995). Therefore, Lawrence and Kurpius (2000) suggest inclusion of the parents during the first meeting to clarify boundaries concerning the sharing of information and to build trust with all parties. Stein (as cited in Lawrence and Kurpius, 2000) also suggests that in instances of divorce, failure to obtain consent from the custodial parent may be grounds for malpractice. The Code of Ethics of the American Mental Health Counselors Association (AMHCA) (AMHCA, 2005) defines and describes the limits of confidentiality in Principle 3. In working with minors, a counselor is obligated to report cases of child abuse but otherwise may include the parent or guardian in the counseling process as appropriate while taking "measures to safeguard the client's confidentiality" (p. ?). Additionally, Section J states that recording sessions with minors may only occur "with their written permission or the written permission of a responsible guardian" (p.?) and "[e]ven with a guardian's written consent, one should not record a session against the expressed wishes of a client." (p. ?)

The limits of confidentiality were largely defined in the context of a landmark legal case, *Tarasoff v Regents of the University of California* (1976). Needs to be added to the references. During a counseling session, a graduate student at the University of California at Berkeley disclosed to his therapist his intent to kill his girlfriend upon her return to campus. Although the therapist contacted the campus police and his supervisor, he did not attempt to notify the girlfriend, Tatiana Tarasoff, as to the threat. As a result of her subsequent death, the court ruled in *Tarasoff* that failure to warn or protect a third party of a specific threat with intent may be grounds for liability. As a result, counselors must explain the limits of confidentiality during the initial session and that confidentiality will be breached if clients threaten to harm others, themselves, or property (Lawrence & Kurpius, 2000).

In their discussion of parental demands for confidential information exchanged during counseling with minor clients, Mitchell, Disque, and Robertson (2002) state that the law and ethical codes concur in that confidentiality should be broken in suspected cases of child abuse, attempted suicide, and where danger to others is imminent. Professionals who work with minors (i.e., teachers, administrators, social workers, school psychologists, and counselors) are required by law to report instances of abuse in order to protect the safety of children. When information that leads one to suspect abuse is disclosed during a counseling session, counselors who are uncertain about their obligations to report should consult with colleagues and attain legal advice when such instances occur (Lawrence & Kurpius, 2000). If another professional's behavior places a child at risk for harm or exploitation, breaking confidentiality may be necessary to prevent further injury (Pomerantz, Santanello, & Kirn, 2006).

In addition to abuse and other types of harm, sexual harassment is a form of discrimination from which minors are entitled to equal protection. The decision in *Oona R. S. v. McCaffery* (1997) Needs to be added to the references. held school officials, including school counselors, liable for failure to act in instances of sexual harassment (Linn & Fua, 1999). As all schools are required by federal law to appoint an official to

attend to sex equity issues under Title IX of the of the Education Amendments of 1972, now known as the Patsy T. Mink Equal Opportunity in Education Act, consultation with the coordinator may help to clarify questionable instances.

According to the National Institute of Mental Health (NIMH, n. d.) suicide was the third leading cause of death of children ages 10 to 14 and adolescents ages 15 to 19 in 2004. Using data from the National Longitudinal Study of Adolescent Health, Pirkis et al. (2003) found that less than one third (28%) of adolescents who report suicidal ideation receive counseling, however, and that those who did were most likely to be treated by private doctors (37%) and schools (34%). However, the risk of suicide can be reduced when therapists focus on adolescents' level of hopelessness, hostility, negative self-concept, and isolation (Rutter & Behrendt, 2004).

In recent years, an increase in incidents of self-injurious behaviors among youth have led to counselor reassessment of "harm-to-self" which had most often been interpreted as threats of suicide or the presence of suicidal ideation. Determining disclosure of confidential information concerning a minor client who self-mutilates may be difficult, as the counselor risks further alienating the child by violating his or her trust (Froeschle & Moyer, 2004). Encouraging clients to share critical information with parents presents an opportunity to teach appropriate communication between the client and parents in a collaborative approach to therapy. If the client refuses to disclose or poses a risk to self, such as presenting with psychotic forms of mutilation (cutting of the arms, legs, or other area as a means of coping with stress, as opposed to body piercings of the ear, nose, brow, navel, etc.), counselor disclosure may be appropriate (Froeschle & Moyer, 2004) or mandated by law in certain states.

Additionally, instances of substance abuse and risky sexual behavior may represent a threat for short - or long-term self-harm. The 2003 National Youth Risk Surveillance Survey (YRSS) of the Centers for Disease Control (as cited in Bartlett, Holditch-Davis, and Belyea, 2007) reported 28% of adolescents age 10-24 participated in heavy episodic drinking in the previous month while 4% reported sniffing or inhaling an intoxicating substance. The CDC also found that 31% of sexually active males did not use a condom and 79% of females did not use birth control pills prior to intercourse. These findings support a previous 1997 study by the National Institute for Alcohol Abuse and Alcoholism, that alcohol abuse places adolescents at risk for school problems, risky sexual behaviors, and criminal behavior (as cited in Bartlett et al.). As a minor may be hesitant to discuss sexual issues if there is the possibility of disclosure to parents or guardians, the counselor should set clear boundaries, cover informed consent, limits of confidentiality, and consult with other professionals as needed (Herring, 2001). Houston-Vega and Neuhring (as cited in Herring, 2001) note that commonly as the courts have not applied duty-to-warn standards in the case of risk of HIV transmittal to partners, the counselor may employ one of several approaches, including discussion of confidentiality-related HIV policies prior to treatment; the transmittal risks involved with specific sexual or drug practices; discussion of specific issues relating to HIV as they arise; offering to speak with the client's partner(s); and awareness of current legal statutes. In the school setting,

Stone (2002) suggests that counselors consider the age and maturity of the student and the student's decision-making ability when discussing sensitive subjects such as pregnancy. For example, if there are no specific policies forbidding the discussion of abortion, counselors must make use their professional judgment about doing so based on their knowledge of the client. In relation to this subject, the Alabama Statutes, Section 26-21-3 (1987), state that "Except as otherwise provided. . .no person shall perform an abortion upon an unemancipated minor unless he or his agent first obtains the written consent of either parent or the legal guardian of the minor" (p. 397). However, the statute further holds that if either or both parents or legal guardian is unavailable or refuses consent, a minor may "petition, on her own behalf, the juvenile court, or court of equal standing, in the county in which the minor resides or in the county in which the abortion is to be performed for a waiver of the consent requirement" following the procedures outlined in Section 26-21-4 (1987, p. 397). Therefore, informing a minor client of her rights to seek treatment or diagnosis of pregnancy as outlined above in Section 22-8-6 (1971) and her right to petition as outlined in Sections 26-21-3 (1987) and 26-21-4 (1987) might be discussed in counseling.

## HIPAA and FERPA Requirements

### Case Notes

As noted by Reamer (2005), Health Insurance Portability and Accountability Act (HIPAA) regulations define psychotherapy notes as any recorded medium by which a mental health professional documents “the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record” (p. 117), excluding session duration, symptoms, client summary of diagnosis, prognosis, treatment modalities and plans, prescriptions, and progress.

In order to define the rights of parents and students regarding educational records, in 1974 Congress passed the Family Education Rights and Privacy Act (FERPA), also referred to as the Buckley Amendment. Needs to be in references. However, Fischer and Sorenson noted, (as cited in Merlone, 2005), counselors’ personal files are not considered to be part of the student record if they are not made available to others and are not stored with the students’ permanent records. Sorenson and Chapman (as cited in Merlone, 2005) caution that once personal notes are shared with anyone, however, they are no longer considered private and must be disclosed to parents if requested.

The U. S. Department of Education further clarified this issue in a manual entitled *Protecting the Privacy of Student Records* Needs to be in records. which states that handwritten notes by a counselor, teacher, or administrator concerning a student are not considered to be educational records under FERPA and are not bound by the rules of disclosure (Cheung, Clements, & Pechman, as cited in Merlone, 2005). Swanson (as cited in Merlone, 2005), cautions that although counseling notes are not educational records, they are open to subpoena and as such should include only necessary information and should be written in behavioral terms. Merlone further cites the American School Counseling Association (ASCA, year ?), Myrick, and Swanson that counselors have successfully protected student confidentiality by testifying that the record is hearsay, that there is no proof supporting the testimony and, therefore, the testimony has no legal validity.

### Conclusions

Entering into counseling relationships with minor clients presents counselors with unique challenges, particularly in relation to consent, assent, and confidentiality. The minor’s legal right to participate in counseling is not always clear, particularly outside of the school setting, and counselors are advised to seek parental or guardian consent as well as the assent of the minor client. Because the very act of gaining consent from parents or guardians means that the counseling relationship is not confidential, issues of confidentiality become paramount. Minor clients should be advised in advance of counseling the limits placed on their privacy. Parental requests for information, suspicions of abuse or neglect, intention to harm self or others, and other types of risky behavior may result in the sharing of information by the counselor to others who are charged with protecting the minor client’s welfare.

In many instances, the counselors of minor clients must make decisions about disclosing client information to others. Some circumstances are clear and demand decisive and immediate action (e.g. mandatory reporting of suspicion of child abuse). Others are less clear (e.g. risky sexual behavior) and require that counselors make judgments about what constitutes risk to a minor client. In the absence of clear guidelines, counselors are encouraged to use a model such as the ones proposed by Lawrence and Kurpius (2000) or Stone (2005) to guide them in making decisions and taking actions that would be viewed by other reasonable, well-trained counselors as the appropriate thing to do.

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