ETHICAL & LEGAL CONSIDERATIONS WHEN COUNSELING TEENS

Presented by David Flack, MA, LMHC, SUDP
Email: david@davidflack.com • Phone: (206) 327-4478 • Web: www.davidflack.com

BASIC LEGAL REQUIREMENTS

In your group, discuss the legal requirements regarding the following topics. You may notice this list doesn't include anything about consent or confidentiality. Don't worry. We'll definitely be talking about those topics today!

Mandated reporting

Basic licensing requirements for providing mental health services in Washington

Supervision requirements for your license (LMHC, LMFT, LICSW, associate)

Counselor disclosure

Online or telehealth counseling

Documentation of sessions and other client interactions

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CASE STUDY: MARIA

Maria is a 14 year old female living with her maternal grandparents. Her grandmother, Dolores, brought her to the intake session. During the intake, Maria barely spoke. Dolores, though, was quite talkative – appearing exhausted, frustrated and genuinely worried about her granddaughter's behavior.

Dolores reported, "I'm pretty sure she's using drugs, but I have no idea where she gets them." She also reported that Maria recently ran away for three nights and "won't say where she was or what she was doing." Dolores said this was "the last straw" – following a year of angry outbursts, frequent arguments, declining grades and "a few brushes with the law."

You encouraged Maria to talk more, but all she did was shrug her shoulders and repeat, "I don't know" or "This is stupid." However, she did sign your informed consent form and agreed to attend counseling "if it will shut my stupid grandmother up."

The next week, Maria returned alone for her first appointment and seemed more willing to engage. She stated she ran away because, "Home sucks. All I do it take care of my little sister, go to school and get in trouble for no reason."

As Maria talked about her home life, her frustration was quite apparent. She fidgeted, her speech appeared forced at times and her expression turned into an obvious scowl. When asked about coping strategies for her anger, she said, "Nothing! My grandparents won't let me leave the house or call my friends or anything! I hate them."

Maria paused for a moment and then asked, "Everything we talk about is confidential, right?" After reviewing confidentiality rules and exceptions, Maria said, "Sometimes when I'm really angry I cut." She reported cutting once or twice a month, always places it wouldn't be visible and "never that deep." She also said she was "absolutely sure" her grandparents didn't know about her cutting.

What ethical or legal concerns do you have about this case?

Three weeks later, Dolores contacts you, stating she found marijuana and a razor in Maria's bedroom, expressing concerns about drug use and possible self-harm. How do you respond?

Discuss your personal beliefs about working with teens engaged in potentially dangerous or harmful behaviors – such as substance use, self-harming or commercial sex. What are some ways that legal requirements, ethical considerations and your personal beliefs may conflict?

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ONLINE COUNSELING

In what ways might the following ACA Principles support – or argue against – conducting teletherapy with teens?

Autonomy

Beneficence

Non-maleficence

Fidelity

Justice

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CASE STUDY: JOHN

John is a 16-year-old male with a diagnosis of Major Depressive Disorder, Attention Deficit Hyperactivity Disorder (combined type), and Oppositional Defiant Disorder. He lives with his mother, father, and two younger siblings. His parents are fairly conservative Christians. In an early session, John reported, "I don't believe all that religion stuff, but my parents sure do."

According to his parents, John has a long pattern of school-related problems, such as not completing homework and skipping "boring classes." His parents also reported a history of "sneaky behavior" and "breaking the house rules."

You've been meeting with John for about five months and currently see him weekly for individual sessions. John lives within walking distance of your office and is responsible for getting himself to appointments. Although appropriately engaged, he has never been especially open or active during sessions.

Early on, John missed several appointments. At the time this was the topic of a rather emotional family session where his parents stated if he missed any further appointments they would send him to a "Christian boarding school." After this, John's attendance improved significantly. However, he's now missed his last two individual sessions.

When you called John on his personal cell phone, he promised to appear for a rescheduled session later that week. He attended as promised, but during it asked, "Can you not tell my parents about those missed appointments? I know they'll be pissed at me. If you don't tell them, I absolutely will not miss anything ever again!"

In the course of this session, John disclosed for the first time that he's gay. He stated there is "no way" his parents would be accepting of this. Based on comments they've previously made, you believe this is likely correct. John also reported he skipped the recent sessions to "hook up with an older guy." When you asked him to clarify, he said he was unwilling to give you "any more details that might get me in trouble."

What ethical or legal concerns do you have about this case?

What are some ideas for addressing these concerns?

How would you respond to John's disclosure regarding *the older guy*?

What challenges might exist for you in working with LGBTQ+ teens? What steps could you take to ethically resolve these challenges?

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SCOPE OF COMPETENCE

Would you consider yourself a *generalist* or a *specialist*? In what ways does this affect your clinical practice?

What areas of clinical practice are well within your scope of competence?

What areas of clinical practice are outside your scope of competence?

What – if any – aspects of Maria's or John's case could lead to challenges regarding your scope of competence? In what ways could you ethically address these challenges?

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CASE STUDY: ANDREW

Andrew never knew his father. Then, at age four he witnessed the death of his mother from an overdose. They were living in a car at the time. With no family members willing to take him in, Andrew entered foster care. Between the ages of four and fifteen, he had nearly a dozen placements. With each move, his behavior became more problematic – including oppositional behavior, angry outbursts, and stealing.

At nine, Andrew started drinking alcohol. By eleven, he was using alcohol and marijuana regularly. At fourteen, he discovered meth and went to inpatient. He ran after three days, later reporting, "Inpatient was stupid. I had to go to my room at, like, 9:00pm and couldn't have any books or music, at least not anything I wanted. Just stupid crap like rainforest sounds. So, I'd just lay there, not sleeping, because nobody goes to sleep that early, and think about stuff. If I didn't leave, I would've gone nuts."

Following inpatient, Andrew's substance use and behavioral issues continued to increase. By sixteen, he was on probation and had moved into a transitional living program after several months on the streets. He reported his drug of choice was meth and he used "something" every day. "Meth if I can get it, but other things, too... Ritalin, coke, crack. Or just drinking or smoking weed. I'm not that picky."

At intake, Andrew met the DSM-5 criteria for alcohol use severe, amphetamine use severe, cannabis use severe, and cocaine use moderate. He also had a long list of pre-existing mental health diagnoses that included PTSD, ADHD, conduct disorder, and major depressive disorder.

Andrew reported a desire to stop using amphetamines, cocaine, alcohol, and heroin. "Those things are messing up my life!" However, despite possible legal consequences, he reported no desire to stop using marijuana. "It's my life. People should just leave me alone. Besides, weed is pretty much the only thing I've got... My friends have ditched me. My family wants nothing to do with me. Why stop?"

Andrew repeatedly stated that he didn't think treatment was necessary, but at the end of the intake session agreed to enter services. "I gotta do it or I'm going to juvie and I don't want that. Besides living on the street isn't really that great, I guess."

What ethical or legal concerns do you have about this case?

What are some ideas for addressing these concerns?

With resistant, mandated clients like Andrew, it can be challenging to fully embrace the ACA Principles of autonomy, beneficence, non-maleficence, fidelity and justice. What steps could you take to help assure this happens?

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